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May 2016

MEDICARE FEE-FOR-SERVICE

Opportunities Remain to Improve Appeals Process

Accessible Version

GAO-16-366

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GAO Highlights

Highlights of GAO-16-366, a report to congressional requesters

Why GAO Did This Study

In fiscal year 2014, Medicare processed 1.2 billion FFS claims submitted by providers on behalf of beneficiaries. When Medicare denies or reduces payment for a claim or a portion of a claim, providers, beneficiaries, and others may appeal these decisions through Medicare's appeals process.

In recent years there have been increases in the number of filed and backlogged appeals (i.e., pending appeals that remain undecided after statutory time frames). GAO was asked to examine Levels 1 through 4 of Medicare's appeals process. This report examines (1) trends in appeals for fiscal years 2010 through 2014, (2) data HHS uses to monitor the appeals process, and (3) HHS efforts to reduce the number of appeals filed and backlogged. GAO analyzed data from the three data systems used to monitor appeals, reviewed relevant HHS agency documentation and policies, federal internal control standards, and interviewed HHS agency officials and others.

What GAO Recommends

GAO recommends that HHS take four actions, including improving the completeness and consistency of the data used by HHS to monitor appeals and implementing a more efficient method of handling appeals associated with repetitious claims. HHS generally agreed with four of GAO's recommendations, and disagreed with a fifth recommendation, citing potential unintended consequences. GAO agrees and has dropped that recommendation.

View GAO-16-366. For more information, contact Kathleen King at (202) 512-7114 or kingk@gao.gov.

What GAO Found

The appeals process for Medicare fee-for-service (FFS) claims consists of four administrative levels of review within the Department of Health and Human Services (HHS), and a fifth level in which appeals are reviewed by federal courts. Appeals are generally reviewed by each level sequentially, as appellants may appeal a decision to the next level depending on the prior outcome. Under the administrative process, separate appeals bodies review appeals and issue decisions under time limits established by law, which can vary by level. From fiscal years 2010 and 2014, the total number of filed appeals at Levels 1 through 4 of Medicare's FFS appeals process increased significantly but varied by level. Level 3 experienced the largest rate of increase in appeals—from 41,733 to 432,534 appeals (936 percent)—during this period. A significant portion of the increase was driven by appeals of hospital and other inpatient stays, which increased from 12,938 to 275,791 appeals (over 2,000 percent) at Level 3. HHS attributed the growth in appeals to its increased program integrity efforts and a greater propensity of providers to appeal claims, among other things. GAO also found that the number of appeal decisions issued after statutory time frames generally increased during this time, with the largest increase in and largest proportion of late decisions occurring at appeal Levels 3 and 4. For example, in fiscal year 2014, 96 percent of Level 3 decisions were issued after the general 90-day statutory time frame for Level 3.

The Centers for Medicare & Medicaid Services (CMS) and two other components within HHS that are part of the Medicare appeals process use data collected in three appeal data systems—such as the date when the appeal was filed, the type of service or claim appealed, and the length of time taken to issue appeal decisions—to monitor the Medicare appeals process. However, these systems do not collect other data that HHS agencies could use to monitor important appeal trends, such as information related to the reasons for Level 3 decisions and the actual amount of Medicare reimbursement at issue. GAO also found variation in how appeals bodies record decisions across the three systems, including the use of different categories to track the type of Medicare service at issue in the appeal. Absent more complete and consistent appeals data, HHS's ability to monitor emerging trends in appeals is limited and is inconsistent with federal internal control standards that require agencies to run and control agency operations using relevant, reliable, and timely information.

HHS agencies have taken several actions aimed at reducing the total number of Medicare appeals filed and the current appeals backlog. For example, in 2014, CMS agreed to pay a portion of the payable amount for certain denied hospital claims on the condition that pending appeals associated with those claims were withdrawn and rights to future appeals of them waived. However, despite this and other actions taken by HHS agencies, the Medicare appeals backlog continues to grow at a rate that outpaces the adjudication process and will likely persist. Further, HHS efforts do not address inefficiencies regarding the way appeals of certain repetitious claims—such as claims for monthly oxygen equipment rentals—are adjudicated, which is inconsistent with federal internal control standards. Under the current process, if the initial claim is reversed in favor of the appellant, the decision generally cannot be applied to the other related claims. As a result, more appeals must go through the appeals process.

Contents

Letter 1

Background 5
Medicare Appeals and Untimely Appeal Decisions Increased from Fiscal Years 2010 through 2014 11
Data Systems Used by HHS to Monitor Appeals Process Do Not Capture Data to Identify Important Trends or Provide Consistent Data for Monitoring Appeals across Levels 25
Despite HHS Actions, the Appeals Backlog and Inefficiencies Related to Certain Repetitive Claims Remain 32
Conclusions 41
Recommendations for Executive Action 42
Agency Comments and Our Evaluation 42

Appendix I: Scope and Methodology 44

Appendix II: Medicare Fee-for-Service Appeals Filed and Decided, Fiscal Years 2010 to 2014 59

Appendix III: Medicare Fee-for-Service Appeal Reversal Rates, Fiscal Years 2010 to 2014 63

Appendix IV: Legislative Proposals Included in the President's Fiscal Year 2017 Budget Related to the Medicare Fee-for-Service Administrative Appeals Process 74

Appendix V: Comments from the Department of Health and Human Services 76

Appendix VI: GAO Contact and Staff Acknowledgments 81

Appendix VII: Accessible Data 82

Agency Comment Letter 82
Data Tables 88

Tables

Table 1: Medicare Fee-for-Service (FFS) Administrative Appeals Process 7
Table 2: Department of Health and Human Services' (HHS) Medicare Fee-for-Service Appeals Data Systems 11
Table 3: Medicare Fee-for-Service Appeals Filed and Percentage Growth in Appeals, Fiscal Years 2010-2014 12
Table 4: Quarterly Minimum and Maximum Percentage of Level 1 Medicare Fee-for-Service Appealed Claim Decisions

Issued After the Statutory Time Frame, by Type of Service, Fiscal Years 2010-2014 17
Table 5: Annual Budget for the Office of Medicare Hearings and Appeals (OMHA) and the Departmental Appeals Board (DAB), Fiscal Years 2010-2016 20
Table 6: GAO Estimate of Pending Medicare Fee-for-Service Appeals at Levels 3 and 4 Resolved by the Centers for Medicare & Medicaid Services (CMS) Global Settlement 36
Table 7: Data Sources Analyzed 44
Table 8: Crosswalk of Service Subcategories for Level 1 Medicare Appeals System (MAS) 47
Table 9: Crosswalk of Service Subcategories for Levels 2 and 3 49
Table 10: Crosswalk of Service Subcategories for Level 4 53
Table 11: Level 1 Medicare Fee-for-Service Appeals Filed and Decided by Appeal Characteristics, Fiscal Years 2010-201459
Table 12: Level 2 Medicare Fee-for-Service Appeals Filed by Appeal Characteristics, Fiscal Years 2010-2014 60
Table 13: Level 3 Medicare Fee-for-Service Appeals Filed by Appeal Characteristics, Fiscal Years 2010-2014 61
Table 14: Level 4 Medicare Fee-for-Service Appeals Filed by Appeal Characteristics, Fiscal Years 2010-2014 62
Table 15: Level 1 Medicare Fee-for-Service Appeal Reversal Rates63
Table 16: Level 2 Medicare Fee-for-Service Appeal Reversal Rates66
Table 17: Level 3 Medicare Fee-for-Service Appeal Reversal Rates69
Table 18: Level 4 Medicare Fee-for-Service Appeal Reversal Rates72
Data Table for Figure 1: Level 3 Medicare Fee-for-Service Appeals Filed, by Type of Service, Fiscal Years 2010-201488
Data Table for Figure 2: Percentage of Level 2 through 4 Medicare Fee-for-Service Appeal Decisions Issued After Statutory Time Frames, Fiscal Years 2010-2014 88
Data Table for Figure 3: Percentage of Fully Reversed Medicare Fee-for-Service Appeals at Levels 1, 2, and 3, Fiscal Years 2010-2014 88
Data Table for Figure 4: Percentage of Fully Reversed Medicare Fee-for-Service Appeals at Levels 1, 2, and 3, by Type of Service, Fiscal Years 2010-2014 89

Figures

Figure 1: Level 3 Medicare Fee-for-Service Appeals Filed, by Type of Service, Fiscal Years 2010-2014 14
Figure 2: Percentage of Level 2 through 4 Medicare Fee-for-Service Appeal Decisions Issued After Statutory Time Frames, Fiscal Years 2010-2014 19
Figure 3: Percentage of Fully Reversed Medicare Fee-for-Service Appeals at Levels 1, 2, and 3, Fiscal Years 2010-2014 22
Figure 4: Percentage of Fully Reversed Medicare Fee-for-Service Appeals at Levels 1, 2, and 3, by Type of Service, Fiscal Years 2010-2014 24

Abbreviations

ALJ	Administrative Law Judge
CMS	Centers for Medicare & Medicaid Services
CROWD	Contractor Reporting of Operational and Workload Data
DAB	Departmental Appeals Board
DMEPOS	durable medical equipment, prosthetics, orthotics, and supplies
ECAPE	Electronic Case Adjudication and Processing Environment
FFS	fee-for-service
HHS	Department of Health and Human Services
HIGLAS	Healthcare Integrated General Ledger Accounting System
LCD	local coverage determination
MAC	Medicare Administrative Contractor
MAS	Medicare Appeals System
MODACTS	Medicare Operations Division Automated Case Tracking System
OIG	Office of Inspector General
OMHA	Office of Medicare Hearings and Appeals
QIC	Qualified Independent Contractor
RA	Recovery Auditor

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U.S. GOVERNMENT ACCOUNTABILITY OFFICE

441 G St. N.W.
Washington, DC 20548

May 10, 2016

The Honorable Orrin G. Hatch
Chairman
The Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate

The Honorable Richard Burr
United States Senate

In fiscal year 2014, Medicare processed 1.2 billion fee-for-service (FFS) claims submitted by providers or suppliers on behalf of beneficiaries.[1] Medicare Administrative Contractors (MAC), on behalf of the Centers for Medicare & Medicaid Services (CMS), an agency within the Department of Health and Human Services (HHS), process and pay FFS claims for health care items and services submitted by Medicare providers. MACs and other CMS contractors also identify and deny for payment health care claims that are invalid or otherwise improper as part of CMS's responsibility to ensure payments to Medicare providers are made correctly.[2] According to HHS, in fiscal year 2014, Medicare denied 128 million FFS claims, or 10.5 percent of claims submitted.

[1]Medicare is the federally financed health insurance program for persons aged 65 and over, certain individuals with disabilities, and individuals with end-stage renal disease. Medicare FFS, or original Medicare, consists of Medicare Parts A and B. Medicare Part A covers hospital and other inpatient stays. Medicare Part B is optional insurance and covers physician, outpatient hospital, home health care, certain other services, and the rental or purchase of durable medical equipment, prosthetics, orthotics, and supplies, which are collectively referred to as DMEPOS.

[2]An improper payment is any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements. It includes any payment to an ineligible recipient, any payment for an ineligible service, any duplicate payment, payment for services not received (except where authorized by law), and any payment that does not account for credit for applicable discounts. Improper Payments Elimination and Recovery Act of 2010, Pub. L. No. 111-204, § 2(e), 124 Stat. 2224, 2227 (codified at 31 U.S.C. § 3321 note).

When Medicare denies or reduces payment for an item or service, health care providers, beneficiaries, and state Medicaid agencies, or their representatives, may appeal these coverage decisions through a Medicare FFS appeals process.[3] This process consists of five, in most cases sequential, levels of review. Appellants typically appeal the coverage decision at the first of the five levels, and, depending on the outcome, may choose to appeal the decision at the next level. CMS contractors and relevant HHS components decide appeals in the administrative portion of the process—that is, Levels 1 through 4. HHS components monitor these appeals, including appeal outcomes and the extent to which the decisions are made within time limits established by law.[4] Level 5 appeals are reviewed by federal courts.

Recently, the administrative appeal levels (i.e., Levels 1 through 4) have experienced pronounced increases in the number of Medicare FFS appeals filed and some levels have also experienced increases in the backlog of appeals, which are pending appeals that remain undecided after statutory time frames.[5] As a result, HHS and members of Congress have considered ways to streamline the Medicare appeals process and improve the timeliness with which appeals are decided.[6]

You asked us to study the administrative portion of the Medicare FFS appeals process to better understand the increase in appeals and efforts

[3]For the purposes of this report, the term “provider” refers to any appellant that is not a beneficiary or state Medicaid agency, including physicians and other suppliers. Beneficiaries eligible for Medicare and Medicaid coverage assign their rights to pursue payment from third-party insurers to state Medicaid agencies, which are the payers of last resort for dual-eligible beneficiaries. Consequently, a state Medicaid agency may file an appeal to Medicare on behalf of a dual-eligible beneficiary when the state Medicaid agency believes Medicare incorrectly denied payment for a service.

[4]In general, federal law requires appeal decisions for Levels 1 and 2 within 60 days and appeal decisions for Levels 3 and 4 within 90 days. See 42 U.S.C. § 1395ff(a)(3)(C)(ii), (c)(3)(C)(i), (d)(1)(A), (d)(2)(A). These statutory time frames may be extended if, for example, additional documentation is submitted by the appellant after the appeal is filed. See 42 C.F.R. §§ 405.950(b)(3), 405.970(b)(3), 405.1018(b), 405.1118 (2015).

[5]In 2015, HHS noted that Level 3 was receiving more than one year’s worth of work every 8 weeks. See Department of Health and Human Services, *Fiscal Year 2016, Justifications of Estimates for Appropriations Committees* (Washington, D.C.: Feb. 2, 2015).

[6]For example, on December 8, 2015, a bill entitled “Audit & Appeals Fairness, Integrity, and Reforms in Medicare Act of 2015” was introduced in the Senate. S. 2368, 114th Cong. (2015).

being taken at HHS to address the growth in the number of appeals and the appeal backlog. In this report, we examine

1. trends in appeals for fiscal years 2010 through 2014;
2. data HHS uses to monitor the Medicare appeals process; and
3. HHS efforts to reduce the number of appeals and the appeal backlog.

To examine trends in appeals for fiscal years 2010 through 2014—the 5 most recent and complete fiscal years at the time we began our analysis—we analyzed extracts of three data systems we obtained from the HHS components responsible for the Medicare appeals process: CMS; the Office of Medicare Hearings and Appeals (OMHA), an HHS staff division; and the Medicare Appeals Council (the Council) within the Departmental Appeals Board (DAB), which is also an HHS staff division.[7] The three appeals data systems are the Contractor Reporting of Operational and Workload Data (CROWD) system, the Medicare Appeals System (MAS), and the Medicare Operations Division Automated Case Tracking System (MODACTS). Using extracts of CROWD, MAS, and MODACTS, we generally determined the number of Medicare FFS appeals filed for Levels 1 through 4 overall, by level, by the type of appellant, by type of service, by subcategory of service, and by whether the appeal resulted from a claim review conducted by a Recovery Auditor (RA), a type of contractor tasked by CMS to identify improper payments after they have been made.[8] We also calculated the percentage of appeal

[7]In this report we use the term "HHS agencies" to refer collectively to CMS, OMHA, and the Council. OMHA and the Council are also responsible for reviewing appeals of other Medicare issues, which are outside the scope of this report, such as entitlement appeals, which are appeals of the Social Security Administration's determination that a beneficiary is not entitled to be a beneficiary of the Medicare program.

[8]We did not analyze data for Level 1 and 2 appeals decided by Quality Improvement Organizations because MACs and Qualified Independent Contractors (QIC) are responsible for handling most Level 1 and Level 2 appeals, respectively. Quality Improvement Organizations are responsible for deciding some Level 1 appeals, on an expedited basis, related to denial of coverage for certain Medicare Part A services, such as hospital inpatient services, as well as Level 1 and Level 2 appeals of denials related to other issues, such as reasonableness of services and appropriateness of setting.

Due to limitations in the way that data are collected in CROWD, some of our analyses for Level 1 differed from that of the other levels.

decisions issued after the statutory time frames.[9] Finally, we analyzed reversal rates, which are the percentage of appeal decisions that reversed a prior decision. To assess the reliability of these data, we performed manual and electronic testing to identify and correct for missing data and other anomalies, interviewed HHS agency officials to confirm our understanding of the data, and reviewed related documentation. We determined that the data were sufficiently reliable for our purposes. To better understand the effect of appeal decisions made after statutory time frames on the amount of interest paid by CMS for successful appeals at Level 3, we also asked CMS officials to estimate the amount of interest the agency has paid as a result.

To examine data HHS uses to monitor the Medicare appeals process, we reviewed documentation describing each appeals data system in use during the time frame of our evaluation to understand the data that track an appeal and appeal decision and how those data are collected and used. In addition, we interviewed officials from HHS agencies about the data systems and how they use the appeals data for monitoring.

To examine actions taken by HHS agencies aimed at reducing the appeals backlog, we identified actions taken that may reduce the number of filed appeals, actions to reduce the number of appeals reaching Levels 3 and 4, and actions to reduce the appeals backlog. To identify these actions, we reviewed relevant regulations, HHS agencies' reports and guidance, and interviewed representatives from HHS agencies and selected contractors that serve as appeals bodies at Levels 1 and 2.[10] When possible, we analyzed data from HHS agencies to determine how some of these actions affected the number of filed appeals and the appeals backlog, and the likelihood that the appeals backlog would persist. Lastly, we examined what, if any, issues that affect the appeals backlog have not been addressed by actions HHS agencies have taken

[9]For Levels 2 and 3, our analysis was limited to appeal decisions issued on the merits, which refers to decisions that affirm or reverse the coverage denial, in whole or in part, based upon a consideration of the facts of the appeal, and does not reflect appeal decisions based on other grounds, such as dismissals for procedural deficiencies. For Level 4, our analysis excluded appeals referred to the Council by CMS, as well as appeals that were dismissed by the Council.

[10]We interviewed officials from five MACs that process Level 1 appeals, which operate in 11 of the 16 MAC jurisdictions; officials with the two QICs that process Level 2 appeals; and officials with the contractor that assists CMS in providing oversight of the appeals process.

to date. To accomplish this, we interviewed representatives from HHS agencies, contractors serving as Level 1 and 2 appeals bodies, and seven provider associations that represent the service areas that generated the greatest number of Medicare appeals in 2013.[11]

For all three objectives, we reviewed HHS documentation, including a June 2015 report to Congress describing the origins of the Medicare appeals backlog and HHS's plans for its resolution, and the HHS budget justification materials accompanying the President's budget request for fiscal years 2016 and 2017.[12] We also reviewed applicable federal standards for internal control.[13] See appendix I for a more detailed description of our scope, methodology, and related limitations.

We conducted this performance audit from March 2015 to April 2016, in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Medicare Prepayment and Postpayment Claim Reviews

Medicare claims can be denied on a prepayment basis (i.e., before the claim is paid) or on a postpayment basis (i.e., after the claim is paid and the payment is identified as improper). Many appeals originate from claims denied on a prepayment basis, but the same appeal rights exist for either scenario. To conduct a prepayment claim review, CMS contractors

[11]We interviewed officials with the American Ambulance Association, American Association for Homecare, American Hospital Association, American Medical Association, American Medical Rehabilitation Providers Association, Council for Quality Respiratory Care, and National Association for Home Care & Hospice.

[12]Department of Health and Human Services, *Medicare Appeals: Process Improvement and Backlog Reduction Plan* (Washington, D.C.: June 2015).

[13]GAO, *Internal Control: Standards for Internal Control in the Federal Government*, GAO/AIMD-00-21.3.1 (Washington, D.C.: November 1999). Internal control is a process effected by an entity's oversight body, management, and other personnel that provides reasonable assurance that the objectives of an entity will be achieved.

conduct several checks to determine whether a claim received from a provider should be paid. These checks include verifying that the provider is enrolled in Medicare, the beneficiary is eligible to receive Medicare benefits, and the service is covered by Medicare. In limited cases, before paying a claim, contractors review the supporting medical documentation for a claim to ensure the service was medically necessary. As a result of these checks or reviews, CMS's contractors may deny Medicare payment for the claim. Most prepayment reviews are conducted by MACs, which are responsible for processing and paying FFS claims within 16 geographic jurisdictions.[14] To conduct a postpayment review, contractors generally select claims from among those that have already been processed and paid, request and review documentation from providers to support Medicare coverage of the services identified in those claims, and apply Medicare coverage and coding requirements to determine if the claims were paid properly, reviewing, for example, whether the service was medically necessary or provided in the appropriate setting.[15] The majority of the postpayment reviews are conducted by RAs.[16]

Medicare Administrative Appeals Process

The Medicare administrative appeals process allows appellants who are dissatisfied with decisions at one level to appeal to the next level. The entities tasked with resolving appeals are referred to as appeals bodies. The statutory time frames for submitting and issuing appeal decisions can vary by level. (See table 1.) When an appeals body cannot render a decision within the applicable statutory time frame at levels 2 through 4, the appellant has the opportunity to escalate the appeal to the next level

[14]Zone Program Integrity Contractors, which investigate potential fraud, also conduct prepayment claim reviews. Additionally, RAs conducted prepayment claim reviews under a CMS demonstration from 2012 through 2014.

[15]Medicare's payment system relies on the coding of beneficiaries' diagnoses or the services, procedures, and devices provided to them to determine proper payment. Payment may be made on the basis of the diagnosis, or of the services, procedures, and devices claimed, depending on the payment method for that type of claim. Because MACs pay claims according to the codes assigned, if the code does not accurately reflect the diagnosis, service, procedure, or device provided, then the claim is considered improper.

[16]Postpayment reviews can also be conducted by MACs, the Comprehensive Error Rate Testing contractor, the Supplemental Medical Review Contractor, and the Zone Program Integrity Contractors. The Comprehensive Error Rate Testing contractor reviews claims to annually estimate Medicare's improper payment rate and the Supplemental Medical Review Contractor conducts postpayment reviews on all types of services as part of studies directed by CMS.

of appeal.[17] CMS may also refer certain decisions made at Level 3 to Level 4.[18]

Table 1: Medicare Fee-for-Service (FFS) Administrative Appeals Process

Appeal level	Appeals body	Statutory time frames	Composition of appeals body[a]
Level 1	Medicare Administrative Contractors (MAC), which are Centers for Medicare & Medicaid Services' (CMS) contractors[b]	Appellant must file within 120 days of receipt of notice that claim was denied Decision should be made within 60 days	9 contractors operate in 16 geographic jurisdictions[c]
Level 2	Qualified Independent Contractors (QIC), which are CMS contractors[b]	Appellant must file within 180 days of receipt of notice that the Level 1 appeal was unfavorable Decision should be made within 60 days	2 contractors operate in 5 geographic jurisdictions
Level 3	Administrative Law Judges (ALJ) within the Office of Medicare Hearings and Appeals (OMHA)	Appellant must file within 60 days of receipt of notice that the Level 2 appeal was unfavorable Decision should be made within 90 days	77 ALJs
Level 4	The Medicare Appeals Council within the Departmental Appeals Board	Appellant must file within 60 days of receipt of notice that the Level 3 appeal was unfavorable Decision should be made within 90 days	6 Administrative Appeals Judges

Source: Department of Health and Human Services. | GAO-16-366

Notes: The statutory time frames in this table may be extended in circumstances defined by regulation. For example, CMS may extend an appellant's filing deadline for good cause. See 42 C.F.R. §§ 405.942(b), 405.962(b) (2015). In addition, the statutory time frame for rendering a decision may be extended if, for example, additional documentation is submitted by the appellant after the appeal is filed. See, e.g., 42 C.F.R. §§ 405.950(b)(3), 405.970(b)(3), 405.1018(b), 405.1118 (2015).

[a]Information is as of February 2016.

[b]MACs and QICs are responsible for handling Level 1 and Level 2 appeals of denials related to most claims; however, Quality Improvement Organizations are responsible for deciding some Level 1 appeals, on an expedited basis, related to denial of coverage for certain Medicare Part A services, such as hospital inpatient services, as well as Level 1 and Level 2 appeals of denials related to other issues, such as reasonableness of services and appropriateness of setting.

[17]When an appellant escalates an appeal not decided within the applicable statutory deadline to the next level of appeal, the higher level appeals body generally has 180 days to issue a decision, except for cases escalated to Level 5. See 42 C.F.R. §§ 405.1016(c), 405.1100(d) (2015).

[18]CMS may refer appeals to Level 4 if, for example, the agency determines that the Level 3 decision contains an error of law material to the case or if CMS or one of its contractors participated in the Level 3 appeal and the agency determines the Level 3 decision is not supported by the preponderance of the evidence. See 42 C.F.R. §§ 405.1010, 405.1100(a)-(b) (2015).

[c]Twelve MACs decide Medicare Part A and Medicare Part B appeals, 4 of which also decide home health and hospice appeals. Four other MACs decide appeals for durable medical equipment, prosthetics, orthotics, and supplies.

Each level of appeal follows similar steps. First, the appellant files an appeal and submits supporting documentation. The appeals body then assigns the appeal to an adjudicator who reviews the appeal, including the relevant Medicare policies and documentation. Adjudicators at all four levels generally conduct what are known as de novo reviews, meaning they conduct an independent evaluation of the claim(s) at issue and are not bound by the prior findings and decisions made by other adjudicators. Next, the appeals body issues the appeal decision and notifies the appellant. If the appellant files an appeal at the next appeal level, the documentation associated with the prior appeal is sent to the next appeal level.

Appeals must meet certain requirements in order to be reviewed. For example, the appeal must be filed by an appropriate party, such as by the provider who furnished the service to the beneficiary and submitted a claim to Medicare for that service. In addition, the appeal must be filed within the required time frame. To be reviewed at Level 3, an appeal must meet or exceed a minimum dollar amount, known as the amount in controversy. Under certain circumstances, appellants may combine claims to meet the amount in controversy requirement, which is $150 in calendar year 2016.[19]

Some differences exist in the criteria appeals bodies use to make their decisions.

- While all levels are bound by statutes, regulations, national coverage determinations, and CMS rulings, only Level 1 is subject to local coverage determinations (LCD) and CMS program guidance, such as

[19]See 42 C.F.R. § 405.1006(b),(e) (2015). When appealing a Level 2 decision to Level 3, either an individual appellant or multiple appellants may aggregate two or more claims to meet the amount in controversy if, among other criteria, the claims involve similar or related services (defined as like or coordinated services or items provided to one or more beneficiaries), or involve common issues of law or fact.

The amount in controversy is adjusted annually based upon a formula prescribed by statute. 42 U.S.C. § 1395ff(b)(1)(E)(iii).

program memoranda and manual instructions.[20] In comparison, Levels 2 through 4 are required to give substantial deference to LCDs and other CMS program guidance if they are applicable to a particular appeal. However, unlike Level 1, Levels 2 through 4 may exercise discretion to decline to follow LCDs and CMS program guidance when issuing an appeal decision, and must explain in the decision the basis for doing so.[21]

- Levels 1 and 2 can also accept and consider new evidence submitted by appellants to support their appeals. For example, to pay claims related to certain durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), CMS requires providers to submit a certificate of medical necessity. If this document was not submitted with the original claim, the provider may submit it as part of the appeal. At Levels 3 and 4, new evidence can generally be accepted only with "good cause."[22]
- Unlike Levels 1, 2, and 4, which decide appeals generally by reviewing the documentation upon which the initial denial was based as well as any supporting documentation the appellant submitted with

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[20]National and local coverage determinations are policies that identify the items and services and the circumstances under which they are covered by Medicare. There are fewer national coverage determinations, which are developed by CMS and apply to all beneficiaries across the country, compared to LCDs, which are developed by MACs and apply to the states in their jurisdictions, which leads to geographic variation in Medicare coverage.

CMS rulings are decisions that serve as final opinions and orders, and statements of policy and interpretation. They provide clarification and interpretation of complex or ambiguous provisions of the law or regulations relating to Medicare, Medicaid, private health insurance, and related matters.

[21]See 42 C.F.R. §§ 405.968(b) and 405.1062(a),(b) (2015).

RAs, Zone Program Integrity Contractors, and other CMS claims review contractors also follow LCDs and CMS program guidance during their reviews.

[22]See 42 U.S.C. § 1395ff(b)(3) and 42 CFR §§ 405.1018(c), 405.968(b), 405.1028, and 405.1122(c) (2015). The good cause standard does not apply to certain beneficiary-filed appeals. As reported by the HHS Office of Inspector General (OIG) in 2012, current regulations regarding the acceptance of new evidence provide little guidance as to what constitutes good cause; thus, OIG recommended that OMHA and CMS revise the regulations to provide additional examples as well as factors for Administrative Law Judges to consider when determining good cause. See Department of Health and Human Services, Office of Inspector General, *Improvements Are Needed at the Administrative Law Judge Level of Medicare Appeals*, OEI-02-10-00340 (Washington, D.C.: November 2012).

the appeal, Level 3 Administrative Law Judges (ALJ) conduct hearings during which appellants are permitted to explain their positions, present evidence, and submit into the record a written statement of the facts and law material to the issue.[23]

All four appeals bodies may issue appeal decisions that do not address the merits of the case:

- Dismiss: The appellant withdraws the request for an appeal or the appeals body determines that the appellant or appeal did not meet certain procedural requirements; for example, the appellant did not file the request within the required time frame.
- Remand: An action that can be taken at Level 2, 3, or 4 which vacates a lower level appeal decision, or a portion of the decision, and returns the case, or a portion of the case, to that level for a new decision.[24]

Appeal decisions for Levels 1 through 3 include the following categories for decisions issued on the merits based upon a consideration of the facts of the appeal:

- Fully reverse: The appeals body fully reverses a prior decision denying coverage and all of the claim(s) in dispute are paid.
- Partially reverse: The appeals body partially reverses a prior decision denying coverage, and those parts of the claim(s) in dispute are paid.
- Not reverse: The appeals body upholds a prior decision denying coverage, and payment of the claim(s) in dispute is denied.

Level 4 uses different categories for decisions issued on the merits. In addition to dismissing or remanding a Level 3 decision, Level 4 appeal decisions can affirm, reverse, or modify a Level 3 decision.[25] Additional information about Level 4 appeal categories is discussed in appendix I.

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[23]At Level 3, appellants may also waive their right to a hearing before an ALJ and instead request that the ALJ issue a decision based on the written evidence in the record. At Level 4, appellants may request the opportunity to present an oral argument before the Council.

[24]At Level 2, remands are limited to instances in which the QIC determines that the MAC inappropriately dismissed a Level 1 appeal. See 42 C.F.R. § 405.974(b)(2) (2015).

[25]According to Council officials, an appeal decision of "modify" does not change the Level 3 decision, but rather corrects, for example, an error of fact in the Level 3 decision.

Medicare FFS Appeals Data Systems

To help manage the Medicare appeals process and track appeal decisions, the appeals bodies use various data systems. (See table 2.) In 2005, CMS implemented MAS, which at the time was intended to support Levels 1 through 4. However, currently, three data systems are used to collect appeals data across the four levels of the Medicare appeals process.

Table 2: Department of Health and Human Services' (HHS) Medicare Fee-for-Service Appeals Data Systems

Appeal level	HHS data system	Appeals body	Responsible agency within HHS
Level 1	(1) Contractor Reporting of Operational and Workload Data system, and (2) Medicare Appeals System (MAS)[a]	Medicare Administrative Contractor (MAC)	Centers for Medicare & Medicaid Services (CMS)
Level 2	MAS	Qualified Independent Contractor	CMS
Level 3	MAS	Administrative Law Judges	Office of Medicare Hearings and Appeals
Level 4	Medicare Operations Division Automated Tracking System	Medicare Appeals Council	Departmental Appeals Board

Source: HHS. | GAO-16-366

[a]In fiscal year 2014, CMS used MAS to track Medicare Part A appeals decided by 7 of the 12 MAC jurisdictions that decide Medicare Part A and Medicare Part B appeals.

Medicare Appeals and Untimely Appeal Decisions Increased from Fiscal Years 2010 through 2014

The total number of Medicare appeals filed and the number of appeal decisions that were issued after statutory time frames at Levels 1 through 4 increased from fiscal years 2010 through 2014, with the largest rate of increase at Level 3. Reversal rates also decreased during this time for most levels of appeals.

Total Number of Medicare Appeals Filed at All Levels Increased from Fiscal Years 2010 through 2014, with the Largest Rate of Increase at Level 3

Between fiscal years 2010 and 2014, the number of filed appeals at all levels of Medicare's appeals process increased significantly, with the rate of increase varying across levels. For example, during this period, the number of Level 1 appeals, which represented the vast majority of all appeals, increased from 2.6 million to 4.2 million—an increase of 62 percent—which was the slowest rate of increase among the four levels. While Level 3 handled fewer appeals overall, it experienced the largest rate of increase in appeals from 41,733 to 432,534 appeals—936 percent—during this period. (See table 3.) For most levels, the largest annual growth over the 5-year period occurred between fiscal years 2012

and 2013, and between fiscal years 2013 and 2014 the rate of growth slowed at all levels.[26]

Table 3: Medicare Fee-for-Service Appeals Filed and Percentage Growth in Appeals, Fiscal Years 2010-2014

	Number of appeals filed					Percentage growth
Appeal level	2010	2011	2012	2013	2014	in appeals
Level 1[a]	2,603,557	2,923,213	3,451,137	3,972,219	4,209,621	62
Level 2	265,140	285,902	456,994	874,778	896,838	238
Level 3	41,733	57,823	127,240	369,668	432,534	936
Level 4[b]	1,264	1,820	2,350	3,593	4,636	267

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS), Office of Medicare Hearings and Appeals, and Departmental Appeals Board data. | GAO-16-366

Notes: Level 1 and Level 2 totals exclude appeals decided by Quality Improvement Organizations, because Medicare Administrative Contractors and Qualified Independent Contractors are responsible for handling Level 1 and Level 2 appeals of denials related to most claims.

[a]CMS officials told us that the agency typically reports appeal workload using the number of appeals decided instead of those filed, due to limitations with Contractor Reporting of Operational and Workload Data. We report the number of filed appeals to be consistent with the other levels.

[b]Level 4 totals exclude the 919 appeals referred by CMS during this period.

For all appeal levels, appeals of claim denials for Medicare Part A (Part A) services showed the most dramatic increase.[27] Among the four levels, Level 3 experienced both the largest increase in appeals overall, as well as the largest increase in Part A appeals, which increased over 2,000 percent between fiscal years 2010 and 2014. (See fig. 1.) Appeals of denied DMEPOS claims also grew substantially during this time at all

[26]CMS officials told us that they attribute the slowdown, at least for Levels 1 and 2, to a decrease in RA activity. The number of RA reviews decreased in fiscal year 2014 compared to the prior year because CMS prohibited the RAs from conducting any claims reviews when the RA contracts were nearing the end of their original performance period. Also, CMS and Congress prohibited the RAs from conducting reviews of short-stay inpatient hospital claims with dates of admission between October 1, 2013, and December 31, 2015, unless there was evidence of fraud or abuse. RAs were reviewing these short-stay inpatient hospital claims to determine whether it was medically necessary for the patient to have been admitted as an inpatient, as opposed to being treated on an outpatient basis.

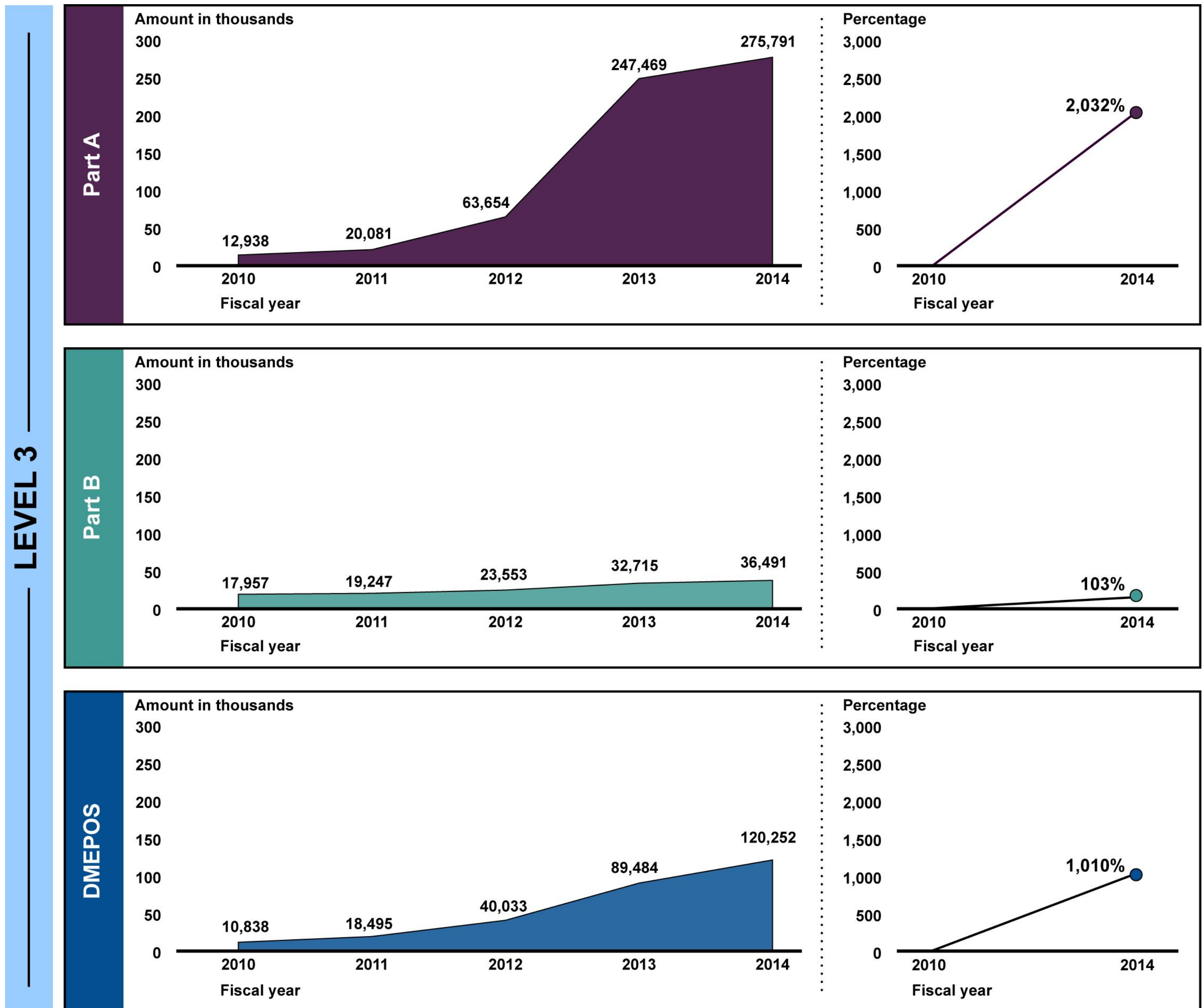
[27]Part A covers hospital and other inpatient stays.

levels.[28] For example, DMEPOS-related appeals increased the most at Level 3 at over 1,000 percent.

[28]Among the reasons for the increase, according to CMS officials, beginning October 1, 2013, CMS began enforcing a new requirement that DMEPOS providers document that the beneficiary had a face-to-face meeting with a health professional before the item is provided. See 42 U.S.C. § 1395m(a)(11)(B).

Although Medicare Part B covers DMEPOS items, for the purposes of our analyses, Medicare Part B appeals are exclusive of appeals of DMEPOS claims.

Figure 1: Level 3 Medicare Fee-for-Service Appeals Filed, by Type of Service, Fiscal Years 2010-2014



Legend: DMEPOS = durable medical equipment, prosthetics, orthotics, and supplies.

Source: GAO analysis of Office of Medicare Hearings and Appeals data. | GAO-16-366

Note: Medicare Part A covers hospital and other inpatient stays. Medicare Part B covers physician, outpatient hospital, home health care, certain other services, and the rental or purchase of DMEPOS. In this figure, Medicare Part B appeals are exclusive of appeals of DMEPOS claims.

HHS attributed the increases in appeals overall to several factors. For example, HHS fiscal year 2016 budget justification materials noted that CMS's increased focus in recent years on expanding new program integrity activities to ensure proper payment has resulted in more denied claims and, therefore, more appeals. Specifically, appeals resulting from RA claim denials began entering the appeals process in fiscal year 2011 after Congress enacted legislation that expanded the RA program from a demonstration operating in six states to a permanent national program, which CMS implemented in fiscal year 2009. In expanding nationally, the RA program added a new set of contractors with the specific purpose of reviewing postpayment claims to identify improper payments. In addition to the large volume of postpayment reviews conducted by the RAs, there was also an increase in overall claim denials from fiscal years 2011 to 2014, according to HHS's June 2015 *Process Improvement and Backlog Reduction Plan*.[29] The number of overall claim denials during this time period for Part A and B claims increased 12.5 and about 9 percent, respectively.[30] For all levels, we found that appeals related to RA denials were a larger contributor to the increase in Part A appeals compared to Part A appeals not related to RAs.[31] For example, at Level 3, RA-related appeals of Part A services grew from 1 percent (140 appeals) of filed Part A appeals in fiscal year 2010 to 78 percent (216,271 appeals) in fiscal year 2014.

[29]See Department of Health and Human Services, *Process Improvement and Backlog Reduction Plan*.

[30]HHS reported that the percentage of overall denials appealed to Level 1 increased from 2.5 percent in fiscal year 2011 to 5.2 percent in fiscal year 2013 for Part A claims and from 2.4 percent in fiscal year 2011 to 3.2 percent in fiscal year 2014 for Part B claims. HHS's Part B estimates include DMEPOS services.

[31]More specifically, for Levels 2 through 4, the increase in Part A appeals was largely a result of appeals related to inpatient hospital services denied by the RAs. In conducting reviews of short-stay inpatient hospital claims, the RAs often determined from the medical documentation that it was not medically necessary for the patient to be admitted as an inpatient because the hospital could have treated the patient safely and effectively as an outpatient. As a result, the RAs denied many inpatient hospital claims. See Centers for Medicare & Medicaid Services, *Recovery Auditing in Medicare for Fiscal Year 2014: FY 2014 Report to Congress as Required by Section 1893(h) of the Social Security Act* (Oct.15, 2015), accessed October 22, 2015, https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/RAC-RTC-FY2014.PDF. Information for Level 1 is unknown because the CROWD system does not track RA-related appeals by subcategory of service.

HHS also attributed the increase in appeals to a greater propensity among providers to appeal denied claims. From fiscal year 2010 to fiscal year 2014, the proportion of appeals filed by providers increased at Levels 2 through 4.[32] The proportion of appeals filed by state Medicaid agencies also increased at Levels 2 and 4, while the proportion of appeals filed by beneficiaries at Levels 2 through 4 declined. According to HHS agency officials, a small number of providers and state Medicaid agencies were responsible for a large share of the appeals. For example, at Level 2, CMS noted that three DMEPOS suppliers filed 12 percent of DMEPOS appeals in calendar year 2012 and 33 percent of Level 2 DMEPOS appeals in calendar year 2014. Similarly, at Level 3, OMHA reported that four DMEPOS providers and one state Medicaid agency filed 51 percent of appeals in the first quarter of fiscal year 2015. In addition, the number of appeals filed by state Medicaid agencies more than doubled at Levels 2 through 4 from fiscal year 2010 to fiscal year 2014. At Level 3, state Medicaid agency appeals increased from 2,617 to 25,195 during that time period. According to HHS's *Process Improvement and Backlog Reduction Plan*, appeals filed by state Medicaid agencies that relate to home health care services provided to beneficiaries eligible for both Medicare and Medicaid services have contributed to the growth in Level 3 appeals, and CMS officials told us that four state Medicaid agencies (Connecticut, Massachusetts, New York, and Vermont) generated the majority of these appeals. (For more information on appeals by appellant type, see app. II.)

[32]The CROWD system, which CMS used to collect the majority of the data on Level 1 appeals from fiscal years 2010 through 2014, does not contain information on appellant categories.

In fiscal year 2014, providers filed 85 percent or more of the appeals at Levels 2 through 4.

Appeal Decisions Exceeding Statutory Time Frames Generally Increased from Fiscal Years 2010 through 2014, with Most Frequent Delays Occurring for Levels 3 and 4

The number of appeal decisions that were issued after statutory time frames generally increased from fiscal years 2010 through 2014. Among the four appeal levels, Levels 1 and 2 had a smaller proportion of decisions exceeding statutory time frames over the period.[33] For example, CMS data show that in fiscal years 2010 and 2011, MACs generally issued less than 10 percent of their Level 1 appeal decisions after the statutory time frame (see table 4). In fiscal year 2012, MACs issued a greater percentage of decisions after statutory time frames and, notably, CMS data show that in the fourth quarter of that year, MACs issued about 68.5 percent of their appeal decisions related to DMEPOS claims after the statutory time frame. CMS officials told us that the delays resulted from two factors: two MACs received a high volume of appeals filed by seven suppliers and one of those MACs also experienced challenges implementing a new tool used to generate correspondence with appellants. In fiscal year 2014, MACs again issued less than 10 percent of Part A and DMEPOS appeals after statutory time frames, though nearly 21 percent of Medicare Part B (Part B) appeal decisions were issued after statutory time frames in one quarter.

Table 4: Quarterly Minimum and Maximum Percentage of Level 1 Medicare Fee-for-Service Appealed Claim Decisions Issued After the Statutory Time Frame, by Type of Service, Fiscal Years 2010-2014

	Medicare Part A		Medicare Part B		Durable medical equipment, prosthetics, orthotics, and supplies	
Fiscal year	Minimum	Maximum	Minimum	Maximum	Minimum	Maximum
2010	0.0	2.8	0.1	1.0	0.0	10.7
2011	0.2	10.0	0.1	3.0	0.0	2.0
2012	8.3	17.0	0.3	6.0	0.2	68.5
2013	4.4	17.8	3.2	21.2	0.1	20.5
2014	3.3	9.5	6.8	20.9	0.0	0.7

Source: Centers for Medicare & Medicaid Services (CMS). | GAO-16-366

Note: CMS appeals data are available at http://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/RedeterminationbyaMedicareContractor.html, downloaded on August 27, 2015. CMS presents data quarterly. In general, appeal decisions should be made within 60 days. Medicare Part B appealed claims processed by one of the Part A Medicare Administrative Contractors (MAC) are included in the Medicare Part A data. The table excludes appeals decided by Quality Improvement Organizations, because MACs are responsible for handling Level 1 appeals of denials related to most claims.

[33]For Levels 2 and 3, our analysis was limited to appeal decisions issued on the merits, and our analysis of Level 4 excluded appeals referred to the Council by CMS as well as appeals that were dismissed by the Council.

Like the MACs, the Qualified Independent Contractors (QIC) also generally had a relatively small proportion of Level 2 decisions exceeding the statutory time frame during this time. CMS data show that the QICs began issuing appeal decisions after the statutory time frame in fiscal year 2011, and the percentage of such appeal decisions increased to 44 percent (345,049 appeals) in fiscal year 2013. However, in fiscal 2014, the QICs issued less than 5 percent of their appeal decisions after the statutory time frame.

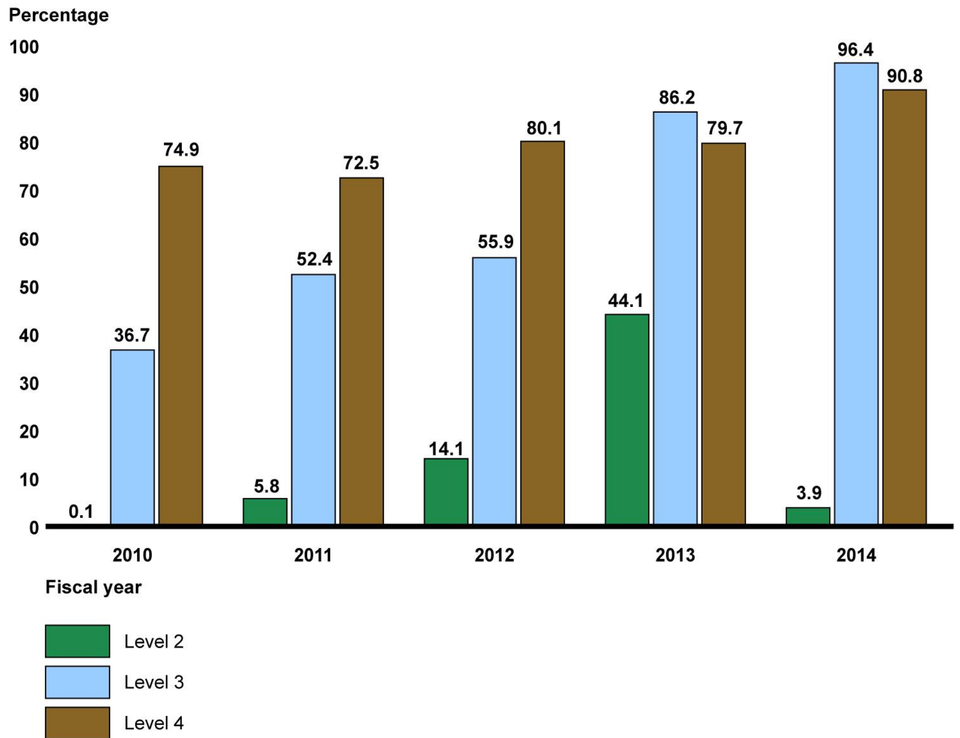
In contrast, the increase in appeal decisions issued after statutory time frames and the proportion of those appeal decisions were greater at Levels 3 and 4. For example, OMHA data show that in fiscal year 2014, ALJs issued 96 percent of their Level 3 appeal decisions after the statutory time frame. Similarly, Departmental Appeals Board (DAB) data show that in fiscal year 2014 the Council issued 91 percent of its Level 4 appeal decisions after the statutory time frame. (See fig. 2.) In fiscal year 2014, Levels 3 and 4 issued decisions within the statutory time frames for a greater percentage of beneficiary-filed appeals than appeals filed by providers or state Medicaid agencies. Recognizing that delays in issuing appeal decisions affects this population most acutely, both levels have instituted processes to move beneficiary appeals to the front of their queues.[34] Between the two appeals bodies, Level 3 ALJs took longer to issue decisions. In fiscal year 2014, ALJs issued 93 percent of their Level 3 appeal decisions in 180 days or more—the statutory time frame is generally 90 days—while the Council issued 67 percent of Level 4 appeal decisions in 180 days or more.[35]

[34]Level 4 also issued decisions within the statutory time frames for a greater percentage of beneficiary-filed appeals in fiscal years 2010 through 2013.

OMHA implemented a process to prioritize beneficiary appeals in July 2013. Similarly, HHS officials told us the Council began prioritizing beneficiary appeals in fiscal year 2014, but did not formalize the process until August 2015.

[35]In fiscal year 2015, OMHA officials reported that the average time to decide Level 3 appeals exclusive of remanded and combined appeals was 689 days, and DAB officials reported that the average time to decide Level 4 appeals was 571 days.

Figure 2: Percentage of Level 2 through 4 Medicare Fee-for-Service Appeal Decisions Issued After Statutory Time Frames, Fiscal Years 2010-2014



Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS), Office of Medicare Hearings and Appeals, and Departmental Appeals Board data. | GAO-16-366

Note: In general, Level 2 appeal decisions should be made within 60 days and Level 3 and 4 appeal decisions within 90 days. Level 2 and Level 3 percentages are calculated based upon appeal decisions issued on the merits—that is decisions that affirm or reverse the coverage denial, in whole or in part, based upon a consideration of the facts of the appeal—and do not reflect appeal decisions based on other grounds, such as dismissals for procedural deficiencies. Level 4 percentages exclude appeals referred to the Medicare Appeals Council (the Council) by CMS and appeals dismissed by the Council. Additionally, for all levels, percentages exclude appeals included in CMS's global settlement as those appeals were put on hold during the settlement process; and Level 2 percentages exclude appeals decided by Quality Improvement Organizations, because Qualified Independent Contractors are responsible for handling Level 2 appeals of denials related to most claims.

According to HHS's *Process Improvement and Backlog Reduction Plan*, the increase in late appeal decisions for Levels 3 and 4 from fiscal year 2010 through 2014 resulted from the increase in the number of appeals filed, as well as the relatively flat budgets of OMHA and the Council, which have prevented the hiring of sufficient staff to address the growing

workload.[36] For example, as previously noted, the number of filed appeals at Level 3 increased over 900 percent from fiscal year 2010 to fiscal year 2014, while OMHA's budget during the same period increased from about $71 million to about $82 million (16 percent). (See table 5.) In addition, HHS noted that neither HHS agency receives funds from recoveries made by the RA program, although they review appeals of claims denied by RAs.[37]

Table 5: Annual Budget for the Office of Medicare Hearings and Appeals (OMHA) and the Departmental Appeals Board (DAB), Fiscal Years 2010-2016

	Annual budget (in millions)						
HHS agency	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**
OMHA	71.1	71.0	72.0	69.4	82.4	87.4	107.4
DAB	10.5	10.6	10.7	10.5	10.5	11.0	11.0

Source: Department of Health and Human Services (HHS). | GAO-16-366

Note: The annual budgets are not limited to funds to review Medicare fee-for-service appeals. OMHA and DAB are also responsible for reviewing appeals of other Medicare issues, such as entitlement appeals, which are appeals of the Social Security Administration's determination that a beneficiary is not entitled to be a beneficiary of the Medicare program. In addition, DAB conducts hearings and reviews, issues decisions, and provides mediation services in other HHS cases.

The increase in the number of decisions made after statutory time frames at Levels 3 and 4 also increases the amount of interest paid by CMS to providers whose postpayment claim denials are reversed upon appeal, thus increasing Medicare's costs. Currently, CMS is prohibited by statute from collecting overpayments from providers who file appeals until after a Level 2 decision is made.[38] CMS is also required to pay providers interest on the overpayments it initially collects after the Level 2 decision is made

[36]The increase in late appeal decisions may also be due, in part, to the increased numbers of Part A appeals filed. Part A inpatient hospital claims are generally more time-consuming for the appeals bodies to review and decide than other types of cases, such as cases involving Part B claims, according to HHS agency officials. According to HHS's fiscal year 2016 budget justification materials, RA-related appeals often take ALJs considerable time to review because they can involve complex factual assessments, multiple parties at a hearing, and varying degrees of documentation.

[37]In contrast, HHS noted in its *Process Improvement and Backlog Reduction Plan* that CMS can use some of the recoveries made by the RA program to cover administrative costs associated with adjudicating appeals that stem from RA-identified overpayments.

[38]See 42 U.S.C. § 1395ddd(f)(2).

and then returns when the appellant wins appeals at Level 3 or higher.[39] In 2014, the annual interest rate paid by CMS to these providers ranged from 9.625 percent to 10.375 percent. As a result, CMS interest payments have increased. Specifically, CMS officials estimate that from fiscal years 2010 through 2015, the agency paid $17.8 million in interest payments to Part A and B providers that it would not have paid had Level 3 issued appeal decisions within statutory time frames.[40] Moreover, CMS estimates that the agency paid about 75 percent of this interest ($13 million) in fiscal years 2014 and 2015, when delays in issuing decisions have been the longest.

Reversal Rates at Levels 1 through 3 Decreased from Fiscal Year 2010 to 2014 and Appeals Reaching Level 3 Were Most Likely to Be Reversed

From fiscal years 2010 through 2014, fully favorable reversal rates decreased for Levels 1 through 3, but varied across levels, with appeals reaching Level 3 the most likely to be reversed.[41] (See fig. 3.) For example, in fiscal year 2014, ALJs fully reversed the prior decision in 54 percent of Level 3 appeal decisions issued on the merits. In contrast, Level 1 and Level 2 adjudicators fully reversed prior decisions in 36 and 19 percent, respectively, of appeal decisions issued on the merits in fiscal year 2014.

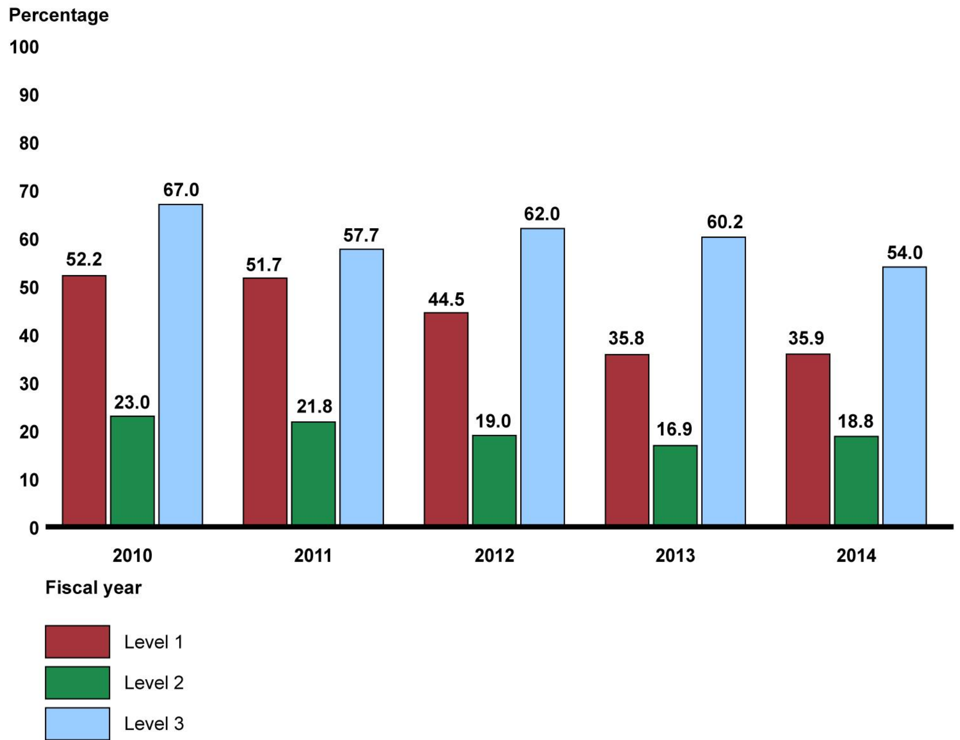
[39]See 42 U.S.C. § 1395g(d). Medicare regulations provide for the assessment of interest, certified quarterly by the Secretary of the Treasury, at the higher of the current value of the funds rate or the private consumer rate. Simple interest is calculated for every 30-day period the overpayment is held by CMS.

[40]Appendix I describes the assumptions CMS made in estimating the amount of interest paid to providers on overpayment determinations reversed on appeal, as well as the limitations of those assumptions.

CMS did not provide an estimate for appeals related to DMEPOS claims because they did not have the necessary data to conduct the analysis.

[41]Because appeal decisions are tracked differently at Level 4, we separately analyzed and reported Level 4 reversal rates.

Figure 3: Percentage of Fully Reversed Medicare Fee-for-Service Appeals at Levels 1, 2, and 3, Fiscal Years 2010-2014



Source: GAO analysis of Centers for Medicare & Medicaid Services and Office of Medicare Hearings and Appeals data. | GAO-16-366

Note: Percentages are calculated based upon appeal decisions issued on the merits—that is decisions that affirm or reverse the coverage denial, in whole or in part, based upon a consideration of the facts of the appeal—and do not reflect appeal decisions based on other grounds, such as dismissals for procedural deficiencies. Level 1 and Level 2 totals exclude appeals decided by Quality Improvement Organizations, because Medicare Administrative Contractors and Qualified Independent Contractors are responsible for handling Level 1 and Level 2 appeals of denials related to most claims.

At different times, HHS has attributed the relatively high reversal rates at Level 3, in part, to the opportunity for hearings and presentation of new evidence at Level 3, and ALJs' exercise of discretion in declining to follow LCDs and CMS program guidance. More specifically, HHS has noted the following:

- ALJs conduct hearings, which provide an opportunity for appellants to explain the rationale for the medical treatment.[42]
- ALJs may consider new evidence admitted for good cause—for example, documentation required for the claim to be approved that the appellant did not submit for consideration at Levels 1 or 2.
- While neither CMS nor OMHA collect data in MAS that would allow us to substantiate to what extent ALJs declining to follow LCDs or CMS program guidance contribute to Level 3 reversals, HHS noted in its *Process Improvement and Backlog Reduction Plan* that this is a factor, and a 2012 HHS Office of Inspector General (OIG) report reached similar conclusions.[43] Furthermore, OMHA's most recent quality assurance evaluation, completed in 2013, identified compliance with and understanding of the role of LCDs and other program guidance as a key issue for improvement.

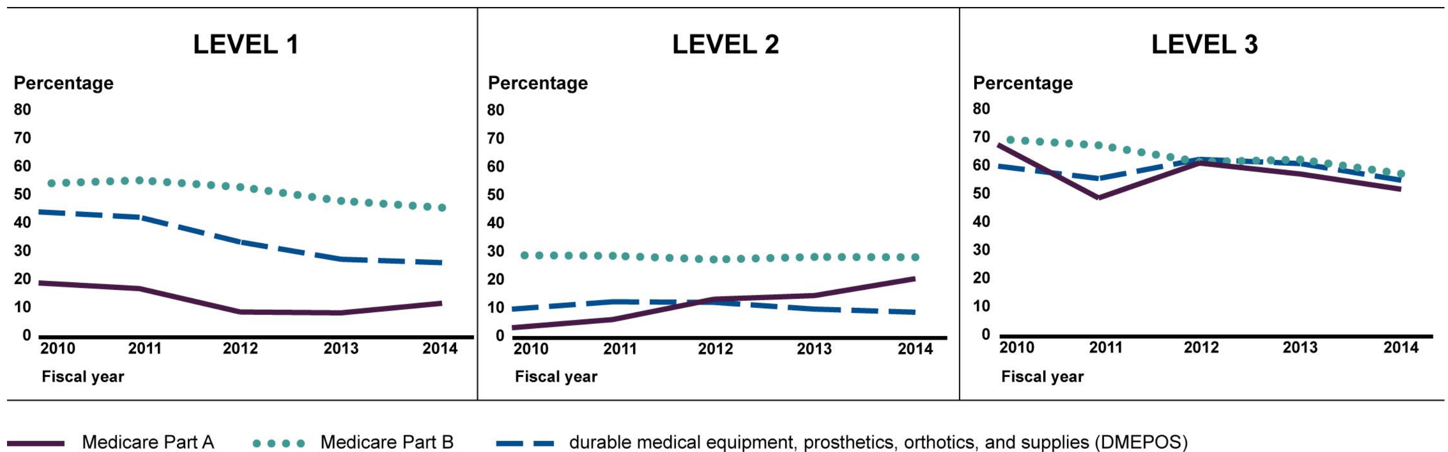
According to HHS's *Process Improvement and Backlog Reduction Plan*, the qualified decisional independence afforded ALJs may result in a more favorable result for appellants at Level 3. Furthermore, as anticipated by the federal law governing administrative procedures, qualified decisional independence leaves substantial room for subjectivity in ALJs' application of policy to the facts of a given case, and consequently, two reasonable reviewers can review the same facts and come to two legally defensible conclusions. Similarly, OMHA's 2013 quality assurance evaluation found that of 60 reviewed cases that were decided after a hearing that involved an LCD or other CMS program guidance, in 30 cases the policy was applied differently than how it was applied at the lower level.

While reversal rates declined across Levels 1 through 3 from fiscal years 2010 through 2014, reversal rates varied by type of service, with Part B appeals having the highest reversal rates. (See fig. 4.)

[42]CMS contractors may also participate in Level 3 hearings. According to HHS's fiscal year 2016 budget justification materials, contractor participation has the potential to reduce the Level 3 reversal rate. A 2012 HHS Office of Inspector General report showed that when CMS contractors participated in Level 3 hearings in fiscal year 2010, ALJs were less likely to decide fully in favor of appellants. See *Improvements Are Needed at the Administrative Law Judge Level of Medicare Appeals*, OEI-02-10-00340.

[43]See *Improvements Are Needed at the Administrative Law Judge Level of Medicare Appeals*, OEI-02-10-00340.

Figure 4: Percentage of Fully Reversed Medicare Fee-for-Service Appeals at Levels 1, 2, and 3, by Type of Service, Fiscal Years 2010-2014



Medicare Part A • • • • Medicare Part B — — durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS)

Source: GAO analysis of Centers for Medicare & Medicaid Services and Office of Medicare Hearings and Appeals data. | GAO-16-366

Note: The percentages are calculated based upon appeal decisions issued on the merits—that is decisions that affirm or reverse the coverage denial, in whole or in part, based upon a consideration of the facts of the appeal—and do not reflect appeal decisions based on other grounds, such as dismissals for procedural deficiencies. Medicare Part B appeals are exclusive of appeals of DMEPOS claims. Level 1 and Level 2 totals exclude appeals decided by Quality Improvement Organizations, because Medicare Administrative Contractors and Qualified Independent Contractors are responsible for handling Level 1 and Level 2 appeals of denials related to most claims.

In addition, fully favorable reversal rates at Levels 1 and 3 during this time generally varied depending upon whether the appeal was RA-related. At Level 1, RA-related appeals often had lower fully favorable reversal rates than did non-RA appeals, though differences exist when rates are compared by type of service. In contrast, RA-related appeals at Level 3 generally had higher fully favorable reversal rates than did non-RA appeals, both overall and for each of Part A and Part B services. (For more information on reversal rates for Levels 1 through 3, see app. III.)

Our analysis of Level 4 appeals data shows that from fiscal years 2010 through 2014, the Council affirmed the Level 3 decision in about two-thirds of appeals, and reversed, dismissed, or remanded the remaining one-third of the decisions. Level 4 decisions on appeals filed by providers, beneficiaries, and state Medicaid agencies were more likely to affirm ALJ decisions compared to decisions on appeals referred by CMS, meaning that the Council's decisions were more likely to uphold lower level decisions to deny Medicare payment for those claims. Specifically, Level

4 decisions affirmed the Level 3 decision in 73 percent of appeals filed by appellants and in only 15 percent of appeals filed by CMS.[44] (For more information on reversal rates for Level 4, see app. III.)

Data Systems Used by HHS to Monitor Appeals Process Do Not Capture Data to Identify Important Trends or Provide Consistent Data for Monitoring Appeals across Levels

HHS agencies use appeals data to monitor the Medicare appeals process, but do not collect information on the reasons for Level 3 appeal decisions or the amounts of allowed Medicare payments in dispute. Further, we identified several instances of inconsistent data across the three data systems used by HHS to monitor appeals.

HHS Agencies Use Data to Monitor Appeals but Do Not Collect Other Data on Reasons for Level 3 Appeal Decisions and Actual Amounts of Medicare Payments at Issue

HHS agencies use data collected in CROWD, MAS, and MODACTS to monitor the Medicare appeals process for Levels 1 through 4. These data systems collect information such as the date when the appeal was filed, the type of service or claim appealed, and the length of time taken to issue appeal decisions. Among other things, HHS agencies use these data to identify emerging trends, such as increases in appeals among certain service categories and changes in reversal rates; determine the extent to which the agencies or their contractors decide appeals within the statutory time frames; and help HHS estimate resource needs. For example, CMS officials told us that using data collected in MAS the agency observed that the largest increases in filed DMEPOS appeals were related to oxygen supplies and diabetic glucose testing supplies. As a result, the agency developed a strategy to help reduce the growth in these types of appeals.

[44] Officials with the CMS contractor responsible for choosing the cases to refer to Level 4 on behalf of CMS said that the following criteria, among others, are considered when selecting appeals for referral: the amount of money at issue and the extent to which an issue could reoccur.

CMS and OMHA are also in the process of making changes to these appeals data systems, and according to agency officials, these changes will improve their monitoring activities. Specifically, CMS plans to transition the collection of all Level 1 appeals data from CROWD into MAS, a process that CMS officials expect could take a minimum of 27 months and is dependent on the receipt of additional funding.[45] CROWD currently collects the majority of Level 1 appeals data, which has less specificity than MAS.[46] For example, CROWD collects only aggregate monthly totals of the number of appeals filed, which does not, for example, enable the tracking of individual Level 1 appeal decisions. Additionally, OMHA is developing the Electronic Case Adjudication and Processing Environment (ECAPE) to help the agency transition from a paper-based business process to a fully electronic one, enabling OMHA officials to automate many aspects of the agency's appeals processes, such as generating appellant correspondence.[47] ECAPE will exchange Level 3 data with MAS and MAS will continue to be the data system of record for Level 3 decisions in order to enable the sharing of common appeals data across the first three levels. According to OMHA officials, the new system will also provide the agency with additional data with which to monitor appeals at Level 3. For example, officials told us that ECAPE will allow the tracking of the time it takes to conduct discrete processes in Level 3, such as the time between when an ALJ provides written instructions to an attorney to when an attorney completes the decision letter draft. Additionally, OMHA officials told us that the data from ECAPE will also provide the agency with additional functionalities not present in MAS that could improve the efficiency with which Level 3 appeals are decided, such as the ability to allow appellants to view on a website the documentation included in their appeal file. Officials expect such a website could reduce the amount of redundant documentation

[45]CMS began transitioning MACs to reporting Level 1 appeals data in MAS in fiscal year 2014. Currently, MACs report some of their appeals data to MAS in 7 of 12 Medicare Part A jurisdictions. HHS officials stated that CMS will begin transitioning the remaining Part A jurisdictions, including the home health and hospice jurisdictions, in fiscal year 2017 if funding is received. CMS estimates that it will cost $9.2 million to fully integrate all the remaining Level 1 appeals workload—that is, Part B and DMEPOS—into MAS.

[46]See Department of Health and Human Services, Office of Inspector General, *The First Level of the Medicare Appeals Process, 2008-2012: Volume, Outcomes, and Timeliness*, OEI-01-12-00150 (Washington, D.C.: October 2013).

[47]Currently, to make an appeal decision ALJs review paper records which are digitized after decisions are made. OMHA officials expect ECAPE to be completed in 2017.

from prior appeal levels submitted by appellants that must be reviewed by OMHA staff.

However, MAS does not collect other information contained in ALJs' appeal decisions issued at Level 3, which is one data source CMS uses to monitor Level 3 appeal decisions. Level 3 decision letters generally document the facts of the case and the rationale for an appeal decision, but MAS does not collect detailed information related to the reasons for the appeal decisions that could be useful to HHS. For example, MAS does not contain information on whether LCDs or other CMS program guidance were among the issues disputed as part of the appeal, whether the ALJ declined to follow such guidance in issuing the decision, whether the ALJ admitted new evidence, or whether other factors contributed to the Level 3 decision. While some information on the reasons for Level 3 denials is collected by a CMS contractor, this information is not maintained in MAS.[48]

Of the three Medicare appeals systems, only MAS collects information on the amount at stake in an appeal. In MAS, the amount is tied to the amount billed by the provider, but this amount can vary substantially from the Medicare allowed amount.[49] According to HHS officials, CMS and OMHA data analyses suggest that, on average, billed amounts are about three times higher than the Medicare allowed amounts, but for some types of service, such as DMEPOS, the billed amount can be as much as eight times higher than the Medicare allowed amount. The Medicare allowed amount is a better approximation of what Medicare will actually pay if the item or service at issue in the appeal was covered.[50] For example, according to CMS data, we found that inpatient hospitals in the

[48]A CMS contractor, on behalf of CMS, reviews Level 3 decision letters for all appeals that reversed (in full or in part) denied claims to determine if CMS should refer the case to Level 4. As part of this review, the contractor provides CMS with information on the reasons for the Level 3 reversals, such as whether the contractor believes the ALJ interpreted the evidence in the case file differently than the lower level or believes the ALJ found the appellant's hearing testimony persuasive.

[49]The Medicare allowed amount is the total amount that providers are paid for claims for particular services.

[50]After some Part A appeal decisions are issued, MAS tracks the amount of money paid to providers. Specifically, MAS tracks this information for fully or partially favorable appeal decisions for appeals whose payments are processed by 7 of 12 MAC jurisdictions that report Part A appeals data to MAS.

United States billed Medicare an average of $6.3 billion for the top 100 diagnoses and procedures in fiscal year 2013, but the Medicare allowed amount for these services averaged $1.4 billion.[51] CMS officials told us that MAS does not track the Medicare allowed amount for prepayment claim denials because the MACs do not compute this amount for those claims. CMS officials also indicated that tracking allowed amounts for all appealed claims at Levels 1 and 2 would be extremely resource intensive and the benefits would be minimal. However, several MACs told us that they compute an estimate of the Medicare allowed amount to determine the Medicare savings associated with their prepayment medical reviews.[52] Additionally, CMS officials told us that MAS currently collects the data that would be used to calculate the Medicare allowed amount, such as procedure codes.

The collection of these types of data, specifically reasons for ALJ decisions and the Medicare allowed amount associated with an appeal, could help HHS agencies strengthen their existing monitoring and data collection activities. This would be consistent with the federal standards for internal control that require agencies to conduct ongoing monitoring to assess the quality of performance over time to ensure operational effectiveness, and to run and control agency operations using relevant, reliable, and timely information.[53] If HHS agencies collected information on the key characteristics that contributed to the Level 3 appeal decision in the appeals data systems, they would have information that could help identify appeal trends, which could help identify payment or claim review policies in need of clarification or additional guidance for appeals bodies or appellants.

Similarly, by not collecting the Medicare allowed amount for all pending appeals, HHS agencies are lacking information that could be useful in three ways.

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[51]See Centers for Medicare & Medicaid Services, *Inpatient Charge Data FY 2013,* accessed October 8, 2015, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/Inpatient2013.html.

[52]MACs report this information to CMS and CMS officials reported using this information as part of the monitoring of MACs' medical review programs.

[53]See GAO/AIMD-00-21.3.1.

- OMHA officials told us that the agency would like to base the amount in controversy on the Medicare allowed amount, as they believe that doing so could help reduce the number of Level 3 appeals filed in two ways. First, by using the Medicare allowed amount, some appeals might fall below the amount in controversy, and, therefore, would not be appealed. Second, appellants could choose to aggregate appeals that individually fall below the amount in controversy, which could also reduce the number of appeals filed. Currently, per regulation, the amount in controversy is computed using the provider billed amount.

- HHS agencies could use the Medicare allowed amount to calculate reversal rates based upon the potential Medicare dollars payable. Currently, HHS agencies calculate reversal rates based upon the number of appeals or appealed claims. Such a methodology does not account for differences in the dollar value of those appeals. Monthly reports from 2014 prepared for CMS on the Medicare appeals process state that the Level 3 reversal rate is higher when it is calculated based upon the amount in controversy, which according to monthly reports indicates that higher value claims are more likely to be reversed on appeal.

- Without the Medicare allowed amount or an approximation of it, HHS agencies do not know the amount of money at issue in the Medicare appeals process.

Inconsistencies across Appeals Data Systems Limit HHS Agencies' Ability to Monitor Appeals

Our review found data inconsistencies across the three appeals data systems and within the appeal levels that use MAS, such as variation in how appeal decisions are recorded at the claim level and how HHS agencies track appeal decisions. These data inconsistencies limit HHS agencies' ability to monitor emerging trends in appeals using consistent and reliable data. Federal standards for internal control call for agencies to establish and control operations using reliable information.

First, our review found variation in how appeal decisions at the claim level are recorded across CROWD, MAS, and MODACTS. Specifically, MAS has the capability to track appeal decisions by each claim, as well as by each line item in a claim, while CROWD and MODACTS do not. A claim for Medicare payment may identify a single procedure or item, or multiple procedures or items. For example, a claim for a continuous positive airway pressure device, a DMEPOS item, can have multiple line items that represent the device, tubes, filters, and mask included on the claim. Payment for some or all of these line items can be denied and then appealed.

We also found variation within MAS in how the Level 1 through 3 appeals bodies record appeal decision data at the claim level. The Level 1 and 2 adjudicators that report appeals data in MAS record an appeal decision for each line item within a claim. MAS then derives a claim-level decision, that reflects the totality of decisions made for each of the claim lines included in the appeal.[54] Using the claim-level decision, CMS can calculate a claim-level reversal rate. For example, the fully favorable reversal rate at the claim-level for an appeal composed of 10 claims, where 4 are fully reversed, would be 40 percent. In contrast, OMHA officials told us that ALJ teams vary in how they record claim-level decisions in MAS. Specifically, OMHA officials told us that while some ALJ teams record the actual decision for every claim included in the appeal, others record the decision for the appeal overall as the decision for each claim in the appeal. In such a circumstance, a comparable claim-level reversal rate cannot be calculated using the hypothetical example of the 10-claim appeal referenced above because all claims would be coded as partially reversed even though 4 claims were reversed and 6 claims were not reversed. Additionally, claim-level reversal rates cannot be compared across Levels 2 and 3. These differences in how data are entered into MAS limit HHS's ability to compare claim-level reversal rates consistently across all appeal levels.

Secondly, we found inconsistencies in how appeals are tracked by appeal level in the three data systems. Specifically, the three data systems use different categories to track the type of Medicare service at issue in the appeal, such as whether the appeal relates primarily to an inpatient hospital claim or a transportation claim. For example, Levels 1 and 3 cannot identify appeals submitted by hospice providers because these appeals at Level 1 are categorized as "other" and at Level 3 they are combined with home health appeals, even though hospice is tracked as its own category at Levels 2 and 4. Some efforts are being made to track appeals across appeal levels more consistently at Levels 2 and 3 in MAS. For example, according to an OMHA official, the agency plans to begin using the same appeal categories to track appeals at Level 3 that are used at Level 2, but has not determined when it will implement this planned change. There are also differences in how each appeal level assigns the appeal category to each appeal. For example, for Level 2

[54]A claim with some fully reversed claim lines and some claim lines not reversed is considered a partially reversed decision, according to CMS officials.

appeals, MAS assigns the appeal category using an algorithm based principally upon the type of claim filed. In contrast, Level 4 staff manually assign and enter the Level 4 appeal category in MODACTS, generally based upon information provided by the appellant in filing the appeal or from the Level 3 decision, according to Council officials. Such differences in how appeal categories are assigned can contribute to differences in how appeals are classified across appeal levels.

Finally, another inconsistency we identified across the appeals data systems is the tracking of whether appeals are related to claims reviewed by the different Medicare review contractors. This is information that CMS can use to monitor the performance of its medical review contractors by tracking their appeal reversal rates. Although CROWD, MAS, and MODACTS track whether an appeal is RA-related, there are inconsistencies in whether appeals related to other medical review contractors are tracked in these systems. For example, only MAS tracks appeals related to the contractor that investigates fraud, and none of the three systems track whether the appeal was related to an improper payment identified by a MAC or by another of CMS's review contractors, the Supplemental Medical Review Contractor.[55]

CMS and OMHA officials told us that they agree that greater data consistency across the Medicare appeals data systems and among the appeal levels using MAS would be beneficial for monitoring purposes. CMS officials told us that the agency awarded a contract in September 2015 to evaluate Levels 1 through 4 of the Medicare appeals process and that the evaluation, which is due in spring 2016, could also identify ways in which the appeals data could be improved. The specific objectives of this evaluation are to identify any changes that could streamline the Medicare appeals process, reduce the backlog of appeals, and reduce the number of filed appeals or the number of appeals reaching Levels 3 and 4. CMS officials told us they also expect the evaluation to identify additional appeals data that should be collected to improve the appeals process; however, this activity was not identified as an objective in the evaluation's statement of work, and therefore, we do not know to what extent the evaluation will focus on the data in the appeals systems. While

[55]CMS officials told us that the agency is working to implement a data field within MAS to track whether an appeal is the result of a review by the Supplemental Medical Review Contractor. However, CMS officials did not provide a time frame for when such a data field would be available to MAS users.

conducting such an evaluation is a good first step and may allow HHS to make improvements to the data systems that collect appeal information, it is unclear what findings the evaluator will recommend related to data consistency as this topic appears to be a small component of the overall evaluation.

Despite HHS Actions, the Appeals Backlog and Inefficiencies Related to Certain Repetitive Claims Remain

HHS agencies have taken several actions to reduce the total number of Medicare appeals filed and the current appeals backlog. However, the Medicare appeals backlog is likely to persist despite actions taken to date, and HHS efforts thus far do not address inefficiencies with the way certain repetitive claims are adjudicated.

HHS Agencies Took Actions to Reduce the Number of Medicare Appeals, the Number of Appeals Reaching Levels 3 and 4, and the Current Appeals Backlog

In order to provide more timely adjudication of appeals of Medicare claim denials, HHS agencies have taken various actions, which can be grouped into three categories:

1. changes to Medicare prepayment and postpayment claims reviews, which may reduce claim denials and, therefore, the number of filed appeals;
2. actions aimed at reducing the number of decisions at lower appeal levels that lead to appeals at Levels 3 and 4; and
3. actions aimed at resolving the current backlog of undecided appeals at Levels 3 and 4.

Actions That May Reduce the Number of Filed Appeals

CMS has made some changes to Medicare prepayment claims reviews, which may reduce the number of claim denials, and as a result, the number of filed appeals. For example, due to concerns about improper payments for certain services, CMS has established four prior authorization models in which providers submit documentation to support a claim for Medicare payment before rendering services, instead of submitting that documentation after the service was provided at the time the claim is submitted for payment. According to CMS officials, this practice allows providers to work with MACs to address potential issues with claims before the services are performed. Since 2012, CMS has implemented three demonstrations that require providers in certain states

to obtain prior authorization for power wheelchairs and scooters, repetitive scheduled non-emergent ambulance transports, and non-emergent hyperbaric oxygen therapy.[56] In addition, CMS established a prior authorization process for certain other DMEPOS items on February 29, 2016. In February 2016, a CMS official said that a recent decline in the number of Level 1 and 2 appeals of denied DMEPOS claims is due, in part, to the power mobility devices and non-emergent hyperbaric oxygen therapy prior authorization demonstrations.

CMS also made changes to the inpatient hospital coverage policy and the RA program, which have reduced the number of Part A filed appeals at Levels 1 and 2. For example, on October 1, 2013, CMS implemented a rule intended to clarify the circumstances under which Medicare would cover short stays in inpatient hospitals in an effort to help reduce the number of providers billing inappropriately for inpatient care instead of outpatient services.[57] As a result of these new coverage policies, CMS prohibited the RAs from conducting reviews of short-stay inpatient hospital claims with dates of admission after October 1, 2013. After several extensions imposed by CMS and Congress, the prohibition ended in January 2016, at which time CMS allowed the RAs to conduct a limited

[56]These demonstrations are projects to test whether prior authorization helps reduce expenditures, while maintaining or improving access to and quality of care. CMS began the power wheelchair and scooter—known collectively as power mobility devices—demonstration in 7 states in 2012, expanded the demonstration to 12 additional states in 2014, and extended the demonstration through 2018 in 2015. A repetitive ambulance service is a medically necessary ambulance transportation provided three or more times during a 10-day period or at least once per week for at least 3 weeks. Within Medicare, this service is typically used to transport individuals to and from dialysis centers for treatment. CMS began the ambulance demonstration in 3 states in 2014 and expanded the demonstration to an additional 6 states in 2016. CMS will evaluate whether to expand the demonstration nationwide by January 1, 2017. Hyperbaric oxygen therapy is a treatment whereby the beneficiary's entire body is exposed to oxygen under increased atmospheric pressure, such as in a pressurized room. CMS began the hyperbaric oxygen therapy demonstration in 3 states in 2015 and this demonstration will conclude in 2018.

[57]Specifically, the regulation states that it is generally appropriate for payment under Medicare Part A when the admitting physician expects the patient to require hospital care that crosses two midnights. 42 C.F.R. § 412.3(d)(1) (2015). In addition, between October 1, 2013, and September 30, 2015, CMS implemented a MAC probe and educate strategy in which MACs reviewed certain inpatient hospital claims on a prepayment basis and provided education to providers in accordance with applicable policies.

number of short-stay inpatient admission reviews.[58] The number of appeals filed related to hospital and other inpatient claims at Levels 1 and 2 declined in 2014 and 2015 from a high in 2013. In addition, in 2015, CMS limited the RA look-back period to 6 months from the date of service for certain patient status reviews instead of 3 years, which reduces the number of claims eligible for RA review and possible denial. RAs are also required to allow for a discussion period, in which providers who receive an improper payment determination can discuss the rationale for the determination and submit additional information that may substantiate payment of their claim prior to the claim adjustment process.

Actions to Reduce the Number of Appeals Reaching Levels 3 and 4

CMS has also taken actions aimed at reducing the number of appeals filed at Levels 3 and 4. In a demonstration that began in January 2016, the QIC responsible for processing DMEPOS appeals will engage in formal discussions with certain providers that are appealing two items—oxygen supplies and diabetic glucose testing supplies—before issuing an appeal decision.[59] CMS officials predict that these discussions will enable the QIC to reverse more claim denials at Level 2, thereby reducing the number of appeals that reach Levels 3 and 4. In future years, CMS plans to expand the demonstration to providers with appeals related to other DMEPOS services.

In another change, effective August 2015, CMS instructed MACs and QICs to focus their reviews of appeals of postpayment claim denials on only the reason(s) for the denial at issue in the original appeal, without introducing new reasons that appellants would need to address in further

[58]Beginning in October 2015, CMS directed Quality Improvement Organizations, another type of CMS contractor, to conduct initial inpatient hospital patient status reviews and instructed them to refer hospitals to the RAs for postpayment claim reviews only when the hospitals have demonstrated persistent noncompliance with Medicare payment policies, including hospitals with high claim denial rates.

[59]Under this demonstration, the QIC also has the authority to reopen other claims associated with appeals pending at Levels 2 or 3, or claims associated with appeals previously adjudicated by the QIC and eligible to be appealed to Level 3 that can be resolved favorably based on information gained through the discussion process. The QIC, as well as other appeals bodies, can use the reopening process to change the claim determination that resulted in an overpayment or an underpayment. Because of this, CMS officials expect that the demonstration will also directly reduce the appeals backlog at Level 3.

appeals.[60] Prior to this change, MACs and QICs reviewing appeals involving prepayment and postpayment claim denials were able to identify new claim denial reasons. CMS's policy change will address stakeholder concerns that when MACs and QICs conducted independent reviews of claims, they often found new reasons to deny the claim, and as a result, appellants would have to file an appeal and provide evidence to address the new denial reason(s) at the next level of appeal. In February 2016, a CMS official reported that the agency believes this policy change has already resulted in an increase in the Level 2 reversal rate, which should reduce the number of appeals reaching Levels 3 and 4.

Actions to Reduce the Appeal Backlog

CMS and OMHA have also taken steps to reduce the number of undecided appeals at Level 3 and Level 4. Under the global settlement CMS offered to hospitals from August to October 2014, CMS agreed to pay 68 percent of the inpatient net payable amount on Part A claims denied because the inpatient setting was determined to be medically unnecessary. In exchange, the hospital withdrew its pending appeals and waived its right to file a future appeal related to the claims.[61] As of June 1, 2015, CMS paid approximately $1.3 billion to providers through the

[60]As an exception to this policy, if the claim was denied due to a lack of documentation that the appellant submitted with its Level 1 or Level 2 appeal request, the MAC or QIC may use that documentation to determine if the claim was paid properly, which could result in new denial reasons.

[61]Claims eligible for the settlement were those (1) denied by a Medicare contractor on the basis that services may have been reasonable and necessary but treatment on an inpatient basis was not, (2) that were either under appeal or within their administrative time frame to request an appeal review, (3) with dates of admissions prior to October 1, 2013, and (4) where the patient was not a Part C enrollee. The hospital could not choose to settle some eligible claims and continue to appeal others. The deadline for hospitals to request a settlement was October 31, 2014.

In response to the number of claim decisions related to inpatient admissions being appealed to and reversed at Levels 3 and 4, CMS issued a ruling in March 2013 that clarified the payment policy for hospital inpatient admissions that had been denied by a Medicare contractor because the inpatient admission was not reasonable and necessary. Specifically, the clarification provides that such hospitals can rebill these Part A claims as Part B claims when the claims would have been payable had the beneficiary originally been treated as a hospital outpatient rather than admitted as an inpatient. CMS formally adopted this policy in a final rule published in August 2013. *Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care; Hospital Prospective Payment System and Fiscal Year 2014 Rates; Quality Reporting Requirements for Specific Providers; Hospital Conditions of Participation; Payment Policies Related to Patient Status*, 78 Fed. Reg. 50,496, (Aug. 19, 2013).

settlement. We estimate that it reduced the number of undecided appeals by 31 percent at Level 3 and 37 percent at Level 4. (See table 6.)

Table 6: GAO Estimate of Pending Medicare Fee-for-Service Appeals at Levels 3 and 4 Resolved by the Centers for Medicare & Medicaid Services (CMS) Global Settlement

Appeal level	Pending appeals workload			Percentage of pending appeals workload reduced
	Pending before the settlement	Appeals resolved by the settlement	Pending after the settlement	
Level 3	786,507	243,389	543,118	31.0
Level 4	7,534	2,796	4,738	37.1

Source: GAO analysis of Office of Medicare Hearings and Appeals (OMHA) and Departmental Appeals Board (DAB) data. | GAO-16-366

Note: GAO analyzed extracts of the Medicare Appeals System (MAS) and Medicare Operations Division Automated Case Tracking System, and a file provided by DAB on November 6, 2015, that identifies pending Level 4 appeals included in the global settlement. This analysis includes appeals that were undecided as of the dates of the data extracts (June 2, 2015, for Level 3 and May 22, 2015, and November 30, 2015, for Level 4) regardless of when the appeal was filed; therefore, this estimate includes some but not all appeals filed in fiscal year 2015. As of February 2016, OMHA and DAB were still in the process of dismissing appeals included in CMS's global settlement. Level 1 is excluded because CMS does not collect this information in the Contractor Reporting of Operational and Workload Data system or MAS. Level 2 is excluded because, compared to Levels 3 and 4, very few appeals were included in the global settlement.

In addition, OMHA has implemented three pilot programs—the settlement conference facilitation pilot, the statistical sampling pilot, and the senior attorney pilot—which focus on resolving appeals at Level 3 more efficiently. OMHA's settlement conference facilitation pilot, which began in June 2014, allows eligible appellants to have their appeals at Level 3 settled through an alternative dispute resolution process rather than an ALJ hearing.[62] OMHA offered the pilot to a limited number of providers initially, and, according to OMHA officials, as of January 2016, had settled with 10 appellants involving about 2,400 appeals. The agency expanded the scope of appeals eligible for participation in the pilot to include appeals of additional Part B claim denials in October 2015 and appeals of certain Part A claim denials in February 2016. OMHA officials told us they are also exploring expansion of the pilot in 2016 to appeals filed by state

[62]During the initial phase of the pilot, only appellants with Part B-related appeals that filed for an ALJ hearing in calendar year 2013 were eligible for participation. Appellants must also meet several other criteria to participate; for example, they must agree to include in the settlement all pending appeals for the same item or service at issue and at least 20 claims must be at issue or at least $10,000 must be in controversy, if fewer than 20 claims are involved.

Medicaid agencies that relate to home health services provided to dually eligible beneficiaries. As noted earlier, appeals from these state Medicaid agencies have increased. We identified approximately 47,000 pending Level 3 appeals as of our June 2015 data extract that are related to this issue, which could take over half of OMHA's ALJs at least a year to adjudicate through a traditional hearing process.

OMHA's statistical sampling pilot began in July 2014 and aims to reduce the appeal backlog by deciding multiple appeals filed by a single appellant using statistical sampling and extrapolation.[63] Under this pilot, an ALJ reviews and issues decisions on a random sample of the appellant's eligible denied claims. The ALJ's decision is then extrapolated to the universe of the appellant's claims in question. As of August 2015, the pilot's success has been limited—according to HHS, only one appellant had elected to participate in this process that would resolve its 405 pending appeals, which equates to about 40 percent of the annual workload of one ALJ. OMHA representatives said the office has conducted outreach to encourage more providers to participate in the pilot and plans to increase the number of claims eligible for the pilot, although as of February 2016, OMHA had not announced any specific plans or time frames to do so.

According to HHS officials, OMHA's senior attorney pilot, which began in July 2015, uses senior attorneys to conduct on-the-record reviews of appeals if the appellant waived the right to an oral hearing. Under this pilot, the senior attorney determines whether an on-the-record decision is warranted, and if so, drafts the decision for an ALJ to review and issue. HHS officials reported that as of March 2016, 671 appeals at Level 3 have been resolved through this initiative and that they plan to increase the number of senior attorneys participating in this program.

Despite Actions Taken to Date, the Backlog of Undecided Medicare Appeals Will Likely Persist

Despite actions HHS agencies have taken, the Medicare appeals backlog will likely persist. While it is too early to predict the ultimate effect many of HHS's current efforts will have on the Medicare appeals backlog, their effect thus far, with the exception of the global settlement, has been limited and the backlog continues to grow at a rate that outpaces the

[63]To be eligible for participation, appellants must meet several criteria. For example, there must be a minimum of 250 claims in dispute and the beneficiary must not have been found liable for payment after the initial appeal or participated in the Level 2 appeal.

adjudication capacities at Levels 3 and 4.[64] According to OMHA representatives, in fiscal year 2015, the number of incoming appeals at Level 3 declined to 235,543 from a high of 432,534 in fiscal year 2014. While this was a significant decrease, it was still three times the number of appeals decided in fiscal year 2015. Further, HHS reported that it expects the number of incoming appeals to increase again when new RA contracts are awarded and the RA program resumes full operation. A similar challenge exists at Level 4. The Council reported that it can adjudicate almost 2,680 appeals each year, which includes both its FFS and non-FFS workload; however, the Council's pending appeals workload as of February 2016 was more than six times that amount and, in fiscal year 2015, it received more than three times the number of appeals it adjudicated in the same year.

OMHA and Council representatives said that the fiscal year 2016 appropriations are unlikely to mitigate the growing appeals backlog at Levels 3 and 4. OMHA received a 20 percent increase in funding in its fiscal year 2016 appropriation, which HHS officials said will allow OMHA to hire 15 additional ALJs as well as expand other efforts to improve the appeals process. However, HHS representatives told us that even with this increase, OMHA will not have the adjudication capacity to stem the growing number of appeals at Level 3. The Council did not receive a funding increase in the fiscal year 2016 appropriations, and Council representatives said that at its present funding levels the Council is unlikely to keep pace with any increases in decisional output at Level 3.[65]

[64]Most of HHS agencies' current actions were implemented during or after 2014. Although the global settlement significantly reduced the backlog, it ended in 2015, and therefore, will not have an effect on the current backlog. HHS stated in a recent report to Congress that a recent pause in the RA program due to contract bid protests also temporarily resulted in fewer Level 3 appeals. In February 2014, CMS required the RAs to stop sending requests for medical documentation to providers, so that the RAs could complete all outstanding claim reviews by the end of their contracts. However, in June 2015, CMS cancelled the procurement for the next round of RA contracts, which had been delayed because of bid protests. Instead, CMS modified the existing RA contracts to allow the RAs to continue claim review activities through July 31, 2016. According to CMS officials, the agency plans to award the next round of RA contracts in 2016.

[65]HHS has stated that any increases in appeal decisions made at Level 3 will almost certainly result in a proportionate increase in appeals filed at Level 4. According to Council officials, 10 percent of cases decided at Level 3 were appealed to Level 4 in fiscal year 2015.

In the fiscal year 2017 HHS budget justification materials, several budgetary and legislative changes were requested to improve the Medicare appeals process and reduce the backlog.[66] For example, additional funding for OMHA and the Council was requested to increase their adjudication capacity, as well as additional funding to CMS to increase QIC participation in Level 3 hearings, which the agency expects will reduce the reversal rate at Level 3.[67] Legislative authority was also requested to allow OMHA and the Council to use a portion of the overpayments collected through the RA program to increase their adjudication capacity. (See app. IV for a description of the legislative proposals included in the President's fiscal year 2017 budget related to the Medicare appeals process.)

HHS Actions Do Not Address Inefficiencies Regarding the Adjudication of Certain Repetitive Claims

HHS's efforts to reduce the number of filed Medicare appeals and the appeals backlog have not addressed inefficiencies regarding the way appeals of certain repetitive claims for ongoing services are decided, although doing so could lead to fewer appeals. According to representatives from one MAC that reviews DMEPOS appeals, under the current process, once a provider submits an initial claim for a recurring service—such as DMEPOS claims for monthly oxygen equipment rentals—and it is denied, all subsequent claims for the service are also denied, requiring providers to file multiple appeals for the recurring service. A beneficiary's one year supply of oxygen, for example, could generate 12 claims, and therefore, 12 denials and possibly 12 appeals. If the appeal for the initial claim is later reversed in favor of the appellant, the appeals of the subsequent claims must continue to go through the appeals process, awaiting separate decisions, because the favorable

[66]These legislative initiatives were developed by an HHS interagency workgroup established in 2013 to help identify ways in which HHS agencies can reduce the Medicare appeals backlog and minimize the number of appeals that reach Levels 3 and 4. Many of the initiatives were also included in the President's proposed fiscal year 2016 budget.

As noted earlier, CMS is conducting an evaluation to identify additional actions that could be taken to reduce the number of filed appeals and the appeals backlog. This study is also expected to identify performance measures that could be used to evaluate the effectiveness of changes to the Medicare appeals process.

[67]OMHA seeks to more than double the number of ALJs—from 92 ALJs by the end of fiscal year 2016 to 193 ALJs in fiscal year 2017. In addition, the Council seeks to hire additional legal staff.

appeal decision on the initial claim cannot generally be applied to the other appeals of subsequently denied claims.[68]

Representatives from some MACs, OMHA, and a provider group we interviewed said that this process is inefficient and suggested approaches to change the way these repetitive claims are adjudicated. In addition, two of the MACs we spoke to had developed their own processes to adjudicate some of these appeals more efficiently. For example, representatives from one of the MACs said that if a decision on an initial repetitive claim is reversed at Level 1, the MAC will apply that decision to related appeals pending within its jurisdiction. Given that these claims are for recurring services that are typically appealed individually, they could contribute substantially to the number of appeals related to DMEPOS. Furthermore, OMHA representatives told us that addressing this issue would achieve major efficiencies for the Medicare appeals process. Doing so is also consistent with internal controls that call for agencies to establish control activities that are effective and efficient in accomplishing the agency's stated goals.

HHS officials told us that the department could address this issue if granted certain statutory authority described in the HHS fiscal year 2017 budget justification materials. Specifically, HHS requested legislative authority to consolidate appeals into a single administrative appeal. While the authority is requested to allow appeals bodies to consolidate appeals for the purposes of sampling and extrapolation, HHS officials said that they could also use this authority to consolidate appeals of certain repetitive claims and decide them jointly. It is unclear whether HHS will be granted this authority. However, department officials acknowledged HHS currently has the authority to promulgate regulations that could help address this issue through the reopening process, although at the time we discussed our findings with department officials, they told us that they prefer to address this issue through the statutory change requested in the President's proposed fiscal year 2017 budget. The reopening process could allow appeals bodies discretion to give deference to a decision made at a higher appeal level upon determining that the beneficiary's condition or other facts and circumstances of the appeal had not changed. For example, an appeals body could apply a decision of a

[68]MACs and QICs generally have the ability to reverse related appeals that are pending within their jurisdiction; however, they are unable to apply an appeal decision to appeals that are pending at another level.

higher appeal level that the appellant met medical necessity requirements, although it would still need to verify certain components of the claim, such as verification of service delivery, in order to prevent fraud and abuse.[69] In doing so, the review of the claim or claims in question could require a less intensive analysis than a de novo review.

Conclusions

Significant growth in the number of appeals at all administrative appeal levels has posed several challenges to the Medicare appeals process. These challenges are particularly pronounced at Levels 3 and 4, which had the largest proportion of decisions issued after the statutory time frames from fiscal year 2010 through fiscal year 2014 and the greatest backlog of pending appeals. This backlog shows no signs of abating as the number of incoming appeals continue to surpass the adjudication capacity at Levels 3 and 4. The current situation whereby Levels 3 and 4 decide a substantial number of appeals after statutory time frames is likely to persist without additional actions.

HHS could take more steps to improve its oversight of the appeals process and its understanding of the characteristics of appeals contributing to the increased volumes and the current appeals backlog. As HHS takes action aimed at reducing the appeals backlog, HHS will need reliable and consistent data to monitor the appeals system, including the effect of any actions taken. Currently, HHS data systems are not collecting additional information that would assist HHS agencies in their monitoring efforts. HHS is awaiting results of an evaluation of the Medicare appeals process that may address data inconsistencies within the three appeals data systems and among levels using MAS. While the evaluation is a good first step to identifying and modifying the data systems, it is unclear how well the evaluation will address these issues because it is not a specific objective of the evaluation. Without more reliable and consistent information, HHS will continue to lack the ability to identify issues and policies contributing to the appeals backlog, as well as measure the funds tied up in the appeals process.

Finally, the manner in which appeals of certain repetitive claims are adjudicated is inefficient, which leads to more appeals in the system than

[69] HHS officials noted that an individual review of repetitive claims would be necessary to ensure that the service was actually ordered and rendered.

necessary. With the appeals backlog as large as it is at Levels 3 and 4, HHS would benefit from a change in the process that could consolidate these appeals and reduce the number of appeals that require decisions. HHS has requested legislative authority to achieve this. Department officials acknowledged HHS currently has the authority to promulgate regulations that could help address this issue through the reopening process, although at the time we discussed our findings with them, we were told that they prefer to address this issue through the statutory change requested in the President's proposed fiscal year 2017 budget.

Recommendations for Executive Action

To reduce the number of Medicare appeals and to strengthen oversight of the Medicare FFS appeals process, we recommend that the Secretary of Health and Human Services take the following four actions:

1. Direct CMS, OMHA, or DAB to modify the various Medicare appeals data systems to
   a. collect information on the reasons for appeal decisions at Level 3;
   b. capture the amount, or an estimate, of Medicare allowed charges at stake in appeals in MAS and MODACTS; and
   c. collect consistent data across systems, including appeal categories and appeal decisions across MAS and MODACTS.
2. Implement a more efficient way to adjudicate certain repetitive claims, such as by permitting appeals bodies to reopen and resolve appeals.

Agency Comments and Our Evaluation

HHS provided written comments on a draft of this report, which are reprinted in appendix V, and provided technical comments, which we incorporated as appropriate. HHS generally agreed with four of the five draft recommendations and outlined a number of initiatives it is taking to improve the efficiency of the Medicare appeals process, reduce the backlog of pending appeals, and mitigate the possibility of future backlogs. HHS also expressed its willingness to modify the appeal data systems in order to collect consistent data across the appeal data systems and to implement a more efficient way to adjudicate certain repetitive claims. In commenting, HHS provided further information for two of the recommendations with which it generally agreed. Regarding our recommendation to collect information on the reasons for appeal decisions at Level 3, HHS indicated that collecting this information in the planned ECAPE system instead of MAS, as we recommended, would be more cost effective. We agree with the department's rationale and modified our recommendation to remove the language specifying that this

information be collected in MAS. Regarding our recommendation that HHS capture the amount of Medicare allowed charges; in its technical comments, the department indicated that it would not do this for all appeals. Specifically, HHS indicated that it has no plans to collect the Medicare allowed amount for Levels 1 and 2 because doing so would require changes to the claims processing system or require manual pricing of all appeals, which would require additional funding for the MACs. We believe that there may be less resource intensive options for implementing the recommendation, and we modified the language of the recommendation to clarify that obtaining an estimate of the Medicare allowed amount would be a way to fulfill the recommendation. In contrast, HHS disagreed with a recommendation related to determining the costs and benefits of delaying CMS's collection of overpayments until after a Level 3 decision is made, stating that such a change would increase the number of appeals filed at Level 3. We agree that this change might increase the number of filed appeals and, therefore, we did not include the recommendation in the final report.

As agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies to the Secretary of Health and Human Services, the Administrator of the Centers for Medicare & Medicaid Services, the Chief Administrative Law Judge of the Office of Medicare Hearings and Appeals, the Chair of the Departmental Appeals Board, appropriate congressional committees, and other interested parties. In addition, this report is available at no charge on the GAO website at http://www.gao.gov.

If you or your staff has any questions about this report, please contact me at (202) 512-7114 or kingk@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix VI.

Kathleen M. King
Director, Health Care

Appendix I: Scope and Methodology

This appendix provides additional details regarding our analysis of (1) trends in Medicare fee-for-service (FFS) appeals for fiscal years 2010 through 2014; (2) differences in claim-level and appeal-level reversal rates; (3) appeals resolved by the Centers for Medicare & Medicaid Services' (CMS) global settlement; (4) CMS's estimate of interest paid by the agency to certain providers; and (5) data reliability.

Trends in Medicare Administrative Appeals for Fiscal Years 2010 through 2014

To examine trends in appeals for fiscal years 2010 through 2014, we analyzed extracts of three data systems obtained from CMS, the Office of Medicare Hearings and Appeals (OMHA), and the Departmental Appeals Board (DAB). (See table 7.)

Table 7: Data Sources Analyzed

Appeal level	Agency	Data source	Date of extract
Level 1	Centers for Medicare & Medicaid Services (CMS)	Contractor Reporting of Operational and Workload Data system	June 24, 2015
		Medicare Appeals System (MAS)	July 13, 2015
Level 2	CMS	MAS	May 29, 2015
Level 3	Office of Medicare Hearings and Appeals	MAS	June 2, 2015
Level 4	The Medicare Appeals Council within the Departmental Appeals Board (DAB)	Medicare Operations Division Automated Case Tracking System	May 22, 2015 and November 30, 2015[a]

Source: GAO. | GAO-16-366

[a]DAB officials sent us an additional extract on November 30, 2015, because the extract dated May 22, 2015, did not include all appeals filed in fiscal year 2014.

Administrative Appeals Filed

To determine the number of Medicare FFS appeals filed for each level overall, by the type of appellant, by type of service, by subcategory of service, and by whether the appeal resulted from a claim review conducted by a Recovery Auditor (RA), we took a number of steps that varied by level due to differences in the systems.

Level 1. While the Contractor Reporting of Operational and Workload Data (CROWD) system extract contained data on most Level 1 appeals filed during the period of our analysis, the Medicare Appeals System (MAS) extract contained Level 1 appeals data for six of the seven Medicare Administrative Contractor (MAC) jurisdictions that reported their Medicare Part A (Part A) appeals data to MAS in fiscal year 2014.[1] Using

[1]The seventh jurisdiction reported to the CROWD system during the period of our review.

the CROWD data, we determined the number of appeals filed by counting the number of requests received less the number of misrouted requests. CMS officials indicated that this approach will likely produce an approximate number of filed appeals for our purposes. However, agency officials also noted that CMS uses the number of requests cleared instead of requests received when representing appeals workload, because the requests received line could overestimate the number of filed appeals. For example, it could count duplicate requests or requests for reopenings as opposed to appeals. CMS officials noted that the agency has made changes, effective in January 2016, to improve the quality of the requests received data. Using MAS data for the Part A appeals data for the remaining six MAC jurisdictions, we also counted appeals filed and excluded misrouted and misfiled appeals. To determine the total number of Level 1 appeals filed, we added counts derived from CROWD and MAS. Our analysis excludes Level 1 appeals decided by Quality Improvement Organizations because MACs are responsible for handling Level 1 appeals of denials related to most claims.

- Type of appellant: We did not determine the number of appeals filed by the type of appellant because this information is not captured in the CROWD system.

- Type of service: To determine the number of appeals that were related to durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) items, using CROWD data we categorized all appeals decided by the four MAC jurisdictions that decide DMEPOS appeals as DMEPOS services.[2] We categorized appeals of Part B services and appeals of Medicare Part B (Part B) services whose claims were decided by the Part A MACs (referred to as Part B of A) as Part B services.[3]

- Subcategory of service: We report the number of appealed claims decided by subcategory of service because CROWD does not track filed appeals or filed appealed claims by subcategory of service. Using the CROWD data, we determined the number of appealed

[2]This approach captures nearly all DMEPOS appealed claims during the period of our analysis; however, some appeals related to DMEPOS claims are decided by Part B MACs, according to CMS officials.

[3]This approach is different than that used by CMS for Levels 1 and 2, which categorizes these services as Part A services.

claims decided using the number of claims cleared. CROWD uses the following subcategories: inpatient hospital, DMEPOS, home health, laboratory, other, outpatient, physician, skilled nursing facility, and ambulance, which we refer to as transportation.[4] Using the MAS data, we determined the number of appealed claims decided by counting the number of claims. Primarily using a crosswalk provided by CMS, we mapped MAS appeal categories to the CROWD subcategories. (See table 8.)

- RA-related: We report the number of RA-related appeals decided using the number of RA redeterminations cleared because CROWD does not have this information for filed appeals.[5] In MAS, we considered an appeal as RA-related if the field RA name was not missing.

[4]We report the number of appealed claims decided based upon the fiscal year that the appeal was decided.

[5]We report the number of appeals decided based upon the fiscal year that the appeal was decided.

Table 8: Crosswalk of Service Subcategories for Level 1 Medicare Appeals System (MAS)

Subcategory of service	Level 1 appeal category
DMEPOS	52-Hosp bed & support surfaces
Home health	[a]
Inpatient hospital	03-Acute inpatient hospital
Laboratory, clinic, and x-ray	04-Office-based lab/x-Ray 30-pathology/laboratory
Other	32-Drugs 42-Acute inpatient rehab 45-Partial psych hosp 48-Rural health clinic/FQHC 49-ESRD facility 50-Other 66-Respiratory/cardiovsclr sur 69-Other surgery 72-Radiation/chemo/infusion 81-Copay/deductible No Match found
Outpatient	06-Outpatient therapies / CORF 41-Outpatient hospital / ASC
Skilled nursing facility	24-Skilled nursing facility
Transportation	07-Ground transportation

Legend: DMEPOS = durable medical equipment, prosthetics, orthotics, and supplies.

Source: Centers for Medicare & Medicaid Services. | GAO-16-366

[a]There were no appeals in MAS with a comparable subcategory.

Level 2. In analyzing MAS data, we excluded combined, deleted, and misrouted appeals, but included reopened appeals. Our analysis also excludes Level 2 appeals decided by Quality Improvement Organizations because Qualified Independent Contractors (QIC) are responsible for handling Level 2 appeals of denials related to most claims.

- Type of appellant: To determine the type of appellant that filed the appeal, we used the field “appeal appellant type.”[6]
- Type of service: To determine whether the appeal was for Part A, Part B, or DMEPOS, we used two MAS fields—“Medicare type” and the name of the QIC.[7] In general, we categorized appeals of Part B services and appeals of Part B of A services as Part B services using “Medicare type.”
- Subcategory of service: To determine the subcategory of service, we used the field “appeal category.” Using appeal category, we mapped Level 3 appeal categories to Level 2 appeal categories generally using a crosswalk provided by OMHA. Using that crosswalk, we grouped services into 10 subcategories. (See table 9.)
- RA-related: We considered an appeal as RA-related if the field “RAC flag” was equal to “yes.”

[6]To categorize appellants, we used the following approach. Provider appeals are those identified as filed by providers, provider representatives, non-participating providers, and prescribing physicians. State Medicaid agency appeals are those identified as filed by state Medicaid agencies. Beneficiary appeals are those that were filed by beneficiaries, beneficiary representatives, estates, and families. Other appeals are those identified as filed by advocacy organizations, Congress members, and others.

[7]Two QIC contractors decide Level 2 appeals in five jurisdictions: two Part A jurisdictions, two Part B jurisdictions, and one DMEPOS jurisdiction.

Table 9: Crosswalk of Service Subcategories for Levels 2 and 3

Subcategory of service	Level 2 appeal category	Level 3 appeal category
DME (exclusive of prosthetics and orthotics)	51-Medical/surgical supplies 52-Hosp bed & support surfaces 53-Oxygen 54-Manual wheelchairs 55-Miscellaneous DMEPOS 58-Enteral/parenteral nutri. 59-Glucose monitors 84-Infustion pumps 85-Power mobility devices 86-Nebulizers & drugs 88-Ostomy & urological 89-Positive airway pressure devices 90-Negative pressure wound therapy 91-Pneumatic compressor 92-Repairs 93-Respiratory-miscellaneous 94-Surgical dressings 95-Therapeutic shoes	DME Medical supplies
Home health and hospice	08-Home health 11-Hospice	Home health/hospice
Inpatient hospital	03-Acute inpatient hospital 42-Acute inpatient rehab. 43-Acute inpatient psych 47-Long term care hospital	Acute hospital
Laboratory, clinic, and x-ray	04-Clinic/lab/X-Ray 30-Pathology/laboratory 31-Imaging/radiology	Clinic/lab/X-Ray

Subcategory of service	Level 2 appeal category	Level 3 appeal category
Other	12-Non-Medicare benefit 21-Out of area 32-Drugs 33-Vision services 34-Chiropractic 35-Dental 39-AC dismissal 50-Other 57-Drugs miscellaneous 79-Technical denial 80-MSP 81-Copay/deductible 82-Eligibility 83-Consolidated billing unspecified	AC dismissal Chiropractic Cost sharing Dental Non-Medicare benefit OON: LTC facility OON: physician office access Other Out of area Prescription drug QIC dismissal Request for tiering exception Unspecified Vision care
Outpatient	06-Outpatient therapies / CORF 41-Outpatient hospital / ASC 44-Outpt psych/Com mental hlth 45-Partial psych hosp 48-Rural health clinic/FQHC 49-ESRD facility	Emergency room Outpatient mental health Outpatient therapies
Practitioner services	60-Office E/M services 61-Hospital E/M services 62-Facility E/M: SNF/asst/home 65-Integum'y/musc-skeletal sur 66-Respiratory/Cardiovsclr sur 67-Nervous system surgery 68-Gastro./urinary/genital sur 69-Other surgery 70-Anesthesia 71-Podiatry 72-Radiation/chemo/infusion 73-Audiology 74-IDTF	Non-MD practitioner Practitioner services
Prosthetics and orthotics	56-Orthoses 87-Prostheses	Prosthetics/orthotics
Skilled nursing facility	05-Nursing home 24-Skilled nursing facility 46-Intermediate care	Nursing home Skilled nursing facility

Transportation	07-Ground transportation 26-Air ambulance	Transportation

Legend: DME = durable medical equipment (exclusive of prosthetics and orthotics).

Source: GAO analysis of information from the Centers for Medicare & Medicaid Services and the Office of Medicare Hearings and Appeals. | GAO-16-366

Level 3. In analyzing MAS data, we excluded appeals that had been combined or deleted, but included reopened appeals.

- Type of appellant: To determine the type of appellant that filed the appeal, we used the MAS field "requester type;" a field created by OMHA for us that indicates that the MAS appeal record included a beneficiary identification number, thus indicating the appeal was filed by a beneficiary; and a file provided to us by OMHA that identified appeals filed by a state Medicaid agency that could not be identified using the field "requester type."[8]

- Type of service: To determine whether the appeal was for a Part A, Part B, or DMEPOS service, we used two MAS fields—"Medicare type" and the name of the QIC. In general we categorized appeals of Part B services and appeals of Part B of A services as Part B services using "Medicare type."

- Subcategory of service and RA-related: We used the same approach described for Level 2 above.

Level 4. In analyzing Medicare Operations Division Automated Case Tracking System (MODACTS) data, we excluded appeals resulting from CMS referrals, and appeals in which the record indicated a final action of lost file or tape as Level 4 did not review the appeal. We counted as one appeal any appeals in which the appellant filed one appeal but the

[8]Provider appeals are those filed by providers, non-contract providers, prescribing physicians, and other; if the appeal record did not contain a beneficiary identification number and the appeal was filed by an advocacy group, attorney, Member of Congress, or representative; or if requester type was missing and the appeal record did not contain a beneficiary identification number. Beneficiary appeals are those appeals filed by beneficiaries, estates, and families; if the appeal record contained a beneficiary identification number and the appeal was filed by an advocacy group, attorney, Member of Congress, or representative; or if requester type was missing and the appeal record did contain a beneficiary identification number. State Medicaid agency appeals are those that were filed by state Medicaid agencies or were identified in a file provided to us by OMHA on November 9, 2015, that contained primary appellant.

Medicare Appeals Council (the Council) issued separate appeal decisions.

- Type of appellant: To determine the type of appellant that filed the appeal, we used the fields "appellant type" and the name of the appellant, where the field "workload" indicated that CMS had not filed the appeal.[9]
- Type of service: To determine whether the appeal was for a Part A or Part B service, we used the field "claim type." We used the field "type of service"—specifically, values of durable medical equipment, orthotic, prosthetic, or surgical dressing—to identify whether the appeal was for a DMEPOS item. We did not take additional steps to categorize appeals of Part B of A services as Part B services as Council officials told us that those services are already categorized as Part B claims.
- Subcategory of service: To determine the subcategory of service, we used the field "type of service." We grouped type of service into 10 subcategories. (See table 10.)
- RA-related: An appeal was RA-related if the field "overpayment" was set to "RAC."

[9]Provider appeals are those filed by providers. State Medicaid agency appeals are those with an appellant type of subrogee or where the appellant name started with "state of." Beneficiary appeals are those with an appellant type of beneficiary, estate, or relative. Other appeals have an appellant type of "other."

Table 10: Crosswalk of Service Subcategories for Level 4

Subcategory of service	Level 4 appeal category
Inpatient hospital	Hospital inpatient Partial hospitalization
DME (exclusive of prosthetics and orthotics)	Durable medical equipment Surgical dressing
Home health and hospice	Home health aide Hospice
Other	Audiology Chiropractic Drugs and biologicals Medical social services Occupational therapy Other - Part A Other - Part B Physical therapy Prescription drug Respiratory therapy Speech therapy
Outpatient	Clinical psychology Hospital outpatient
Practitioner Services	Anesthesia Physician services
Prosthetics and orthotics	Orthotic Prosthetic
Radiology	Radiology
Skilled nursing facility	Skilled nursing services
Transportation	Ambulance - air Ambulance - ground

Legend: DME = durable medical equipment (exclusive of prosthetics and orthotics).

Source: GAO analysis of information obtained from the Departmental Appeals Board. | GAO-16-366

Time Frames for Issuing Appeal Decisions

For all appeal levels, we determined the percentage of appeal decisions issued after the statutory time frames. This analysis is based on the fiscal year that the appeal was decided. Thus, appeals in which no appeal decision had been issued from fiscal year 2010 through fiscal year 2014 are excluded from our analyses.

Level 1. Our analysis for Level 1 is different from those for Levels 2, 3, and 4. Specifically, the Level 1 analysis presents information on a quarterly basis by type of service (i.e., Part A, Part B, and DMEPOS) and

the percentages of Part B of A services are included in totals for Part A services. We derived this information from CMS's "Appeals Fact Sheets," which contain the percentage of appealed claims decided on-time on a quarterly basis by type of service.[10] Using these data, which are presented on a calendar year basis, we determined the percentage of appealed claims on a fiscal year basis that were not issued on-time.

Level 2, Level 3, and Level 4. To determine the percentage of appeals issued after the statutory time frame, we determined the number of appeals issued after the deadline date overall and by type of appellant for Levels 3 and 4.[11] The deadline date is captured and adjusted in MAS (Levels 2 and 3) and MODACTS (Level 4) to reflect any reasonable changes to the deadline, such as if the appellant submitted additional documentation after the appeal was filed. We found that the deadline date was missing in MODACTS for over one-third of appeals that had been decided during the time frame of our analysis. As a result, we set the deadline date for these appeals to 90 days after the appeal start date. DAB officials indicated this approach was generally appropriate. For Levels 2 and 3, we limited this analysis to appeal decisions issued on the merits.[12] As a result, appeals with the following appeal decisions are excluded from the calculation: dismissed or escalated at Level 2; and dismissed, escalated, remanded, or in which no decision on the denied claim was made at Level 3. For Level 4, we excluded appeals referred to the Council by CMS, as well as appeals that were dismissed by the Council under the circumstances set forth in 42 C.F.R. §405.1114 at Level 4.

We also calculated the percentage of appeal decisions issued on the merit that were issued after at least twice the statutory time frame, which

[10]Information is available at http://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/RedeterminationbyaMedicareContractor.html, downloaded on August 27, 2015.

[11]A small number of Level 3 decisions not subject to the statutory time frames may be included in our analysis, but they could not be identified in the data extract. For example, OMHA officials told us there were less than 300 such appeals in fiscal year 2014.

[12]Appeal decisions issued on the merits refers to decisions that affirm or reverse the coverage denial, in whole or in part, based upon a consideration of the facts of the appeal, and does not reflect appeal decisions based on other grounds, such as dismissals for procedural deficiencies.

we report for Levels 3 and 4, by determining the number of appeals in which decisions were issued 90 or more days after the deadline date.

We excluded from these calculations appeals that were put on hold during CMS's global settlement process. We estimated the number of Levels 2, 3, and 4 appeals resolved through the global settlement based on information as provided to us by CMS, OMHA, and DAB.[13] Specifically, for Levels 2 and 3 we used fields in MAS, and for Level 4 we used a file provided to us by the Council within DAB on November 6, 2015. HHS officials noted that as of February 2016, OMHA and DAB were still in the process of dismissing appeals included in CMS's global settlement.[14] The dismissal process includes a review by OMHA and DAB of each settlement agreement which could result in the identification of appealed claims that were inadvertently included in the settlement. Therefore, our estimates may differ from the number of appeals settled once the dismissal process is complete.

Reversal Rates

For Levels 1 through 3, we determined the proportion of appeals in which the appeals body reversed a coverage denial. For Level 4, we separated appeal decisions into different categories to better understand how the Level 4 appeal decision affected the Level 3 appeal decision.

Level 1, Level 2, and Level 3. We report the number of appeals in which a decision was issued on the merits and the percentage of appeals that fully reversed, partially reversed, or did not reverse the coverage denial. In calculating those percentages, we do not reflect decisions based on other grounds, such as dismissals.[15] As noted above, for Levels 1 through 3, we categorized appeals of Part B of A services as Part B services. As a result, the reversal rates we present may differ from reversal rates that categorize appeals of Part B of A services as Part A services.[16] We

[13]Level 1 is excluded because CMS does not collect information that would enable us to determine this information.

[14]OMHA and DAB count these appeals as part of their pending workload until they are dismissed.

[15]This approach is consistent with how CMS presents reversal rates for Levels 1 and 2; however, HHS officials told us that OMHA generally includes dismissals in their calculations of reversal rates.

[16]For example, at Level 1, fully favorable reversal rates for Part A services were higher when appeals of Part B of A services are categorized as Part A services. CMS categorizes appeals of Part B of A services as Part A services.

calculated reversal rates overall, by type of service, and by whether or not the appeal was RA-related. For comparison purposes, we also report the total number of appeals in which a decision was issued, which is not limited to decisions issued on the merit.

Level 4. We report the number of appeals that affirmed, reversed, dismissed, or remanded Level 3 decisions as well as the percentage of those appeals in each category. We calculated these percentages overall and by whether an appellant filed an appeal or whether CMS referred the appeal. For comparison purposes, we also report the total number of appeals in which a decision was issued, which is not limited to the four final action categories. Because the following Level 4 decisions do not comment on the Level 3 decision, we excluded them from our analysis: appeal decisions of other, special disposition, and dismiss request for review. Similarly, we excluded appeals that were escalated from OMHA because Level 3 did not issue a timely appeal decision and appeals in which the Council was asked to reopen an appeal it already decided. Our categorization of Level 4 decisions is as follows.

- Affirmed the Level 3 decision: (a) a final action of affirm; (b) a final action of modify; (c) if CMS did not refer the appeal, a final action of denial of request for review; and (d) if CMS referred the appeal, decline protest.[17]
- Reversed the Level 3 decision: a final action of reverse decision.
- Dismissed the Level 3 decision: a final action of dismiss request for hearing.[18]
- Remanded appeal to Level 3: a final action of remand to the Administrative Law Judge (ALJ), which has the effect of vacating the

[17]According to Council officials, "modify" does not change the outcome, but adds or clarifies the rationale for the Level 3 decision or corrects a factual error in it; "denial of request for review" indicates that Level 4 agreed with the Level 3 decision to dismiss the case; and "decline protest" indicates that Level 4 declined to review a Level 3 ruling referred by CMS.

[18]According to Council officials, for cases not escalated from OMHA, this indicates that Level 3 should not have ruled on the appeal because it did not have merit jurisdiction.

Level 3 decision and generating a new Level 3 appeal, according to Council officials.[19]

Estimate of Pending Medicare Administrative Appeals at Levels 3 and 4 Resolved by CMS's Global Settlement

To report on the effect of CMS's global settlement on the number of appeals pending decisions at Levels 3 and 4, we determined the number of appeals pending a decision as of the dates of our extract files. To determine the number of those appeals pending after the global settlement, we subtracted the number of appeals we estimated to be included in the global settlement from the number of pending appeals.

CMS's Estimate of Interest Paid by the Agency to Certain Providers

To better understand the effect of late appeal decisions on the amount of interest paid by CMS to certain providers who have their postpayment claim denials reversed upon appeal, we asked CMS for (a) the amount of interest CMS paid to providers on the overpayments the agency initially collected and then returned after the appellant won a Level 3 appeal; and (b) the amount of interest that CMS would have paid to those providers if Level 3 had adhered to the 90-day statutory time frame for issuing appeal decisions. CMS officials told us that their data system did not enable them to create similar estimates for appeals reversed at Levels 4 or 5. To report on the amount of interest that CMS would not have paid if Level 3 had issued decisions within the statutory time frame, we subtracted estimate (b) from (a).

To respond to our inquiry, CMS developed an estimate, which is based on several assumptions and is subject to certain limitations. To report on the amount of interest paid, CMS identified transactions in its Healthcare Integrated General Ledger Accounting System (HIGLAS) that were categorized as related to this type of interest payment. To report on the amount of interest that CMS would have paid if Level 3 had adhered to a 90-day time frame for issuing appeal decisions, CMS created an estimated date whereby the ALJ would have issued the appeal decision, because this information is not calculated in HIGLAS. This date was set

[19]According to Council officials, reasons why Level 4 remands appeals to Level 3 include the following: the ALJ erred in dismissing the request for a hearing; the Level 3 decision did not adequately develop the administrative record; a legal error occurred, often the result of the decision being issued; the ALJ issued the decision on the record without a hearing and the appellant had requested a hearing; and a failure to notify all the parties to the appeal.

equal to 180 days after HIGLAS indicated the overpayment collection was initiated by the MAC, and accounts for the following: the time it would take the MAC to collect the overpayment after the appellant lost the Level 2 appeal, the time it took for the appellant to file a Level 3 appeal, and the 90-day time frame for Level 3 to issue an appeal decision. Because overpayments can be collected over multiple dates, CMS set the date of the recoupment equal to the median date of all recoupment dates. CMS officials acknowledged that their estimate has limitations. First, CMS officials told us that the recording of overpayment adjustments, the assignment of codes which categorize types of accounts receivable, and the determination of interest payments is a manual process conducted by the MACs and that MACs may not, for example, be using the appropriate codes. Second, use of a median date to estimate the interest that would have been payable results in different estimates than if CMS were able to apply the interest rate separately for each recoupment made based on the actual date the overpayment was recouped. Third, CMS's estimate is limited to Part A and Part B appeals and excludes any interest associated with DMEPOS appeals because CMS officials told us they did not have the necessary data in-house to conduct the analysis and obtaining access to the necessary data would have been administratively burdensome.

Data Reliability

To assess the reliability of the data used in this report, we performed manual and electronic testing to identify and correct for missing data and other anomalies; interviewed or obtained written information from CMS, OMHA, and DAB officials to confirm our understanding of the data; and reviewed related documentation. We determined that the data were sufficiently reliable for our purposes.

Appendix II: Medicare Fee-for-Service Appeals Filed and Decided, Fiscal Years 2010 to 2014

Tables 11 through 14 provide information on the number and characteristics of appeals filed and decided at Levels 1 through 4 of the Medicare fee-for-service appeals process from fiscal year 2010 to fiscal year 2014.

Table 11: Level 1 Medicare Fee-for-Service Appeals Filed and Decided by Appeal Characteristics, Fiscal Years 2010-2014

Characteristic[a]	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Total appeals filed[b]	**2,603,557**	**2,923,213**	**3,451,137**	**3,972,219**	**4,209,621**
Type of service	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**
Part A	51,279	116,097	310,465	478,791	307,799
Part B	2,177,481	2,348,435	2,482,232	2,648,633	2,917,583
DMEPOS	374,797	458,681	658,440	844,795	984,239
Total appeals decided	**2,172,247**	**2,320,197**	**2,838,590**	**3,137,823**	**3,284,005**
Recovery Auditor-related appeals	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**
Total	16,482	89,495	256,878	475,514	403,311
Part A	717	36,876	177,205	387,263	297,890
Part B	11,195	42,165	72,301	74,033	92,228
DMEPOS	4,570	10,454	7,372	14,218	13,193
Total appealed claims decided	**2,613,359**	**2,865,793**	**3,511,405**	**4,023,918**	**4,229,784**
Subcategory of service	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**
DMEPOS	503,532	644,866	831,782	1,309,575	1,488,206
Home health	41,483	51,267	108,440	96,164	86,504
Inpatient hospital	7,844	45,090	212,931	436,200	288,995
Laboratory, clinic, x-ray	92,390	97,135	122,154	121,910	155,999
Other	198,398	211,290	237,353	281,519	279,318
Outpatient	159,243	196,809	190,215	169,454	209,807
Physician	1,407,099	1,415,769	1,544,786	1,406,343	1,513,618
Skilled nursing facility	10,387	10,347	13,179	11,939	24,338
Transportation	192,983	193,220	250,565	190,814	182,999

Legend: DMEPOS = durable medical equipment, prosthetics, orthotics, and supplies; FY = Fiscal Year.

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) data. | GAO-16-366

Notes: This table excludes appeals decided by Quality Improvement Organizations, because Medicare Administrative Contractors are responsible for handling Level 1 appeals of denials related to most claims.

[a]We have not presented appeals filed or decided by appellant category for Level 1 because the Contractor Reporting of Operational and Workload Data (CROWD) system, which collected most of

the data on Level 1 appeals filed between fiscal year 2010 and fiscal year 2014, does not contain information on appellant categories.

[b]CMS officials told us that the agency typically reports appeal workload using the number of appeals decided instead of those filed, due to limitations with CROWD data. We report the number of filed appeals to be consistent with the other levels.

Table 12: Level 2 Medicare Fee-for-Service Appeals Filed by Appeal Characteristics, Fiscal Years 2010-2014

Characteristic	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Total appeals filed	**265,140**	**285,902**	**456,994**	**874,778**	**896,838**
Type of service	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**
Part A	23,723	39,177	158,805	426,853	369,589
Part B	186,654	162,929	185,405	214,209	240,377
DMEPOS	54,763	83,796	112,784	233,716	286,872
Subcategory of service	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**
DME	50,087	78,605	100,211	213,188	262,890
Home health and hospice	13,836	14,952	28,540	49,724	35,709
Inpatient hospital	3,531	16,321	122,513	368,310	321,459
Laboratory, clinic, x-ray	35,244	26,194	27,794	36,837	38,396
Other	41,944	39,417	48,611	56,457	61,089
Outpatient	28,735	31,922	36,058	37,905	54,234
Practitioner services	62,615	50,297	53,880	66,139	72,589
Prosthetics and orthotics	4,073	3,793	4,968	7,499	11,209
Skilled nursing facility	7,156	7,867	7,515	9,042	11,532
Transportation	17,915	16,496	26,606	29,018	27,182
Appellant category	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**
Provider	228,063	249,565	398,031	797,167	840,104
State Medicaid agency	5,017	5,220	16,104	34,634	18,740
Beneficiary	18,912	18,672	21,032	24,866	24,944
Other	13,140	12,395	21,675	18,085	13,040
Recovery Auditor-related appeals	377	12,620	102,151	310,233	310,289
Part A	84	10,759	99,343	305,933	296,290
Part B	163	1,495	2,704	3,604	12,697
DMEPOS	130	366	104	696	1,302
Total appeals decided	**264,431**	**263,101**	**417,734**	**837,522**	**913,817**

Legend: DMEPOS = durable medical equipment, prosthetics, orthotics, and supplies; and DME = durable medical equipment (exclusive of prosthetics and orthotics); FY = Fiscal Year.

Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-16-366

Note: This table excludes appeals decided by Quality Improvement Organizations, because Qualified Independent Contractors are responsible for handling Level 2 appeals of denials related to most claims. The sum of the subcategories may not equal total appeals filed due to missing information.

Table 13: Level 3 Medicare Fee-for-Service Appeals Filed by Appeal Characteristics, Fiscal Years 2010-2014

Characteristic	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Total appeals filed	**41,733**	**57,823**	**127,240**	**369,668**	**432,534**
Type of service	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**
Part A	12,938	20,081	63,654	247,469	275,791
Part B	17,957	19,247	23,553	32,715	36,491
DMEPOS	10,838	18,495	40,033	89,484	120,252
Subcategory of service	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**
DME	10,538	17,954	37,994	81,396	109,738
Home health and hospice	7,013	10,588	11,667	29,268	33,816
Inpatient hospital	2,764	3,850	48,170	215,359	238,196
Laboratory, clinic, x-ray	2,781	2,476	2,891	4,366	4,864
Other	3,865	6,063	7,611	9,131	5,979
Outpatient	4,159	5,844	7,895	6,996	15,473
Practitioner services	5,491	5,208	2,503	7,879	6,141
Prosthetics and orthotics	220	134	381	5,360	8,799
Skilled nursing facility	2,650	3,363	3,058	2,870	3,474
Transportation	2,252	2,342	5,069	7,043	6,054
Appellant category	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**
Provider	37,398	49,998	117,365	342,935	404,377
State Medicaid agency	2,617	6,181	7,751	24,062	25,195
Beneficiary	1,718	1,643	2,123	2,670	2,962
Recovery Auditor-related appeals	201	1,910	41,340	186,619	219,850
Part A	140	1,739	40,942	186,139	216,271
Part B	5	66	326	370	2,634
DMEPOS	56	105	72	110	945
Total appeals decided	**37,381**	**51,925**	**61,508**	**99,930**	**84,829**

Legend: DMEPOS = durable medical equipment, prosthetics, orthotics, and supplies; DME = durable medical equipment (exclusive of prosthetics and orthotics); FY = Fiscal Year.

Source: GAO analysis of Office of Medicare Hearings and Appeals data. | GAO-16-366

Note: The sum of the subcategories may not equal total appeals filed due to missing information.

Table 14: Level 4 Medicare Fee-for-Service Appeals Filed by Appeal Characteristics, Fiscal Years 2010-2014

Characteristic[a]	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Total appeals filed	**1,264**	**1,820**	**2,350**	**3,593**	**4,636**
Type of service	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**
Part A	433	529	1,331	2,553	3,635
Part B	484	655	578	519	475
DMEPOS	347	636	441	521	526
Subcategory of service	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**
DMEPOS	342	630	430	495	506
Home health and hospice	115	139	111	100	352
Inpatient hospital	90	97	919	2,301	3,077
Radiology	14	20	19	21	11
Other	227	322	278	183	179
Outpatient	14	15	16	12	15
Practitioner services	204	220	171	192	174
Prosthetics and orthotics	5	6	11	26	20
Skilled nursing facility	150	236	221	101	93
Transportation	77	110	156	131	140
Appellant category	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**
Provider	942	1,425	2,045	3,329	3,922
State Medicaid agency	44	101	64	69	259
Beneficiary	267	276	238	190	417
Other	11	18	3	5	34
Recovery Auditor-related appeals	31	10	621	1,562	2,036
Part A	29	4	611	1,534	2,016
Part B	2	2	5	7	12
DMEPOS	0	4	5	21	8
Total appeals decided	**1,039**	**1,196**	**1,375**	**1,504**	**1,412**

Legend: DMEPOS = durable medical equipment, prosthetics, orthotics, and supplies; and DME = durable medical equipment (exclusive of prosthetics and orthotics); FY = Fiscal Year.

Source: GAO analysis of Departmental Appeals Board data. | GAO-16-366

Notes: The sum of the subcategories may not equal total appeals filed due to missing information.

[a]The counts of appeals filed and decided exclude appeals referred by the Centers for Medicare & Medicaid Services during this period.

Appendix III: Medicare Fee-for-Service Appeal Reversal Rates, Fiscal Years 2010 to 2014

Tables 15 through 18 provide information on appeal reversal rates by type of service and whether the appeal was Recovery Auditor-related at Levels 1 through 4 of the Medicare fee-for-service appeals process for appeals decided from fiscal year 2010 to fiscal year 2014.

Table 15: Level 1 Medicare Fee-for-Service Appeal Reversal Rates

	Category	Fiscal year				
		2010	**2011**	**2012**	**2013**	**2014**
1. Overall	a. Appeals decided	2,172,247	2,320,197	2,838,590	3,137,823	3,284,005
	Appeals decided on the merit	1,880,222	2,071,916	2,580,460	2,882,152	2,997,728
	Percentage fully reversed	52.2	51.7	44.5	35.8	35.9
	Percentage partially reversed	4.0	4.4	3.3	3.1	4.0
	Percentage not reversed	43.9	43.9	52.2	61.1	60.1
	b. Recovery Auditor-related appeals decided	16,482	89,495	256,878	475,514	403,311
	Appeals decided on the merit	15,230	85,116	249,497	464,813	393,023
	Percentage fully reversed	64.8	44.6	26.3	18.5	22.2
	Percentage partially reversed	2.0	2.9	2.0	0.4	1.4
	Percentage not reversed	33.2	52.6	71.7	81.1	76.6
	c. Not Recovery Auditor-related appeals decided	2,155,765	2,230,702	2,581,712	2,662,309	2,880,694
	Appeals decided on the merit	1,864,992	1,986,800	2,330,963	2,417,339	2,604,705
	Percentage fully reversed	52.1	52.0	46.4	39.1	38.0
	Percentage partially reversed	4.0	4.5	3.4	3.7	4.4
	Percentage not reversed	43.9	43.5	50.1	57.2	57.6
2. Part A	a. Appeals decided	44,652	91,502	309,359	530,900	410,230
	Appeals decided on the merit	42,568	87,793	301,560	520,311	399,881
	Percentage fully reversed	19.3	17.3	9.0	8.7	12.2
	Percentage partially reversed	2.5	1.6	0.5	0.3	1.0
	Percentage not reversed	78.1	81.0	90.5	91.0	87.0
	b. Recovery Auditor-related appeals decided	717	36,876	177,205	387,263	297,890
	Appeals decided on the merit	697	36,190	173,441	381,888	293,265

	Category	Fiscal year				
		2010	2011	2012	2013	2014
	Percentage fully reversed	52.5	21.1	9.3	7.7	11.1
	Percentage partially reversed	4.2	1.0	0.2	0.0	0.7
	Percentage not reversed	43.3	77.9	90.5	92.2	88.4
	c. Not Recovery Auditor-related appeals decided	43,935	54,626	132,154	143,637	112,340
	Appeals decided on the merit	41,871	51,603	128,119	138,423	106,616
	Percentage fully reversed	18.8	14.7	8.5	11.4	15.2
	Percentage partially reversed	2.5	2.1	1.1	1.1	1.9
	Percentage not reversed	78.7	83.2	90.4	87.5	83.1
3. Part B	a. Appeals decided	1,805,171	1,832,818	2,019,640	1,810,731	1,959,786
	Appeals decided on the merit	1,543,458	1,612,608	1,801,126	1,602,403	1,734,952
	Percentage fully reversed	54.5	55.7	53.3	48.4	46.0
	Percentage partially reversed	3.7	4.0	2.9	3.3	4.5
	Percentage not reversed	41.8	40.3	43.8	48.3	49.5
	b. Recovery Auditor-related appeals decided	11,195	42,165	72,301	74,033	92.228
	Appeals decided on the merit	10,495	39,256	68,901	69,782	88,017
	Percentage fully reversed	80.0	68.4	67.1	74.2	58.0
	Percentage partially reversed	1.4	4.9	6.3	2.3	3.5
	Percentage not reversed	18.7	26.8	26.6	23.5	38.6
	c. Not Recovery Auditor-related appeals decided	1,793,976	1,790,653	1,947,339	1,736,698	1,867,558
	Appeals decided on the merit	1,532,963	1,573,352	1,732,225	1,532,621	1,646,935
	Percentage fully reversed	54.4	55.3	52.7	47.3	45.4
	Percentage partially reversed	3.7	4.0	2.8	3.3	4.6
	Percentage not reversed	42.0	40.6	44.5	49.4	50.1
4. DMEPOS	a. Appeals decided	322,424	395,877	509,591	796,192	913,989
	Appeals decided on the merit	294,196	371,515	477,774	759,438	862,895
	Percentage fully reversed	44.5	42.6	33.8	27.7	26.5

Category	Fiscal year				
	2010	2011	2012	2013	2014
Percentage partially reversed	5.9	6.8	6.3	4.8	4.4
Percentage not reversed	49.6	50.7	59.8	67.6	69.0
b. Recovery Auditor-related appeals decided	4,570	10,454	7,372	14,218	13,193
Appeals decided on the merit	4,038	9,670	7,155	13,143	11,741
Percentage fully reversed	27.5	35.7	44.2	34.8	32.0
Percentage partially reversed	3.3	1.7	6.5	1.4	2.8
Percentage not reversed	69.2	62.6	49.3	63.8	65.1
c. Not Recovery Auditor-related appeals decided	317,854	385,423	502,219	781,974	900,796
Appeals decided on the merit	290,158	361,845	470,619	746,295	851,154
Percentage fully reversed	44.7	42.7	33.7	27.5	26.4
Percentage partially reversed	5.9	6.9	6.3	4.8	4.5
Percentage not reversed	49.4	50.3	60.0	67.6	69.1

Legend: DMEPOS = durable medical equipment, prosthetics, orthotics, and supplies.

Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-16-366

Note: This table excludes appeals decided by Quality Improvement Organizations, because Medicare Administrative Contractors are responsible for handling Level 1 appeals of denials related to most claims. Percentages are calculated based upon appeal decisions issued on the merits—that is decisions that affirm or reverse the coverage denial, in whole or in part, based upon a consideration of the facts of the appeal—and do not reflect appeal decisions based on other grounds, such as dismissals for procedural deficiencies. Percentages within each category may not sum to 100 percent because of rounding.

Table 16: Level 2 Medicare Fee-for-Service Appeal Reversal Rates

	Category	Fiscal year				
		2010	2011	2012	2013	2014
1. Overall	a. Appeals decided	264,431	263,101	417,734	837,522	913,817
	Appeals decided on the merit	232,760	233,520	376,978	781,687	863,844
	Percentage fully reversed	23.0	21.8	19.0	16.9	18.8
	Percentage partially reversed	4.4	4.1	2.9	1.6	1.9
	Percentage not reversed	72.6	74.0	78.0	81.6	79.3
	b. Recovery Auditor-related appeals decided	265	7,287	74,775	297,558	332,154
	Appeals decided on the merit	239	7,157	73,758	289,262	330,052
	Percentage fully reversed	24.7	16.3	16.0	14.9	20.8
	Percentage partially reversed	1.7	2.6	0.3	0.1	0.2
	Percentage not reversed	73.6	81.1	83.7	85.0	79.0
	c. Not Recovery Auditor-related appeals decided	264,166	255,814	342,959	539,964	581,662
	Appeals decided on the merit	232,521	226,363	303,220	492,425	533,791
	Percentage fully reversed	23.0	22.0	19.8	18.0	17.5
	Percentage partially reversed	4.4	4.2	3.6	2.5	3.0
	Percentage not reversed	72.6	73.8	76.6	79.5	79.5
2. Part A	a. Appeals decided	23,623	32,822	115,843	416,508	404,332
	Appeals decided on the merit	22,585	31,577	113,421	405,082	400,630
	Percentage fully reversed	3.6	6.5	13.7	15.0	19.7
	Percentage partially reversed	2.2	1.6	0.3	0.2	0.2
	Percentage not reversed	94.2	91.9	86.0	84.8	80.1
	b. Recovery Auditor-related appeals decided	66	5,849	72,106	293,926	321,473
	Appeals decided on the merit	52	5,753	71,204	285,732	319,590
	Percentage fully reversed	42.3	13.9	15.7	14.8	20.8
	Percentage partially reversed	0.0	0.1	0.0	0.0	0.1
	Percentage not reversed	57.7	86.1	84.3	85.2	79.1

	Category	Fiscal year				
		2010	2011	2012	2013	2014
	c. Not Recovery Auditor-related appeals decided	23,557	26,973	43,737	122,582	82,858
	Appeals decided on the merit	22,533	25,824	42,217	119,350	81,039
	Percentage fully reversed	3.5	4.9	10.3	15.6	15.3
	Percentage partially reversed	2.2	1.9	0.8	0.5	0.9
	Percentage not reversed	94.3	93.2	88.9	83.9	83.8
3. Part B	a. Appeals decided	189,245	164,479	177,054	202,701	240,981
	Appeals decided on the merit	163,416	141,772	151,547	175,834	210,081
	Percentage fully reversed	29.3	29.1	27.8	28.7	28.6
	Percentage partially reversed	5.1	5.5	5.2	4.7	5.2
	Percentage not reversed	65.5	65.5	67.0	66.6	66.2
	b. Recovery Auditor-related appeals decided	101	1,141	2,477	3,363	9,024
	Appeals decided on the merit	90	1,116	2,366	3,261	8,805
	Percentage fully reversed	38.9	31.9	26.2	28.2	23.5
	Percentage partially reversed	3.3	15.9	8.3	3.2	5.0
	Percentage not reversed	57.8	52.2	65.5	68.6	71.5
	c. Not Recovery Auditor-related appeals decided	189,144	163,338	174,577	199,338	231,957
	Appeals decided on the merit	163,326	140,656	149,181	172,573	201,276
	Percentage fully reversed	29.3	29.0	27.8	28.7	28.9
	Percentage partially reversed	5.1	5.4	5.2	4.7	5.2
	Percentage not reversed	65.5	65.6	67.0	66.6	65.9
4. DMEPOS	a. Appeals decided	51,563	65,800	124,837	218,313	268,504
	Appeals decided on the merit	46,759	60,171	112,010	200,771	253,133
	Percentage fully reversed	10.2	12.8	12.6	10.2	9.1
	Percentage partially reversed	3.1	2.4	2.5	1.8	2.0
	Percentage not reversed	86.8	84.8	84.9	88.0	88.9
	b. Recovery Auditor-related appeals decided	98	297	192	269	1,657

Category	Fiscal year				
	2010	2011	2012	2013	2014
Appeals decided on the merit	97	288	188	269	1,657
Percentage fully reversed	2.1	5.2	4.3	6.3	5.3
Percentage partially reversed	1.0	0.7	0.5	0.4	0.6
Percentage not reversed	96.9	94.1	95.2	93.3	94.1
c. Not Recovery Auditor-related appeals decided	51,465	65,503	124,645	218,044	266,847
Appeals decided on the merit	46,662	59,883	111,822	200,502	251,476
Percentage fully reversed	10.2	12.8	12.7	10.2	9.1
Percentage partially reversed	3.1	2.4	2.5	1.8	2.0
Percentage not reversed	86.7	84.8	84.9	88.0	88.9

Legend: DMEPOS = durable medical equipment, prosthetics, orthotics, and supplies.

Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-16-366

Note: This table excludes appeals decided by Quality Improvement Organizations, because Qualified Independent Contractors are responsible for handling Level 2 appeals of denials related to most claims. Percentages are calculated based upon appeal decisions issued on the merits—that is decisions that affirm or reverse the coverage denial, in whole or in part, based upon a consideration of the facts of the appeal—and do not reflect appeal decisions based on other grounds, such as dismissals for procedural deficiencies. Percentages within each category may not sum to 100 percent because of rounding.

Table 17: Level 3 Medicare Fee-for-Service Appeal Reversal Rates

	Category	Fiscal year				
		2010	2011	2012	2013	2014
1. Overall	a. Appeals decided	37,381	51,925	61,508	99,930	84,829
	Appeals decided on the merit	32,743	45,028	51,879	57,391	57,799
	Percentage fully reversed	67.0	57.7	62.0	60.2	54.0
	Percentage partially reversed	7.6	7.3	7.4	7.1	4.1
	Percentage not reversed	25.4	34.9	30.6	32.8	41.9
	b. Recovery Auditor-related appeals decided	771	343	12,841	37,359	28,690
	Appeals decided on the merit	703	299	11,672	12,001	21,131
	Percentage fully reversed	79.1	80.6	69.5	68.1	57.0
	Percentage partially reversed	5.7	5.0	7.6	8.3	0.8
	Percentage not reversed	15.2	14.4	22.9	23.5	42.1
	c. Not Recovery Auditor-related appeals decided	36,610	51,582	48,667	62,571	56,139
	Appeals decided on the merit	32,040	44,729	40,207	45,390	36,668
	Percentage fully reversed	66.8	57.6	59.8	58.1	52.3
	Percentage partially reversed	7.6	7.4	7.3	6.7	6.0
	Percentage not reversed	25.6	35.1	32.8	35.2	41.7
2. Part A	a. Appeals decided	11,924	17,501	26,091	53,547	43,000
	Appeals decided on the merit	10,971	15,525	23,315	21,950	31,987
	Percentage fully reversed	68.0	49.1	61.4	57.7	52.2
	Percentage partially reversed	8.2	7.0	7.6	7.6	1.9
	Percentage not reversed	23.8	43.9	31.0	34.7	45.9
	b. Recovery Auditor-related appeals decided	762	220	12,605	37,097	28,495
	Appeals decided on the merit	695	191	11,511	11,830	21,009
	Percentage fully reversed	79.4	82.7	69.6	68.2	57.0
	Percentage partially reversed	5.5	1.0	7.6	8.4	0.8
	Percentage not reversed	15.1	16.2	22.8	23.5	42.2

	Category	Fiscal year				
		2010	2011	2012	2013	2014
	c. Not Recovery Auditor-related appeals decided	11,162	17,281	13,486	16,450	14,505
	Appeals decided on the merit	10,276	15,334	11,804	10,120	10,978
	Percentage fully reversed	67.2	48.7	53.5	45.4	43.1
	Percentage partially reversed	8.4	7.1	7.6	6.7	3.9
	Percentage not reversed	24.4	44.2	38.9	47.9	53.0
3. Part B	a. Appeals decided	16,435	18,151	15,409	15,503	12,978
	Appeals decided on the merit	13,813	15,207	12,100	11,571	9,367
	Percentage fully reversed	70.0	68.1	62.0	62.7	57.8
	Percentage partially reversed	7.0	7.3	6.6	6.5	8.2
	Percentage not reversed	22.9	24.6	31.4	30.8	34.0
	b. Recovery Auditor-related appeals decided	8	42	125	222	171
	Appeals decided on the merit	7	37	103	138	110
	Percentage fully reversed	42.9	73.0	73.8	71.0	68.2
	Percentage partially reversed	28.6	13.5	3.9	2.9	9.1
	Percentage not reversed	28.6	13.5	22.3	26.1	22.7
	c. Not Recovery Auditor-related appeals decided	16,427	18,109	15,284	15,281	12,807
	Appeals decided on the merit	13,806	15,170	11,997	11,433	9,257
	Percentage fully reversed	70.0	68.1	61.9	62.6	57.6
	Percentage partially reversed	7.0	7.3	6.6	6.5	8.2
	Percentage not reversed	22.9	24.6	31.5	30.9	34.1
4. DMEPOS	a. Appeals decided	9,022	16,273	20,008	30,880	28,851
	Appeals decided on the merit	7,959	14,296	16,464	23,870	16,445
	Percentage fully reversed	60.4	56.0	62.8	61.3	55.4
	Percentage partially reversed	7.6	7.7	7.7	6.9	6.1
	Percentage not reversed	31.9	36.3	29.5	31.9	38.5
	b. Recovery Auditor-related appeals decided	1	81	111	40	24

Category	Fiscal year				
	2010	2011	2012	2013	2014
Appeals decided on the merit	1	71	58	33	12
Percentage fully reversed	100.0	78.9	34.5	42.4	33.3
Percentage partially reversed	0.0	11.3	8.6	15.2	0.0
Percentage not reversed	0.0	9.9	56.9	42.4	66.7
c. Not Recovery Auditor-related appeals decided	9,021	16,192	19,897	30,840	28,827
Appeals decided on the merit	7,958	14,225	16,406	23,837	16,433
Percentage fully reversed	60.4	55.9	62.9	61.3	55.4
Percentage partially reversed	7.6	7.7	7.7	6.8	6.1
Percentage not reversed	31.9	36.4	29.4	31.9	38.5

Legend: DMEPOS = durable medical equipment, prosthetics, orthotics, and supplies.

Source: GAO analysis of Office of Medicare Hearings and Appeals data. | GAO-16-366

Note: Percentages are calculated based upon appeal decisions issued on the merits—that is decisions that affirm or reverse the coverage denial, in whole or in part, based upon a consideration of the facts of the appeal—and do not reflect appeal decisions based on other grounds, such as dismissals for procedural deficiencies. Percentages within each category may not sum to 100 percent because of rounding.

Table 18: Level 4 Medicare Fee-for-Service Appeal Reversal Rates

Category		Fiscal year 2010	2011	2012	2013	2014	5-year total
1. Overall	Appeals decided	1,104	1,320	1,632	1,744	1,606	7,406
	Appeals decided that affirmed, reversed, dismissed, or remanded Level 3 decisions	954	1,108	1,386	1,388	1,319	6,155
	Percentage that affirmed Level 3 decision[a]	70.1	66.7	65.4	66.5	58.0	65.0
	Percentage that reversed Level 3 decision	10.7	10.4	15.2	13.6	12.3	12.6
	Percentage that dismissed Level 3 decision	1.2	1.9	2.3	1.1	3.9	2.1
	Percentage that remanded appeal to Level 3	18.0	21.0	17.2	18.8	25.8	20.2
2. Appellant-filed appeals decided[b]	Appeals decided	1,039	1,196	1,375	1,504	1,412	6,526
	Appeals decided that affirmed, reversed, dismissed, or remanded Level 3 decisions	889	984	1,130	1,149	1,125	5,277
	Percentage that affirmed Level 3 decision[a]	73.7	73.8	77.4	75.5	66.3	73.3
	Percentage that reversed Level 3 decision	8.3	6.5	7.6	7.4	7.3	7.4
	Percentage that dismissed Level 3 decision	1.2	1.2	1.5	0.7	1.6	1.3
	Percentage that remanded appeal to Level 3	16.8	18.5	13.5	16.4	24.8	18.0
3. CMS-referred appeals decided	Appeals decided	65	124	257	240	194	880
	Appeals decided that affirmed, reversed, dismissed, or remanded Level 3 decisions	65	124	256	239	194	878
	Percentage that affirmed Level 3 decision[a]	21.5	10.5	12.1	23.0	9.8	15.0
	Percentage that reversed Level 3 decision	43.1	41.1	48.4	43.5	41.2	44.1
	Percentage that dismissed Level 3 decision	0.0	7.3	5.9	2.9	17.5	7.4
	Percentage that remanded appeal to Level 3	35.4	41.1	33.6	30.5	31.4	33.5

Source: GAO analysis of Departmental Appeals Board data. | GAO-16-366

[a]"Affirmed" are appeals with the following Level 4 decisions: affirm; modify; denial of request for review, if the Centers for Medicare & Medicaid Services (CMS) did not refer the appeal; and decline protest, if CMS did refer the appeal.

[b]Appellant-filed appeals are generally those filed by or on behalf of providers, beneficiaries, or state Medicaid agencies.

Appendix IV: Legislative Proposals Included in the President's Fiscal Year 2017 Budget Related to the Medicare Fee-for-Service Administrative Appeals Process

Proposals that supplement fiscal year 2017 appropriations requested	
Provide the Office of Medicare Hearings and Appeals (OMHA) and Departmental Appeals Board (DAB) authority to use Recovery Auditor (RA) collections	This proposal would expand the authority of the Secretary of Health and Human Services to retain a portion of RA recoveries for the purpose of administering the RA program and allows RA program recoveries to fully fund RA-related appeals at OMHA and DAB.
Establish a refundable filing fee	This proposal would institute a refundable filing fee for Medicare Parts A and B appeals for providers, suppliers, and state Medicaid agencies, including those acting as a representative of a beneficiary, and requires these entities to pay a per-claim filing fee at each level of appeal. According to the Department of Health and Human Services' (HHS) budget justification materials, this filing fee will allow HHS to invest in the appeals system to improve responsiveness and efficiency. Fees will be returned to appellants who receive a fully favorable appeal determination.
Other proposals that affect Medicare claim review contractors	
Allow prior authorization for Medicare fee-for-service items and services	This proposal would extend the Centers for Medicare & Medicaid Services' (CMS) prior authorization authority to all Medicare fee-for-service items and services, in particular those that are at the highest risk for improper payment. The proposal observes that CMS currently has authority to require prior authorization for only specified Medicare fee-for-service items and services.
Pay RA after Level 2 makes a decision on appealed claims	This proposal would allow the Secretary to withhold payment to an RA if a provider has filed an appeal at Level 2 and a decision is pending. According to HHS's budget justification materials, aligning the RA contingency fee payments with the outcome of the appeal will ensure that CMS has assurance of the RA's determination before making payment.
Other proposals that affect all appeal levels	
Sample and consolidate similar claims for administrative efficiency	This proposal would allow the Secretary to adjudicate appeals through the use of sampling and extrapolation techniques. Additionally, this proposal authorizes the Secretary to consolidate appeals into a single administrative appeal at all levels of the appeals process. Parties who are appealing claims included within an extrapolated overpayment or consolidated previously will be required to file one appeal request for any such claims in dispute.
Remand appeals to Level 1 with the introduction of new evidence	This proposal would remand an appeal to Level 1 when new documentary evidence is submitted into the administrative record at Level 2 or above. Exceptions may be made if evidence was provided to the lower level adjudicator but erroneously omitted from the record, or an adjudicator denies an appeal on a new and different basis than earlier determinations. According to HHS's budget justification materials, this proposal incentivizes appellants to include all evidence early in the appeals process and ensures the same record is reviewed and considered at subsequent levels of appeal.
Other proposals that specifically affect Level 3	
Increase minimum amount in controversy for Administrative Law Judge (ALJ) adjudication of claims to equal amount required for judicial review	This proposal would increase the minimum amount in controversy for ALJ adjudication to the federal court (Level 5) amount in controversy requirement ($1,500 in calendar year 2016). According to HHS's budget justification materials, this will allow the amount at issue to better align with the amount spent to adjudicate the claim.

Establish magistrate adjudication for claims with amount in controversy below new ALJ amount in controversy threshold	This proposal would allow OMHA to use attorneys called Medicare magistrates to adjudicate appealed claims of lower amounts in controversy—specifically, amounts that fall below the federal district court amount in controversy threshold.
Expedite procedures for claims with no material fact in dispute	This proposal would allow OMHA to issue decisions without holding a hearing if there is no material fact in dispute. These cases include appeals, for example, in which Medicare does not cover the cost of a particular drug.

Source: HHS. | GAO-16-366

Note: With the exception of the two proposals that would affect Medicare claim review contractors, these proposals were also included in the President's Budget request for fiscal year 2016, but were not enacted by Congress.

Appendix V: Comments from the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

APR 1 8 2016

Kathleen M. King
Director, Health Care
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Ms. King:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, *"MEDICARE FEE-FOR-SERVICE: Opportunities Remain to Improve Appeal Process"* (GAO-16-366).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

Jim R. Esquea
Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: MEDICARE FEE-FOR-SERVICE: OPPORTUNITIES REMAIN TO IMPROVE APPEALS PROCESS (GAO-16-366)

The Department of Health and Human Services (HHS) appreciates the opportunity to review and comment on this draft report. HHS is committed to providing high quality health care to the millions of Americans covered by Medicare. At the same time, we are dedicated to providing strong fiscal stewardship of the Medicare program through robust program integrity initiatives. In the normal course of business, providers, suppliers, and beneficiaries may disagree with payment determinations made by the Centers for Medicare & Medicaid Services (CMS), and a strong appeals system is essential to providing quality care and assuring appropriate Medicare payments.

For those reasons, HHS is committed to addressing the backlog of pending appeals at the Office of Medicare Hearings and Appeals (OMHA) and the Departmental Appeals Board (DAB) through improvements across the Department.

HHS has developed a series of initiatives to improve the efficiency of the Medicare appeals process, reduce the backlog of pending appeals, and mitigate the possibility of future backlogs. HHS' plan includes a three-pronged strategy. First, take administrative actions to reduce the number of pending appeals and encourage resolution of cases earlier in the process. Second, request new resources to invest at all levels of appeal to increase adjudication capacity and implement new strategies to alleviate the current backlog. Third, propose legislative reforms that provide additional funding and new authorities to address the appeals volume.

For example, to reduce the volume of inpatient status claims pending in the appeals process, HHS offered an administrative agreement to any hospital willing to withdraw their pending appeals in exchange for timely partial payment. HHS has executed settlements with more than 1,900 hospitals, representing approximately 300,000 claims. GAO estimated in its report that this action reduced the backlog of appeals at Level 3 and Level 4 of the appeals process by over 30 percent based on the number of pending appeals on June 2, 2015 and May 22, 2015, respectively. To further address pending appeals, HHS has also implemented voluntary pilot processes to allow eligible appellants to have their appeals at Level 3 settled through an alternative dispute resolution process; statistical sampling and extrapolation; or senior attorney on-the-record process.

HHS also has a number of initiatives to resolve claim disputes as early as possible in the appeals process. For example, HHS has implemented discussion periods for providers who receive an improper payment determination from a Recovery Auditor. During this time, providers can discuss the improper payment rationale with the Recovery Auditor and submit additional information that may substantiate payment of their claim. The discussion period allows providers to seek resolution of their concerns without entering the formal appeals process.

Additionally, HHS has launched a new demonstration that will provide selected Durable Medical Equipment (DME) suppliers with second level appeal requests the opportunity to participate in a discussion with the DME Qualified Independent Contractor (QIC). Suppliers will be able to discuss the facts of the case and provide additional documentation that could assist in reaching a favorable determination. Additionally, under this demonstration the QIC will have the authority to conduct reopenings on similar claims that are pending at Level 3.

1

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: MEDICARE FEE-FOR-SERVICE: OPPORTUNITIES REMAIN TO IMPROVE APPEALS PROCESS (GAO-16-366)

HHS has also implemented prior authorization models through which a request for provisional affirmation of coverage is submitted for review before the service is furnished to a beneficiary and before a claim is submitted for payment. Commonly used in the private sector, prior authorization helps ensure that applicable coverage, payment, and coding rules are met before services are rendered.

HHS is also planning to invest new resources to increase adjudication capacity. The "Consolidated Appropriations Act, 2016" appropriated OMHA $107.381 Million, an additional $20 Million above the fiscal year (FY) 2015 funding level, which will allow for the hiring of 15 Administrative Law Judges (ALJ) and adjudication teams by the end of the fiscal year; that work is already underway. These new ALJ teams will enable OMHA to fully staff the new Kansas City field office, expand the Arlington field office, and establish a new field office in Seattle, Washington. The FY 2017 President's budget requests funding for a 110 percent increase in adjudicatory capacity above the funding level in the "Consolidated Appropriations Act, 2016" at Level 3 of the appeals process, and a 65 percent increase in adjudicatory capacity at Level 4 of the appeals process. The budget also proposes retaining a portion of Recovery Auditor recoveries to fully fund Recovery Auditor-related appeals at Levels 3 and 4 of the appeals process.

The FY 2017 President's Budget also includes a number of legislative proposals for new authorities to address the appeals volume and the pending backlog. One proposal would institute a refundable per claim filing fee for Medicare Parts A and B appeals for providers, suppliers, and State Medicaid Agencies at each level of appeal. This filing fee would allow HHS to invest in the appeals systems to improve responsiveness and efficiency. The President's Budget also proposes to allow the Secretary to adjudicate appeals through the use of sampling and extrapolation techniques and to consolidate appeals into a single administrative appeal at all levels of the appeals process.

GAO's recommendations and HHS' responses are below.

GAO Recommendation
Determine the costs and benefits of delaying CMS's collection of overpayments until after a Level 3 decision is made and, if the benefits exceed the costs, request such authority from Congress.

HHS Response
HHS does not concur with this recommendation. While HHS paid $17.8 million in interest subsequent to Level 2 decisions from FYs 2010 to 2015, HHS collected more than $1 billion in overpayments for all Level 2 decisions. Delaying the collection of debts until after the ALJ level would increase the number of appeals filed at Level 3 and make it more difficult to reduce the backlog of appeals at Levels 3 and 4. HHS believes that addressing the backlog of pending appeals at Levels 3 and 4 is the best way to reduce interest payments to appellants.

GAO Recommendation

2

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: MEDICARE FEE-FOR-SERVICE: OPPORTUNITIES REMAIN TO IMPROVE APPEALS PROCESS (GAO-16-366)

Modify the Medicare appeals data systems to collect information on the reasons for appeal decisions at Level 3 in the Medicare Appeals System (MAS).

HHS Response
HHS concurs with the recommendation to modify data systems to collect information on the reason for appeal decisions at Level 3. While we agree that capturing the reasons for decision outcomes issued at Level 3 could be useful, we do not believe that it would be cost effective from a resource or timing perspective to do that in MAS in light of OMHA's development of the Electronic Case Adjudication and Processing Environment (ECAPE), which will replace the use of MAS at Level 3. OMHA will explore the technical feasibility, the cost effectiveness, and funding limitation of implementing the recommendation in ECAPE. Additionally, we will explore the implicit costs of adding data entry requirements on OMHA adjudication staff in light of the current workload volume and need to decide cases as expeditiously as possible. OMHA will need to balance the desirability and usefulness of additional data captured against the time required for skilled staff to perform analysis and data entry in lieu of other decisional activities.

GAO Recommendation
Modify the Medicare appeals data systems to capture the amount of Medicare allowed charges at stake in appeals in MAS and the Medicare Operations Division Automated Case Tracking System (MODACTS).

HHS Response
HHS concurs with GAO's recommendation and believes that calculating the amount in controversy based upon the Medicare allowable or Medicare payable amounts instead of the provider billed charges would more accurately measure the amount at issue and could reduce the number of appeals that are eligible for filing at Level 3. HHS will explore using Medicare allowed amounts when claims are based on a fee schedule.

GAO Recommendation
Modify the Medicare appeals data systems to collect consistent data across systems, including appeal categories and appeal decisions across MAS and MODACTS.

HHS Response
HHS concurs with the recommendation to modify the data systems to collect consistent data across systems. HHS will work to standardize appeal categories and decision data collection and reporting to the extent funding is available and these changes are feasible. HHS will not be able to achieve consistent data for Level 1 appeals until all of the Medicare Administrative Contractors (MACs) are on MAS. As GAO notes in this report, HHS has not received funding to onboard the remaining MACs to MAS. The FY 2017 President's Budget requests funding to complete the onboarding of the remaining MACs to MAS. Additionally, at OMHA, ECAPE is designed to adopt the Level 2 appeal categories to enhance consistency of data. However, OMHA does not believe that it would be cost effective to make similar adjustments for the current Level 3 functionality in MAS in light of the pending roll-out of ECAPE. Further, DAB is continuing to work with OMHA at Level 3 to create and ensure interoperability between each level's case tracking systems. The DAB too would

3

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: MEDICARE FEE-FOR-SERVICE: OPPORTUNITIES REMAIN TO IMPROVE APPEALS PROCESS (GAO-16-366)

require increased funding to both access MAS data and collect and share additional information on appeal categories and decisions at Level 4.

GAO Recommendation

Implement a more efficient way to adjudicate certain repetitive claims, such as by permitting appeal bodies to reopen and resolve appeals.

HHS Response

HHS concurs with GAO's recommendation. The FY 2017 President's Budget proposes to allow the Secretary to consolidate appeals into a single administrative appeal at all levels of the appeals process. If enacted, this proposal would allow HHS to more efficiently adjudicate appeals of certain repetitive claims. HHS will also assess the use of reopenings to address this issue.

HHS thanks GAO for their efforts on this issue and looks forward to working with GAO on this and other issues in the future.

4

Appendix VI: GAO Contact and Staff Acknowledgments

GAO Contact

Kathleen M. King, (202) 512-7114 or kingk@gao.gov.

Staff Acknowledgments

In addition to the contact named above, Lori Achman, (Assistant Director), Todd Anderson, Susan Anthony, Christine Davis, Julianne Flowers, Krister Friday, Shannon Legeer, Amanda Pusey, Lisa Rogers, Cherie' Starck, and Jennifer Whitworth made key contributions to this report.

Appendix VII: Accessible Data

Agency Comment Letter

Text of Appendix V: Comments from the Department of Health and Human Services

Page 1

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OFFICE OF THE SECRETARY

Assistant Secretary for Legislation

Washington, DC 20201

APR 18 2015

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HHS thanks GAO for their efforts on this issue and looks forward to working with GAO on this and other issues in the future.

Data Tables

Data Table for Figure 1: Level 3 Medicare Fee-for-Service Appeals Filed, by Type of Service, Fiscal Years 2010-2014

	Number of appeals filed				
	2010	**2011**	**2012**	**2013**	**2014**
PART A	12,938	20,081	63,654	247,469	275,791
PART B	17,957	19,247	23,553	32,715	36,491
DMEPOS	10,838	18,495	40,033	89,484	120,252

Percentage growth	From FY10 to FY14
PART A	2032%
PART B	103%
DMEPOS	1010%

Legend: DMEPOS = durable medical equipment, prosthetics, orthotics, and supplies.

Data Table for Figure 2: Percentage of Level 2 through 4 Medicare Fee-for-Service Appeal Decisions Issued After Statutory Time Frames, Fiscal Years 2010-2014

	2010	2011	2012	2013	2014
Level 2	0.1	5.8	14.1	44.1	3.9
Level 3	36.7	52.4	55.9	86.2	96.4
Level 4	74.9	72.5	80.1	79.7	90.8

Data Table for Figure 3: Percentage of Fully Reversed Medicare Fee-for-Service Appeals at Levels 1, 2, and 3, Fiscal Years 2010-2014

LEVEL 1

	2010	*2011*	*2012*	*2013*	*2014*
Total	52.2	51.7	44.5	35.8	35.9

LEVEL 2

	2010	2011	2012	2013	2014
Total	23	21.8	19	16.9	18.8

LEVEL 3

	2010	2011	2012	2013	2014
Total	67.0	57.7	62.0	60.2	54.0

Data Table for Figure 4: Percentage of Fully Reversed Medicare Fee-for-Service Appeals at Levels 1, 2, and 3, by Type of Service, Fiscal Years 2010-2014

LEVEL 1

	2010	**2011**	***2012***	***2013***	***2014***
Medicare Part A	19.3	17.3	9.0	8.7	12.2
Medicare Part B	54.5	55.7	53.3	48.4	46.0
DMEPOS	44.5	42.6	33.8	27.7	26.5

LEVEL 2

	2010	2011	2012	2013	2014
Medicare Part A	3.6	6.5	13.7	15.0	19.7
Medicare Part B	29.3	29.1	27.8	28.7	28.6
DMEPOS	10.2	12.8	12.6	10.2	9.1

LEVEL 3

	2010	2011	2012	2013	2014
Medicare Part A	68.0	49.1	61.4	57.7	52.2
Medicare Part B	70.0	68.1	62.0	62.7	57.8
DMEPOS	60.4	56.0	62.8	61.3	55.4

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