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OFFICE OF INSPECTOR GENERAL

THE FIRST LEVEL OF THE MEDICARE APPEALS PROCESS, 2008–2012: VOLUME, OUTCOMES, AND TIMELINESS

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EXECUTIVE SUMMARY: THE FIRST LEVEL OF THE MEDICARE APPEALS PROCESS, 2008–2012: VOLUME, OUTCOMES, AND TIMELINESS
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WHY WE DID THIS STUDY

The Medicare appeals process serves as an important protection for beneficiaries and providers. This study represents the Office of Inspector General's (OIG) first examination of redetermination, i.e., the first level of the appeals process for Medicare Parts A and B. This study contributes to OIG's body of work concerning the Medicare appeals system.

HOW WE DID THIS STUDY

This study focused on redeterminations processed for Medicare Parts A and B during 2008–2012. We obtained and analyzed data on redeterminations and claims processed from the Centers for Medicare & Medicaid Services' (CMS) Contractor Reporting of Operational and Workload Data system for calendar years 2008–2012. We surveyed 18 contractors that process redeterminations for Medicare Parts A and B and interviewed 5 of them to learn more about how they process redeterminations.

WHAT WE FOUND

In 2012, contractors processed 2.9 million redeterminations, which involved 3.7 million claims, an increase of 33 percent since 2008. Although 80 percent of all redeterminations in 2012 involved Part B services, redeterminations involving Part A services have risen more rapidly. By 2012, appeals involving recovery audit contractors accounted for 39 percent of all appealed Part A claims. Contractors decided in favor of Part A appellants at a lower rate than that for Part B appellants. Also, contractors largely met required timeframes for processing redeterminations and paying appeals decided in favor of appellants, but they fell short of meeting timeframes for transferring case files for second-level appeals. In addition, contractors use information from redeterminations in a variety of ways to improve their operations and to educate providers. Finally, CMS employs multiple methods to improve contractors' processing of redeterminations, including fostering communication among contractors and implementing the Medicare Appeals System (MAS) for first-level appeals.

WHAT WE RECOMMEND

We recommend that CMS (1) use the MAS to monitor contractor performance, (2) continue to foster information sharing among Medicare contractors, and (3) monitor the quality of redetermination data in MAS. CMS concurred with all three recommendations.

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OBJECTIVES

1. To describe the volumes and trends in redeterminations in Medicare Parts A and B processed in 2008–2012.
2. To assess the outcomes and timeliness of Medicare contractors' processing of redeterminations for Parts A and B.
3. To assess the Centers for Medicare & Medicaid Services' (CMS) monitoring of redetermination processing.

BACKGROUND

The Medicare Fee-for-Service Appeals Process

Medicare providers, beneficiaries, and other parties (such as State Medicaid agencies) may appeal certain decisions related to Medicare claims.[1] The Medicare appeals process includes five levels (see Table 1). This study focuses on the first level, redetermination.

Table 1: Levels of the Medicare Fee-For-Service Appeals Process

Level	Steps Taken
First level	Redetermination by a Medicare claims administration contractor
Second level	Reconsideration by a Qualified Independent Contractor (QIC)
Third level	Hearing by an Administrative Law Judge in the Office of Medicare Hearings and Appeals
Fourth level	Review by the Medicare Appeals Council within the Departmental Appeals Board
Fifth level	Judicial review in U.S. District Court

Source: CMS, *Original Medicare (Fee-for-service) Appeals Process*, accessed at http://www.cms.gov/orgmedffsappeals on February 14, 2013.

Overview of the Redetermination Process

Requesting redetermination. Appellants must file requests for redetermination within 120 days of receiving notice of the claim determination. Such notice includes, for providers, Medicare Remittance Advice or, for beneficiaries, the Medicare Summary Notice. Providers may also request a redetermination when notified that a postpayment review has determined that an overpayment has been made. Such reviews are conducted by Recovery Audit Contractors (RAC), Zone Program Integrity Contractors (ZPIC), and Program Safeguard Contractors (PSC),

[1] Social Security Act, § 1869; 42 CFR §§ 405.906(b) and 908. For the purposes of this report, we use the term "provider" to refer both to providers and suppliers that provide items and services under Medicare Parts A and B.

as well as CMS's Comprehensive Error Rate Testing (CERT) program.[2] The timeframes and procedures for appealing overpayments from postpayment review are the same as those that concern initial claim determinations.

Appellants must file redetermination requests in writing and must also indicate the reason why they disagree with the initial determinations.[3] The redetermination request can cover one or multiple claims. Appellants may also submit additional evidence, such as medical records or other documents that should be considered when the redeterminations are made.

Decisionmaking process. The request for redetermination is filed with, and the redetermination is made by, either the same Medicare claims administration contractor (hereafter, contractor) that made the initial determination or the contractor that is currently operating in that jurisdiction. As of May 2013, these contractors include 16 Medicare Administrative Contractors (MACs), as well as one fiscal intermediary and one carrier.[4]

The redetermination is considered a second look at a claim and its supporting documentation. It must be conducted by an employee of the contractor who was not involved in making the initial determination.[5] Depending on the nature of the redetermination, the review may be conducted by a medical review staff member, such as a nurse. When making the redetermination, contractor staff must follow the same requirements as they would for initial claim determinations. Examples of these requirements include statutory and regulatory requirements, as well as national and local coverage determinations.[6]

Upon receiving the redetermination request, a contractor generally has 60 days to make the redetermination and provide written notice of its decision to the appellant.[7] However, if the appellant submits additional evidence after filing the redetermination request, the contractor may extend the decisionmaking date by 14 days.[8]

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[2] See CMS, *Medicare Claim Review Programs*, accessed at https://www.cms.gov/MLNProducts/downloads/MCRP_Booklet.pdf on May 3, 2013. In January 2012, CMS changed the name of RACs to Recovery Auditors.

[3] 42 CFR § 405.944(b); 42 CFR § 405.946(a).

[4] CMS, *Status of Medicare Administrative Contract (MAC) Awards (as of April 26, 2013)*, accessed at www.cms.gov on May 3, 2013.

[5] Social Security Act, § 1869(a)(3)(B)(ii); CMS, *Medicare Claims Processing Manual*, ch. 29, § 310.

[6] CMS, *Medicare Claims Processing Manual*, ch. 29, § 310.

[7] 42 CFR § 405.950(a).

[8] 42 CFR §§ 405.946(b) and 405.950(b).

Outcomes of redeterminations. The result of a redetermination may be fully or partially favorable to the appellant (i.e., a full or partial Medicare payment will be made) or unfavorable to the appellant (i.e., no Medicare payment will be made).[9] Favorable or partially favorable redeterminations are generally paid within 30 days, but may take up to 60 days.[10]

Appellants who are dissatisfied with the redetermination decisions may request reconsideration, which is the second level of the appeals process. Appellants must file requests for reconsideration with a QIC within 180 days of the redetermination decisions. Upon receipt of a reconsideration request, a QIC requests the redetermination case file from the contractor, which must provide it to the QIC within 7 calendar days of the date of the QIC's request.[11]

CMS's Tracking of Medicare Appeals

Currently, no tracking system contains details on individual redeterminations that contractors process. The Medicare Appeals System (MAS), which is intended to support appeals processing across the first four levels of the appeals process, contains information only on appeals at the second and third levels. CMS will begin to integrate redeterminations into MAS beginning in September 2013.[12] Currently, contractors maintain case files and redetermination tracking systems for their own internal use.

Though CMS does not track individual redeterminations, its Contractor Reporting of Operational and Workload Data (CROWD) system, which it uses to monitor all aspects of contractors' workloads, includes aggregated information on redeterminations.[13] On a monthly basis, contractors electronically submit to CMS data from CROWD on redetermination processing (hereinafter, CROWD data).[14] Table 2 on page 4 shows some of the variables included in CROWD data. Because redeterminations that result from overpayments identified by RACs (hereinafter, RAC-related redeterminations) are funded in a manner different from that for other

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[9] Under certain circumstances, contractors may dismiss redetermination requests and appellants may withdraw their requests for redetermination. Dismissals and withdrawals occur before a redetermination decision is made or communicated. See CMS, *Medicare Claims Processing Manual*, ch. 29, §§ 310.1(B)(4) and 310.6.

[10] CMS, *Part A and Part B Medicare Administrative Contractor Statement of Work*, Attachment J-1, § C.5.10.2.

[11] CMS, *Medicare Claims Processing Manual*, ch. 29, § 320.4. That manual provision was last revised in October 2005, whereas most contractors' statements of work specify a case file transfer timeframe of 5 calendar days.

[12] *Capital Asset Plan and Business Case Summary for the Medicare Appeals System*, accessed from www.itdashboard.gov on March 29, 2012.

[13] CMS, *Medicare Financial Management Manual*, ch. 6, §§ 10.1 and 10.2.

[14] CMS, *Medicare Financial Management Manual*, ch. 6, § 460.

types of redeterminations, CROWD also includes a separate set of variables for tracking RAC-related redeterminations.[15]

Table 2: Examples of Variables in CROWD Data

Variables
Number of redetermination requests received
Redetermination requests completed
Types of claims involved in redetermination requests (skilled nursing facility, home health, inpatient hospital, outpatient, laboratory, ambulance, durable medical equipment, physician, other)
Outcomes of redeterminations (fully favorable, partially favorable, unfavorable, dismissed/withdrawn)
Completion timeframes for redeterminations
Number of case files requested by QICs and timeframes for forwarding case files to QICs
Number of favorably redetermined claims paid within 30 days[16]

Source: CMS, *Monthly Statistical Report on Intermediary and Carrier Part A and Part B Appeals Activity Form* (CMS-2592).

Identifying Suspected Fraud During the Redetermination Process

CMS instructs contractors to ensure that sufficient documentation and evidence exist to show that services were furnished.[17] If a contractor has "substantial basis" for determining that an appealed service was not furnished, it may deny or reduce the payment.[18] The contractor must also document this decision in the case file, as well as send a copy of the decision to the PSC or ZPIC.

Contractors' Analysis of Redetermination Data

CMS requires contractors to analyze all available data, including redetermination data, for developing provider outreach and education.[19] Moreover, CMS considers a contractor's data analysis program to be the basis of an effective quality improvement program.[20] For both of these purposes, contractors' data analysis programs should identify trends or

[15] CMS, *Medicare Financial Management Manual*, Transmittal 144, Change Request 6251, November 28, 2008.

[16] CMS refers to this as effectuation. See CMS, *Medicare Claims Processing Manual*, ch. 29, § 310.11.

[17] CMS, *Medicare Claims Processing Manual*, ch. 29, § 310.4.

[18] CMS, *Medicare Claims Processing Manual*, ch. 29, § 280.3.

[19] CMS, *Medicare Contractor Beneficiary and Provider Communications Manual*, ch. 6, § 20.3.

[20] CMS, *Medicare Claims Processing Manual*, ch. 29, § 350.

aberrancies in redeterminations, as well as any inefficiencies or problems.[21]

Concerns about Appeals Processing

Three Office of Inspector General (OIG) reports have raised concerns about aspects of appeals processing at the second and third levels, as well as problems with the quality of data in MAS. A report from 2012 on the third level of the appeals process found issues with incomplete or disorganized case files.[22] A report from 2008 on the third level of the appeals process identified problems with incomplete and inaccurate data in MAS, including inconsistencies in appellant information and omitted dates.[23] In addition, a report from 2008 that examined the second level of the appeals process found unmet timeframes for the processing of Part B appeals; these unmet timeframes were attributed to (1) delays in receiving case files from the contractors that processed redeterminations, (2) unexpected volume of appeals, and (3) challenges with using MAS.[24] The report also identified that inaccurate information was entered into MAS for 54 percent of second-level appeals.

In 2003, the Government Accountability Office (GAO) reported that CMS had limited understanding of the nature and types of Parts A and B appeals.[25] Specifically, GAO highlighted that CMS did not collect data on the characteristics of appeals, such as the reason for the appeal, the type of denial being appealed, and the type of appellant. As previously mentioned, CMS still does not collect these data for redeterminations.

METHODOLOGY

Scope

This study focused on redeterminations processed for Medicare Parts A and B during 2008–2012. We did not examine expedited redeterminations for Part A services, which are handled by Quality Improvement Organizations.[26]

[21] Ibid.

[22] OIG, *Improvements Are Needed at the Administrative Law Judge Level of Medicare Appeals*, OEI-02-10-00340, November 2012.

[23] OIG, *Medicare Administrative Law Judge Hearings: Early Implementation, 2005–2006*, OEI-02-06-00110, July 2008.

[24] OIG, *Early Implementation Review of Qualified Independent Contractor Processing of Medicare Appeals Considerations*, OEI-06-06-00500, July 2008.

[25] GAO, *Medicare Appeals: Disparity between Requirements and Responsible Agencies' Capabilities*, GAO-03-841, September 2003.

[26] 42 CFR § 405.1202.

Data Sources and Analysis

CROWD Data. We obtained CROWD data on redeterminations from CMS's Contractor Management Information System (CMIS) for calendar years 2008–2012. We analyzed these data to determine the number of redeterminations processed, the types of claims involved in redeterminations, and the outcomes. We also analyzed these data to determine the extent to which contractors met the required timeframes for processing redeterminations, forwarding case files to QICs, and paying favorably redetermined claims. Finally, we analyzed the data to determine the number of claims processed and denied in these timeframes.

In addition, we also analyzed data from CMIS on the number of claims for Medicare Parts A and B that were processed and denied from 2008–2012.

Survey of Contractors. In January 2013, we surveyed the 18 contractors then in operation that processed redeterminations for Parts A and B. The questionnaire collected information on the following areas: redetermination workload, contractor analysis of redetermination data, redetermination requests from beneficiaries, suspected fraud and abuse, working with other contractors, working with CMS, implementation of MAS, and contractor challenges with processing redeterminations. Our response rate was 100 percent.

Contractor Interviews. We interviewed five purposively selected contractors to learn more about how they process redeterminations. We conducted these interviews either by telephone or onsite. For each contractor, we interviewed management and key staff responsible for redeterminations, including those that process redeterminations and develop provider outreach and education strategies. We used a structured protocol that addressed the following topics: contractor processes for redeterminations, trends in redeterminations volume, systems for analyzing redeterminations data, processes for referral of redeterminations because of suspicion of fraud or abuse, provider outreach and education, interaction with CMS, collaboration with other contractors, and challenges contractors faced concerning redetermination processing.

Interviews With CMS Staff. We interviewed relevant staff from CMS's Medicare Contractor Management Group and Medicare Enrollment and Appeals Group to learn about their oversight of redeterminations. We used a structured protocol. We collected information on the activities that CMS conducts to monitor redetermination processing, the actions CMS had taken to address recent increases in appeals volume, progress towards implementing MAS, and the challenges that CMS faces in overseeing redeterminations.

Review of CMS Documents. We obtained and reviewed relevant policies, manuals, and other documents issued by CMS regarding redeterminations. This included the *Medicare Claims Processing Manual*, the *Medicare Financial Management Manual*, the *Medicare Contractor Beneficiary and Provider Communications Manual*, contractor statements of work, and other relevant documentation regarding redetermination processing.

Limitations

CROWD data are self-reported by contractors, and we did not independently verify them.

Standards

This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

FINDINGS

In 2012, contractors processed 2.9 million redeterminations, which involved 3.7 million claims, an increase of 33 percent since 2008

Redeterminations may involve multiple claims and service types; therefore, the number of redeterminations is smaller than the number of claims. The number of claims involved in redeterminations in 2012 were only 2.6 percent of denied claims and only 0.3 percent of the 1.2 billion claims processed in that year (Table 3). In addition, the redeterminations processed in a given year could involve claims from previous years and are not a subset of the claims denied in that year.

Table 3: Redeterminations and Medicare Claims Processed, 2008–2012

Year	Redeterminations processed	Number of claims involved in redeterminations processed	Total Medicare claims processed	Total Medicare claims denied	Percentage of denied claims with redeterminations processed
2008	2,206,331	2,820,726	1,189,655,945	159,437,418	1.8%
2009	2,161,360	2,656,577	1,182,234,051	129,800,982	2.0%
2010	2,190,693	2,652,725	1,175,428,235	118,080,657	2.2%
2011	2,417,753	2,989,687	1,184,826,848	118,931,285	2.5%
2012	2,937,983	3,664,599	1,230,162,749	139,275,486	2.6%

Source: OIG analysis of CROWD data, 2013.

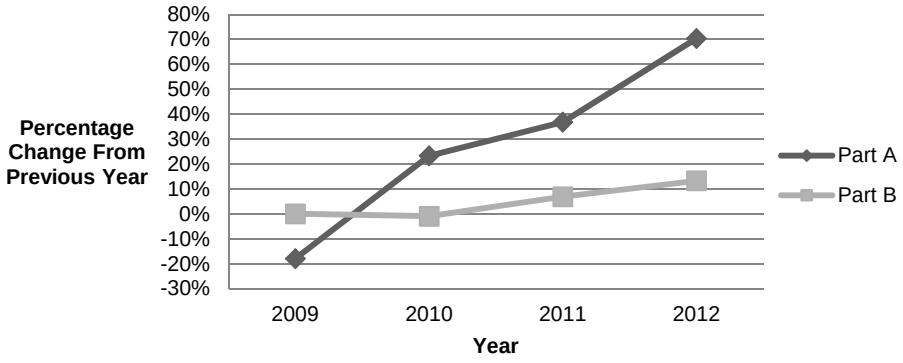
On our survey, 14 of the 18 contractors estimated that 5 percent or less of the redetermination requests they receive come from beneficiaries or their representatives. Although CROWD data do not contain information on whether requests for redetermination are filed by providers or beneficiaries, our interviews and survey data suggest that requests for redetermination are typically filed by providers rather than beneficiaries.

The percentage increase in Medicare redeterminations from 2008–2012 outpaced the percentage increase in the total number of Medicare claims processed. From 2008 to 2012, the number of redetermination requests processed increased by 33 percent, while the overall number of Medicare claims processed increased by 3 percent.

Although 80 percent of all redeterminations in 2012 involved Part B services, redeterminations involving Part A services have risen more rapidly. In 2012, redeterminations involving Part A services totaled fewer than 600,000, versus 2.3 million for Part B. However, from 2008 through 2012, Part A redetermination requests increased by 136 percent, versus 20 percent for Part B. (See Figure 1 for annual changes in redeterminations processed.) In addition, although there were fewer

Part A redeterminations, contractors we interviewed noted that Part A redeterminations are generally much more time and resource intensive to process than are those for Part B. Typically, Part A redeterminations involve the review of an entire medical record, which must be conducted by a nurse or other clinical staff member and may take much longer to process than those that do not need medical review.

Figure 1: Percentage Change in Redeterminations Processed From Previous Year



Source: OIG analysis of CROWD data, 2013.

Appeals of inpatient hospital claims, the most commonly appealed Part A services, primarily drove the large increase in Part A redeterminations between 2008 and 2012 (Table 4). The number of appealed Part A home health claims also grew dramatically between 2008 and 2012, by 700 percent.

Table 4: Part A Medicare Claims Appealed From 2008 to 2012

Service type	Claims appealed in 2008	Claims appealed in 2012	Percentage change in claims appealed from 2008 to 2012
Inpatient	45,532	283,697	523%
Outpatient	140,926	177,709	26%
Home Health	14,248	114,453	703%
Laboratory	1,701	1,131	-34%
Ambulance	5,723	3,488	-39%
Skilled Nursing Facility	8,928	11,367	27%
Other	45,945	61,267	33%
Total	263,003	653,112	148%

Source: OIG analysis of CROWD data, 2013.

From 2008 to 2012, the number of appealed Part B claims increased by 18 percent across service types (Table 5). Most Part B redeterminations involved durable medical equipment (DME) and physician claims. The largest increases from 2008 to 2012 were for laboratory (39 percent) and DME (38 percent) claims.

Table 5: Part B Medicare Claims Appealed From 2008 to 2012

Service type	Claims appealed in 2008	Claims appealed in 2012	Percentage change in claims appealed from 2008 to 2012
Physician	1,360,286	1,480,832	9%
DME	703,513	968,873	38%
Ambulance	226,553	233,941	3%
Laboratory	80,015	111,291	39%
Other	187,351	216,550	16%
Total	2,557,718	3,011,487	18%

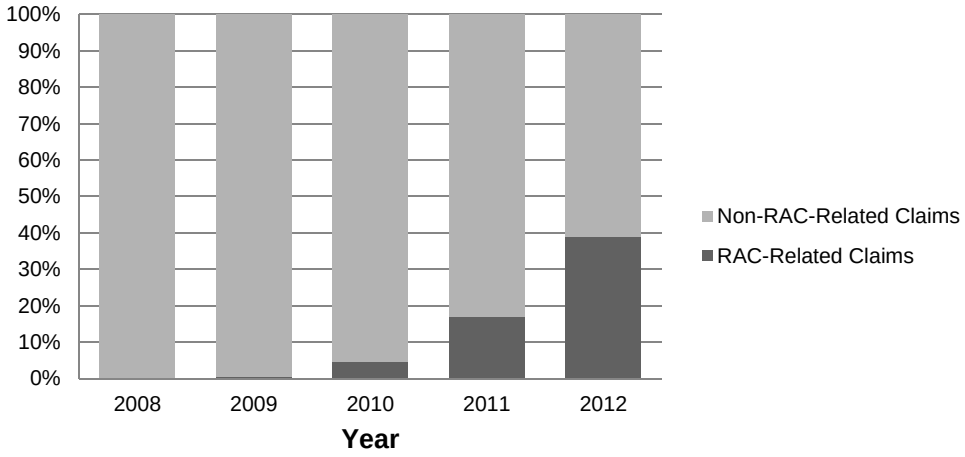
Source: OIG analysis of CROWD data, 2013.

An increase in claims from RAC-related redeterminations—which account for 39 percent of all appealed Part A claims in 2012—explains the fivefold increase in appealed inpatient hospital claims since 2008

During our site visits, contractors noted that the growth of the RAC program, which CMS fully implemented in 2009, had resulted in increased appeals of RAC decisions. From 2010 to 2012, appealed Part A RAC claims increased from 13,605 to 254,898, while non-RAC Part A claims increased from 279,546 to 398,214 (Figure 2). CMS's CROWD data track whether RAC-related redeterminations involve Part A or Part B claims, but do not track the specific types of services involved. However, contractors told us that RAC-related claims most frequently involved short-term inpatient stays, which often require medical review.

In contrast to the increase in appealed Part A claims, the increases in appealed Part B claims do not appear to be driven by an increase in RAC-related redeterminations. RAC-related claims made up only 1 percent of appealed Part B claims in 2010 and 3 percent of appealed Part B claims in both 2011 and 2012.

Figure 2: Percentage of Appealed Part A Claims Related to RAC Decisions



Source: OIG analysis of CROWD data, 2013.

Although CROWD does not contain data on the reasons for redeterminations, contractors reported other reasons for the increase in redeterminations workload (Table 6). In addition to RAC audits, these reasons included efforts to prevent improper payments, such as PSC/ZPIC reviews and prepayment edits. Changes in payment policies—such as local coverage determinations—also increased the redeterminations workload, particularly for Part B.

Table 6: Contractor-Reported Factors That Increased Redeterminations Workload

Factor	Number of contractors reporting factor as increasing Part A redeterminations (n=13)	Number of contractors reporting factor as increasing Part B redeterminations (n=17)
Audits by RACs	13	15
Reviews by PSCs/ZPICs	11	14
Prepayment Edits	11	11
Local Coverage Decisions	7	15
CMS Program Changes	8	16

Source: OIG survey of contractors, 2013.

Contractors decided in favor of Part A appellants at a lower rate than that for Part B appellants

Contractors' decisions on redeterminations may be fully favorable to appellants, partially favorable to appellants, or unfavorable to appellants. Redetermination decisions also varied by the type of claims involved. For

this study, decided redeterminations include all processed redeterminations that were not dismissed by contractors or withdrawn by appellants.[27] From 2008–2012, 7 percent of Part A redetermination requests and 12 percent of Part B redetermination requests were dismissed or withdrawn.

From 2008 to 2012, the rate of favorable decisions on Part A redeterminations decreased

As Table 7 shows, contractors decided fully or partially in favor of appellants for less than a quarter of Part A redeterminations in 2012. The rate of fully or partially favorable decisions for Part A redeterminations decreased by over half from 2008 to 2012, from 50 percent to 24 percent.

Table 7: Outcomes of Part A Redeterminations, 2008–2012

Year	Redeterminations decided	Percentage of redeterminations fully or partially favorable to appellants	Percentage of redeterminations unfavorable to appellants
2008	225,983	50%	50%
2009	189,251	50%	50%
2010	234,902	49%	51%
2011	323,507	40%	60%
2012	565,457	24%	76%

Source: OIG analysis of CROWD data, 2013.

For Part A RAC-related redeterminations, the rate of favorable decisions decreased even more dramatically (Table 8). In 2009 and 2010, the first 2 years that contractors processed RAC-related redeterminations, most contractor decisions were fully or partially favorable to appellants. However, as the volume of RAC-related redeterminations grew substantially in 2011 and 2012, the favorable rate declined substantially, with just 11 percent of RAC-related redeterminations decided fully or partially in favor of appellants in 2012. Contractors and CMS officials we interviewed noted that since RACs began their operations, they have become more skilled in interpreting Medicare payment policies.

[27] See CMS, *Medicare Claims Processing Manual*, ch. 29, § 310.6, for the circumstances under which contractors may dismiss redetermination requests.

Table 8: RAC-Related and Non-RAC-Related Part A Redeterminations That Were Favorable to Appellants, 2008–2012

Year	Overall percentage of redeterminations favorable to appellants (fully or partially)	Percentage of RAC-related redeterminations favorable to appellants (fully or partially)	Percentage of non-RAC-related redeterminations favorable to appellants (fully or partially)
2008	50%	N/A	50%
2009	50%	83%	50%
2010	49%	80%	47%
2011	40%	21%	44%
2012	24%	11%	33%

Source: OIG analysis of CROWD data, 2013.

The outcomes of Part A redeterminations also varied on the basis of types of claims appealed. In 2012, only 4 percent of redeterminations for home health claims and 10 percent of redeterminations for inpatient hospital claims were fully or partially favorable to appellants. In contrast, 54 percent of redeterminations for claims for outpatient hospital services were fully or partially favorable to appellants in 2012.

From 2008–2012, about half of Part B redeterminations were favorable to appellants

As Table 9 shows, the percentage of Part B redeterminations decided fully or partially in favor of appellants decreased slightly from 2008 to 2012, with the largest drop resulting between 2011 and 2012. Physician claims, which represent the largest volume of Part B appeals, maintained steady favorable rates. However, the percentage of appealed DME claims decided in favor of appellants (either fully or partially) dropped from 51 percent in 2008 to 38 percent in 2012.

Table 9: Outcomes of Part B Redeterminations, 2008–2012

Year	Redeterminations decided	Percentage of redeterminations fully or partially favorable to appellants	Percentage of redeterminations unfavorable to appellants
2008	1,674,860	65%	35%
2009	1,667,217	60%	40%
2010	1,677,976	57%	43%
2011	1,844,316	58%	42%
2012	2,115,319	51%	49%

Source: OIG analysis of CROWD data, 2013.

Contractors largely met required timeframes, with some exceptions

By law, contractors are required to process 100 percent of redeterminations within required timeframes. The 100-percent standard also applies to meeting the timeframes for transferring redetermination case files for second-level appeals, as well as to paying claims that were decided in the appellants' favor.

Contractors largely met timeframes for processing redeterminations

Contractors are required to complete redeterminations within 60 days of receipt; if appellants submitted additional information after filing a redetermination request, these redeterminations must be completed within 74 days.[28] As Table 10 shows, the median completion rate (i.e., the percentage of redeterminations completed within the required timeframe) for Part A redeterminations ranged from 98 to 100 percent from 2008 to 2011, but dropped to 89 percent in 2012. Contractors' annual median completion rate for Part B redeterminations was 99 percent in 2008 and 100 percent from 2009–2012.

Table 10: Completion Rates for Processing Redeterminations, 2008–2012

Medicare Part	Year	Number of contractors	Overall percentage completed within timeframes	Median contractor completion rate	Lowest contractor completion rate	Highest contractor completion rate
Part A	2008	20	84%	98%	55%	100%
	2009	22	98%	99%	58%	100%
	2010	16	99%	100%	95%	100%
	2011	17	93%	100%	55%	100%
	2012	18	86%	89%	42%	100%
Part B	2008	26	92%	99%	29%	100%
	2009	25	97%	100%	90%	100%
	2010	21	99%	100%	94%	100%
	2011	23	99%	100%	70%	100%
	2012	24	91%	100%	56%	100%

Source: OIG analysis of CROWD data, 2013.

The increased demand on contractors' medical review staff could explain contractors' difficulty in meeting processing timelines for Part A redeterminations. Contractors we interviewed cited the need to hire additional medical reviewers to handle the influx of Part A appeals. On

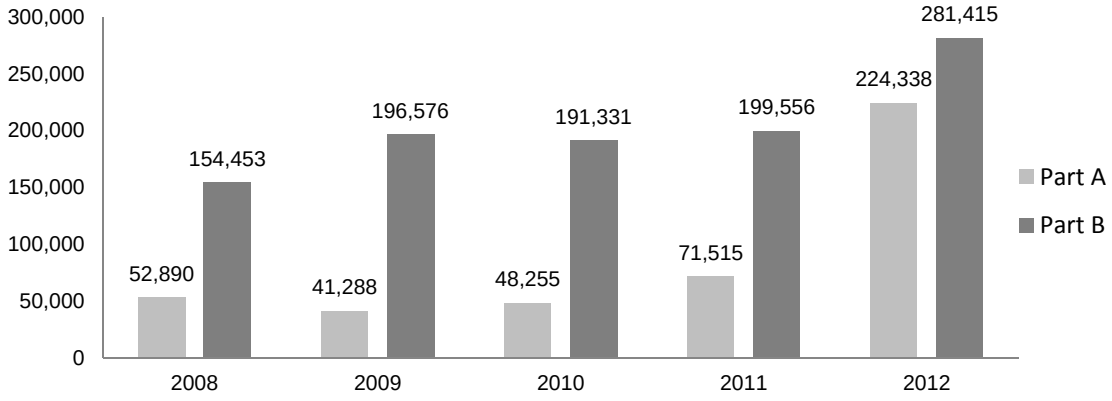
[28] 42 CFR § 405.946(b). The contractor's 60-day decisionmaking timeframe is automatically extended for 14 calendar days for each submission of additional information. See CMS, *Medicare Claims Processing Manual*, ch. 29, § 310.4.

our survey, 14 of 18 contractors indicated that recruiting staff to conduct medical reviews was a challenge. In our interviews, contractors told us that hiring medical review staff can be a major challenge when those skills are in demand. Moreover, the influx of RAC-related redeterminations has led to contractors' training their medical review staff on the services involved in those redeterminations.

Contractors fell short of meeting timeframes for transferring case files for second level appeals, likely because of substantial increases in the number of such files

Appellants that are unsatisfied with the outcomes of redeterminations can file appeals at the second level within 180 days of receiving their outcomes. Given the growth in redeterminations that were unfavorable to appellants, the volume of case files that contractors transferred to the second level also grew markedly. In 2012, contractors transferred over half a million case files to QICs for second-level appeals (see Figure 3). This was a 144-percent increase in case files transferred from 2008 to 2012 and an 87-percent increase in files transferred from 2011 to 2012. The number of Part A case file transfers increased by 324 percent between 2008 and 2012. This increase corresponds largely to the volume of unfavorable redeterminations for Part A.

Figure 3: Number of Case Files Transferred From Contractors to QICs by Medicare Part, 2008–2012



Source: OIG analysis of CROWD data, 2013.

Likely as a result of the increase in Part A case files transferred, the timeliness of contractors' transfer of these case files to QICs within 5 days dropped to 79 percent in 2012 (See Table A1 in Appendix A). In the previous 3 years, contractors had transferred close to 90 percent of case

files within 5 days. The median percentage of Part A case files transferred to QICs within required timeframes across contractors lagged in 2012 as well, dropping to 83 percent. The percentage of Part B case files transferred within 5 days remained high, with 98 percent transferred within this timeframe in 2012.

Contractors largely paid favorably appealed claims within timeframes

In most instances, CMS requires contractors to issue payment within 30 days for claims that were decided fully or partially in the appellants' favor. Across contractors, the median percentage of claims paid within that timeframe in 2011 and 2012 was 99 percent for Part A and 100 percent for Part B (see Table A2 in Appendix A).

Fluctuating workloads affect contractors' ability to meet redetermination timelines

On our survey, 17 of 18 contractors cited fluctuating redetermination workloads as a challenge in meeting mandated timeframes for processing. Increases in workload pose challenges when the volume exceeds the amount for which a contractor has budgeted. Because appellants have 120 days to file requests for redetermination, it is difficult to predict when the changes in workload might occur. Managers at one contractor told us that, along with hiring additional staff to keep up with the workload, they had also borrowed staff from other departments, instituted mandatory overtime, and hired temporary staff. Managers at other contractors told us that they had to hire several more medical review staff members because of the increase in Part A RAC-related redeterminations. Nonetheless, contractors find it difficult to plan resource needs when they are unsure how long their workload will keep increasing.

Contractors use information from redeterminations in a variety of ways to improve their operations

CMS requires contractors to analyze redeterminations data. Contractors use the results of these analyses to inform provider education and outreach, as well as to improve their internal operations. In addition, contractors train redetermination staff to identify potential instances of fraud while reviewing redeterminations.

Contractors used information from redeterminations for educating providers and improving their internal operations

CMS instructs contractors to use all data they have available, including data related to appeals, for developing provider outreach and education.[29] On our survey, contractors reported that they analyzed a variety of redetermination-related data sources as a part of their data analysis programs. The most common types of data that contractors reported analyzing "all of the time" include the timeframes for processing redeterminations (16 of 18 contractors), feedback from staff (13 contractors), outcomes of redeterminations (11 contractors), and reasons for claim denials that result in redeterminations (9 contractors). Moreover, all 18 contractors reported that they had identified trends, aberrancies, or patterns through the data they analyzed in the past year.

The information from contractors' analysis of redetermination-related data informs the provider outreach and education that they conduct relative to appeals. On our survey, 16 of 18 contractors reported that their data analysis informs their education and outreach "to some extent" or "to a large extent." Contractors used the results from their data analysis to target specific providers for increased education and to develop outreach and education related to specific billing issues and aspects of the redetermination process. For example, 1 contractor uses data on the top 10 reasons that redeterminations occur as the basis for provider teleconferences and listserv messages. Other contractors use data analysis to target provider-specific education, such as letters or in-person meetings. Provider-specific education may address correct billing for items or services as well as aspects of the appeals process, such as correctly submitting redetermination requests or the difference between redeterminations and reopening of claims.[30]

In addition, contractors also used the results from their data analysis to improve their internal redetermination processes. On our survey, 10 of 18 contractors reported that they used these results for process improvements "to some extent" or "to a large extent." Most contractors that used data for improving their redetermination processes reported that they used the information to improve training for staff and make changes to procedures. For example, one contractor's analysis revealed that the provider contact center received a large volume of calls on redeterminations. As a result,

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[29] CMS, *Medicare Contractor Beneficiary and Provider Communications Manual,* ch. 6, § 20.3.

[30] Reopening is a process that is separate from appeals. See CMS, *Medicare Claims Processing Manual*, ch. 34, § 10.

the contractor instituted training on redeterminations for provider contact center staff.

Although detecting suspected fraud through the redetermination process presents difficulties, contractors train their redetermination staff on fraud detection

On our survey, 15 of 18 contractors reported that they have limited ability to detect suspected fraud primarily through the redetermination process. Moreover, contractors that we interviewed cited difficulties in detecting fraud solely through the redetermination process. As the managers at one contractor told us, an appeal represents an isolated case, which limits the ability to identify fraud during that process. Managers at another contractor mentioned that they focus their efforts on fraud prevention efforts, such as implementing edits. Managers at one contractor mentioned that when any questionable redeterminations are identified, staff refer them internally to their benefit protection unit, which will refer them to the ZPIC if appropriate.

Despite the limited ability to detect fraud through the redetermination process, all contractors provide training to staff concerning suspected fraud. On our survey, 16 of 18 contractors reported conducting fraud-related training annually, with the remaining 2 providing it quarterly. All contractors reported training staff at all levels of the redetermination process, including clerical staff, redetermination review staff, medical review staff, management, and mailroom staff.

CMS employs multiple methods to improve contractors' processing of redeterminations

During our interviews, CMS staff noted that they oversee the redetermination process through a variety of contract management activities. CMS examines CROWD data and reviews contractors' monthly status reports to monitor performance on redetermination processing and identify any problems with meeting timeframes. In biweekly conference calls with each contractor, CMS discusses contractors' workload and progress towards meeting timeframes. Moreover, CMS reviews redetermination processing as part of the Quality Assurance Surveillance Plan for MACs.[31]

[31] See OIG, *Medicare Administrative Contractors' Performance*, OEI-03-11-00740, forthcoming.

CMS has taken steps to address the increase in redeterminations

CMS expects contractors to manage the increasing workload by identifying and reacting quickly to workload changes. CMS has been working to help contractors manage the increased workload by providing additional funding where necessary. On our survey, the most common redeterminations-related issue that contractors reported discussing with CMS concerned RAC-related redeterminations (11 of 18 contractors). CMS coordinates with the RACs to predict increases in the redetermination workload. Furthermore, CMS and the contractors meet with RACs to discuss which program areas the RACs will be focusing on and to ensure that the RACs are correctly interpreting Medicare payment policies.

Nevertheless, CMS noted that the recent increases in the redetermination workload are a significant challenge. CMS officials attributed the surge in workload to the increasing audit and program integrity activity, most notably audits by RACs, reviews by PSCs/ZPICs, and the CERT program. During our interview, one CMS manager also commented that any change in the program results in an increase in appeals.

With the increasing workload, ensuring that contractors meet the 100-percent timeliness standard for processing redeterminations is a challenge for CMS. This standard is mandated by law and is resource intensive for contractors to achieve. CMS provides additional funding to contractors to help them meet this standard; however, as one CMS manager commented, the amount of resources necessary to get from 98 to 100 percent is "extraordinary."

CMS fosters communication among contractors concerning processing redeterminations

Despite the competitive nature of contracting, CMS has fostered interaction among contractors. On our survey, 14 of 17 contractors reported that CMS had facilitated discussions on redeterminations among the contractors and 12 of 17 contractors reported meeting monthly or more frequently with other contractors to discuss redeterminations. In particular, DME contractors highlighted strong collaboration among the four DME contractors.

Moreover, 16 of 17 contractors indicated that they would welcome increased interaction with other contractors regarding redeterminations. Some of the topics in which contractors expressed interest include consistency of processes and policies, language used in redetermination decision letters, and sharing of best practices.

Implementation of MAS will improve CMS's ability to oversee the redetermination process

Currently, CMS collects aggregate data on redeterminations from CROWD but does not collect information on individual redeterminations and appealed claims. As a result, CMS has limited information on the types of services that are appealed and the types of appellants that are filing requests for redeterminations. Once MAS is implemented, CMS will have access to indepth data about individual redeterminations directly from MAS. This will enable CMS to conduct more detailed analysis of the redetermination process and will ease contractor workload because contractors will no longer have to report these data. On our survey, all 17 respondents indicated that they expect MAS to be useful for managing their workloads.

MAS implementation will also eliminate the need for contractors to transfer case files to the QICs. With MAS, QICs will be able to pull files on redeterminations directly from the system, saving the contractors from transferring them. When surveyed about the usefulness of MAS for transferring case files to QICs, all 17 respondents indicated that they expect MAS will be very useful.

CONCLUSION AND RECOMMENDATIONS

The percentage increase in Medicare redeterminations from 2008–2012 outpaced the percentage increase in the total number of Medicare claims processed; this growth can likely be attributed to efforts to reduce improper payments. Although CROWD data cannot provide many specifics on the nature of redeterminations, we identified substantial growth in Part A RAC-related redeterminations, which increasingly were decided unfavorably to appellants. Despite efforts by CMS and its contractors to manage the timeliness of redetermination processing, the increasing volume of redeterminations has posed challenges to meeting the required timeframes, especially in the past 2 years. Contractors have used information from redetermination processing to target provider education, and CMS has also made efforts to encourage information-sharing across contractors.

In the fall of 2013, CMS will begin to integrate redeterminations into MAS. Once fully implemented, it will create efficiencies in redetermination processing. Most notably, the manual, labor-intensive transfer of case files between the first and second levels of the appeals process will become obsolete. MAS will also equip CMS with readily accessible data on redeterminations.

We recommend that CMS:

Use MAS to monitor contractor performance

Once MAS is implemented, CMS will have access to indepth data about individual redeterminations in real time. CMS should use these data to closely monitor the timeliness of redetermination processing, particularly during the implementation of MAS. CMS should also use MAS data to conduct more detailed analyses of redeterminations trends.

Continue to foster information sharing among Medicare contractors

CMS has increased interaction among its contractors, and contractors expressed interest in even more interaction. CMS should continue to facilitate information sharing on best practices for redetermination processing. This might be particularly useful during MAS implementation. CMS should also continue to encourage information sharing with the contractors that conduct postpayment reviews, such as RACs, ZPICs, and PSCs. This would help contractors better predict and prepare for future workload fluctuations.

Monitor the quality of redeterminations data in MAS

Previous OIG reports that examined the second and third levels of the Medicare appeals process identified concerns about inaccuracies and data

missing from MAS. As CMS begins to integrate redeterminations into MAS, it should develop a strategy to monitor the quality, accuracy, and completeness of the data entered into MAS. Where possible, CMS should also ensure that data quality checks and validation are built into MAS.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS concurred with all three of our recommendations.

In response to our first recommendation, CMS stated that MAS will enable enhanced monitoring and tracking of contractor performance. It also noted that it will be able to use MAS to conduct more detailed analyses and identify trends and patterns with redeterminations.

In response to our second recommendation, CMS stated that it had facilitated meetings among contractors related to MAS implementation and participation in hearings for the third level of the appeals process. It also noted that contractors often share in sessions concerning MAS implementation, and it intends to continue these sessions after MAS is implemented so they can continue to share. In addition, CMS stated that the recent increases in the appeals workload show why it is essential for information sharing to occur among the contractors that conduct postpayment reviews.

In response to our third recommendation, CMS stated that contractors' use of MAS data should ensure greater accuracy, timeliness, and efficiency in the appeals process. In addition, it stated that additional automation that will be implemented into MAS should reduce instances of erroneous and missing data that were identified by previous OIG reports on the second and third level of the appeals process. CMS also noted that it will explore adding data metrics related to MAS to its Quality Assurance Surveillance Plans and Award Fee Plans for MACs.

For the full text of CMS's comments, see Appendix B.

APPENDIX A

Additional Data Tables

Table A1: Timeliness of Case File Transfer to Qualified Independent Contractors, 2008–2012

Medicare Part	Year	Number of contractors	Percentage of case files transferred within 5 days	Contractor percentages		
				Median transfer rate	Lowest transfer rate	Highest transfer rate
Part A	2008	20	64%	85%	20%	100%
	2009	22	87%	100%	61%	100%
	2010	16	87%	100%	59%	100%
	2011	17	89%	99%	50%	100%
	2012	18	79%	83%	42%	100%
Part B	2008	26	81%	89%	14%	100%
	2009	25	97%	99%	56%	100%
	2010	21	99%	100%	93%	100%
	2011	23	99%	100%	92%	100%
	2012	20*	98%	99%	75%	100%

* At different points in 2012, CMS changed each of the four DME contractors' file transfer timeframe from 5 days to 7 days. Because CROWD lacks a discrete category for reporting file transfer within this timeframe, we excluded these contractors from the 2012 percentages.

Source: OIG analysis of CROWD data, 2013.

Table A2: Timeliness of Payment of Favorably Redetermined Claims, 2008-2012

Medicare Part	Year	Number of contractors	Percentage of favorably appealed claims paid within 30 days	Contractor percentages		
				Median paid within 30 days	Lowest paid within 30 days	Highest paid within 30 days
Part A	2008	20	97%	98%	69%	100%
	2009	22	93%	97%	44%	100%
	2010	16	92%	99%	9%	100%
	2011	17	98%	99%	65%	100%
	2012	18	92%	99%	62%	100%
Part B	2008	26	92%	97%	6%	100%
	2009	25	96%	98%	84%	100%
	2010	21	98%	100%	88%	100%
	2011	23	97%	100%	77%	100%
	2012	24	93%	100%	46%	100%

Source: OIG analysis of CROWD data, 2013.

Table A3: Outcomes of Redeterminations for Skilled Nursing Facility Claims, 2008–2012

Year	Redeterminations decided	Percentage of redeterminations fully favorable to appellants	Percentage of redeterminations partially favorable to appellants	Percentage of redeterminations unfavorable to appellants
2008	8,455	19%	8%	74%
2009	7,614	17%	5%	78%
2010	9,851	16%	4%	82%
2011	11,785	24%	6%	70%
2012	10,654	16%	3%	77%

Source: OIG analysis of CROWD data, 2013.
Note: Some percentages do not sum to 100 percent because of rounding.

Table A4: Outcomes of Redeterminations for Home Health Claims, 2008–2012

Year	Redeterminations decided	Percentage of redeterminations fully favorable to appellants	Percentage of redeterminations partially favorable to appellants	Percentage of redeterminations unfavorable to appellants
2008	13,385	22%	2%	76%
2009	17,116	35%	4%	61%
2010	46,037	9%	1%	89%
2011	58,713	6%	1%	94%
2012	112,844	3%	1%	95%

Source: OIG analysis of CROWD data, 2013.
Note: Some percentages do not sum to 100 percent because of rounding.

Table A5: Outcomes of Redeterminations for Inpatient Hospital Claims, 2008–2012

Year	Redeterminations decided	Percentage of redeterminations fully favorable to appellants	Percentage of redeterminations partially favorable to appellants	Percentage of redeterminations unfavorable to appellants
2008	41,042	31%	0%	69%
2009	10,929	30%	1%	70%
2010	9,477	26%	2%	65%
2011	63,918	16%	2%	83%
2012	276,232	10%	0%	90%

Source: OIG analysis of CROWD data, 2013.
Note: Some percentages do not sum to 100 percent because of rounding.

Table A6: Outcomes of Redeterminations for Outpatient Claims, 2008–2012

Year	Redeterminations decided	Percentage of redeterminations fully favorable to appellants	Percentage of redeterminations partially favorable to appellants	Percentage of redeterminations unfavorable to appellants
2008	124,185	55%	5%	39%
2009	126,908	52%	4%	44%
2010	159,088	53%	5%	42%
2011	172,806	49%	6%	44%
2012	161,707	49%	6%	46%

Source: OIG analysis of CROWD data, 2013.
Note: Some percentages do not sum to 100 percent because of rounding.

Table A7: Outcomes of Redeterminations for Laboratory Claims, 2008–2012

Year	Redeterminations decided	Percentage of redeterminations fully favorable to appellants	Percentage of redeterminations partially favorable to appellants	Percentage of redeterminations unfavorable to appellants
2008	67,520	55%	2%	43%
2009	74,804	45%	4%	52%
2010	83,355	48%	5%	48%
2011	87,933	54%	4%	42%
2012	100,261	52%	2%	45%

Source: OIG analysis of CROWD data, 2013.
Note: Some percentages do not sum to 100 percent because of rounding.

Table A8: Outcomes of Redeterminations for Ambulance Claims, 2008–2012

Year	Redeterminations decided	Percentage of redeterminations fully favorable to appellants	Percentage of redeterminations partially favorable to appellants	Percentage of redeterminations unfavorable to appellants
2008	217,258	68%	1%	32%
2009	155,871	61%	1%	38%
2010	173,966	52%	1%	47%
2011	201,138	48%	0%	52%
2012	225,684	43%	0%	57%

Source: OIG analysis of CROWD data, 2013.
Note: Some percentages do not sum to 100 percent because of rounding.

Table A9: Outcomes of Redeterminations for Durable Medical Equipment Claims, 2008–2012

Year	Redeterminations decided	Percentage of redeterminations fully favorable to appellants	Percentage of redeterminations partially favorable to appellants	Percentage of redeterminations unfavorable to appellants
2008	628,712	46%	5%	32%
2009	423,150	48%	7%	45%
2010	485,295	44%	5%	50%
2011	636,222	40%	6%	54%
2012	897,500	33%	5%	62%

Source: OIG analysis of CROWD data, 2013.
Note: Some percentages do not sum to 100 percent because of rounding.

Table A10: Outcomes of Redeterminations for Physician Claims, 2008–2012

Year	Redeterminations decided	Percentage of redeterminations fully favorable to appellants	Percentage of redeterminations partially favorable to appellants	Percentage of redeterminations unfavorable to appellants
2008	1,112,028	60%	3%	37%
2009	1,280,691	54%	3%	43%
2010	1,150,788	54%	4%	42%
2011	1,257,177	55%	3%	42%
2012	1,298,987	52%	2%	46%

Source: OIG analysis of CROWD data, 2013.

Table A11: Outcomes of Redeterminations for Other Claims, 2008–2012

Year	Redeterminations decided	Percentage of redeterminations fully favorable to appellants	Percentage of redeterminations partially favorable to appellants	Percentage of redeterminations unfavorable to appellants
2008	196,640	53%	2%	45%
2009	166,697	45%	2%	53%
2010	176,085	43%	2%	55%
2011	181,088	45%	2%	53%
2012	250,403	33%	1%	66%

Source: OIG analysis of CROWD data, 2013.

Note: The data presented in these tables were self-reported by contractors to the Centers for Medicare & Medicaid Services. We did not independently verify the accuracy of these data.

APPENDIX B

Agency Comments

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: AUG 2 3 2013

TO: Daniel R. Levinson
Inspector General

FROM: Marilyn Tavenner /S/
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "The First Level of the Medicare Appeals Process, 2008-2012: Volume, Outcomes, and Timeliness" (OEI-01-12-00150)

Thank you for the opportunity to review and comment on the OIG draft report. The OIG's study focused on redeterminations, i.e., the first level of the appeals process for Medicare Parts A and B, processed during 2008-2012. The purpose of the report was to describe the volumes and trends in redeterminations in Medicare Parts A and B processed in 2008-2012; assess the outcomes and timeliness of Medicare contractors' processing of redeterminations for Parts A and B, and assess the Centers for Medicare & Medicaid Services' (CMS) monitoring of redetermination processing. We appreciate OIG's time and effort in reviewing our processes. The CMS concurs with OIG's recommendations and our comments on each recommendation are below.

OIG Recommendation

The OIG recommends CMS use the Medicare Appeals System (MAS) to monitor contractor performance.

CMS Response

The CMS concurs with this recommendation. Currently, MAS supports the processing of qualified independent contractor reconsiderations and Administrative Law Judge (ALJ) hearings, i.e., the second and third level of the appeals process for Medicare Parts A and B. In the fall of 2013, four Medicare Administrative Contractors (MACs) will begin processing Part A redeterminations in MAS. This is an important step in CMS' phased-in approach to implementing MAS at all of the MACs. The MAS will provide CMS with real-time data and standardized reports to allow enhanced monitoring and tracking of MAC performance. Additionally, MAS will provide a broader reporting structure with a much greater level of specificity than the current redeterminations reporting mechanisms that are part of the Contractor Reporting of Operational and Workload Data (CROWD) system. CMS will then be able to

conduct more detailed analyses, and identify redetermination trends and patterns. Until MAS is fully implemented at all of the MACs, CMS will continue to review CROWD reports to monitor MAC timeliness and performance. CMS is effectively monitoring MAC performance as part of the MAC Quality Assurance Surveillance Plans and provides incentives for superior levels of redetermination processing through Award Fee Plans.

OIG Recommendation

The OIG recommends CMS continue to foster information-sharing among Medicare contractors.

CMS Response

The CMS concurs with this recommendation. In response to a previous OIG report, CMS facilitates regularly scheduled meetings with or for contractors to discuss best practices and share information related to participating in ALJ hearings. As part of these meetings, improving the consistency and accuracy of redeterminations is often discussed.

CMS has facilitated a number of sessions to discuss implementation of MAS at the MACs. In addition to business requirements associated with processing redeterminations, contractors often share best practices and explain efficient business processes that work well for their organization. The CMS intends to hold similar sessions after all of the MACs are processing redeterminations in MAS so contractors can continue to share best practices and provide insights for system and process improvements.

The recent increases in appeals workload demonstrate why it is essential for CMS to continue to encourage contractors that conduct post-payment reviews, such as Recovery Auditors, Zone Program Integrity Contractors, and Program Safeguard Contractors, to share information with MACs. Advance notification of the types and volume of audits to be performed will allow CMS and MACs to better predict and manage appeals workload fluctuations.

OIG Recommendation

The OIG recommends CMS monitor the quality of redeterminations data in MAS.

CMS Response

The CMS concurs with this recommendation. MAC utilization of MAS to process redeterminations should ensure greater accuracy, timeliness, and efficiency in the Medicare appeals process. However, these goals will not be obtained if the quality of redetermination data in MAS is incomplete or inaccurate. Due to the additional automation that is being implemented in MAS as it is rolled out to the MACs, a large number of data fields will be pre-populated and validated across multiple systems of record. The increased automation should greatly reduce missing data elements and data entry errors that the OIG identified as problems at the Qualified Independent Contractor and ALJ levels in previous reports. CMS will also explore adding MAS data metrics to MAC Quality Assurance Surveillance Plans and Award Fee Plans to evaluate and monitor MAC compliance.

Again, thank you for the opportunity to review and comment on the draft report.

ACKNOWLEDGMENTS

This report was prepared under the direction of Joyce Greenleaf, Regional Inspector General for Evaluation and Inspections in the Boston regional office, and Russell Hereford and Kenneth Price, Deputy Regional Inspectors General.

Maria Maddaloni served as the team leader for this study. Other Office of Evaluation and Inspections staff from the Boston regional office who conducted the study include Jessica Fargnoli. Central office staff who provided support include Heather Barton, Kevin Farber, Dave Graf, Althea Hosein, Scott Manley, and Christine Moritz.

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