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Report to Congressional Committees

July 1990

MEDICARE APPEALS PROCESS

Part B Changes Appear to Be Fulfilling Their Purpose

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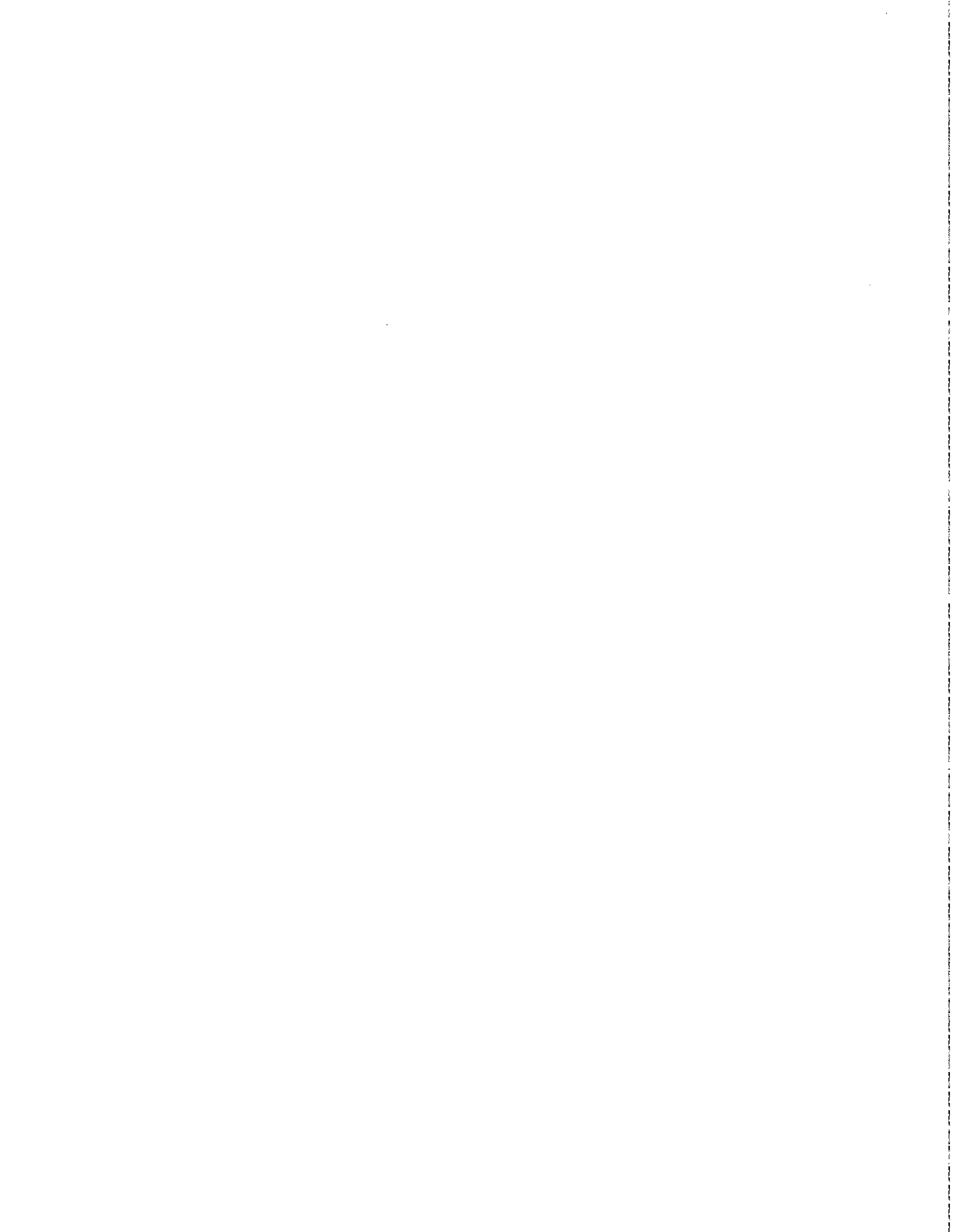


United States
General Accounting Office
Washington, D.C. 20548

Human Resources Division

B-234417

July 16, 1990

The Honorable Lloyd Bentsen
Chairman, Committee on Finance
United States Senate

The Honorable John D. Rockefeller, IV
Chairman, Subcommittee on Medicare and
Long Term Care
Committee on Finance
United States Senate

The Honorable Dan Rostenkowski
Chairman, Committee on Ways and Means
House of Representatives

The Honorable Pete Stark
Chairman, Subcommittee on Health
Committee on Ways and Means
House of Representatives

As agreed with your offices, this study provides information on the changes in claim volume and outcomes at the carrier level following recent changes in the Medicare Part B appeals process.[1] This report also provides information regarding the requirement that a claimant appeal an adverse decision to the carrier before being permitted to appeal to a federal administrative law judge (ALJ) when the disputed amount is more than $500. Further, it assesses the potential change in the ALJ caseload if the disputed amount threshold was lowered.

This report also fulfills our mandate under the Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203, section 4082 (d)). The act directed us to study the cost effectiveness of the Health Care Financing Administration's (HCFA's) requirement that Part B cases go through a hearing at the carrier level before they are appealed to an ALJ.[2]

[1] The initial determinations about coverage for particular services and the amount of payment for Part B claims are made by carriers, such as Blue Cross/Blue Shield or other commercial insurance companies, which are generally performing this function under contract to the Health Care Financing Administration.

[2] A separate report provided statistical information on the ALJ hearings process, including the number and status of ALJ cases filed, the outcome of cases by type of hearing, and the time required to complete the hearing process. See Statistics on the Part B Administrative Law Judge Hearings Process (GAO/HRD-90-18, Nov. 28, 1989).

Background

Title XVIII of the Social Security Act authorizes the Medicare Part B program to provide supplemental medical insurance coverage for most individuals age 65 and older. HCFA, within the Department of Health and Human Services, administers the Medicare program. In fiscal year 1989, Part B covered approximately 32.4 million enrollees and paid benefits of about $38.7 billion.

The Medicare program provides specific appeal rights for Part B claimants. These are the individual beneficiary or a medical provider such as a physician, laboratory, or supplier of medical equipment or services. At the inception of the program, Part B claims were not accorded the same appeal rights as Part A claims (the hospital insurance portion) because they were expected to be for substantially smaller amounts than Part A claims. In addition, Part B claims are far more numerous than Part A claims, and this posed the possibility of a substantial workload if judicial review was accorded to all of them.

Recent legislative and administrative changes were made in the appeals process because claimants expressed concerns about the fairness and adequacy of the Part B appeals process. For example, claimants were concerned that the hearing officers at the carrier level were not objective because their continued employment may depend on the carriers' being satisfied with the decisions they render. To attempt to resolve claimants' concerns about the Part B process, the Congress changed the process to make it more like Part A by adding appeal options beyond the carrier. Review of Part B claims by an ALJ is now available if the disputed amount is $500 or more and judicial review is available if the disputed amount is $1,000 or more.[3] A claimant can combine denied claims to meet these limitations.

The 1987 legislative change and the need for program economies prompted HCFA to revise the way carriers processed appeals.

Part B Appeals Process Before 1987

Before 1987, the appeals process worked as follows. First, the claim underwent a "carrier review," which is a review of written case documentation by a claims processor other than the one that made the "initial claim determination." If the carrier review decision agreed with the initial determination and the amount in dispute was at least $100, the

[3]The Omnibus Budget Reconciliation Act of 1986 (P.L. 99-509, section 9341), amending the Social Security Act. The change was effective January 1, 1987

case could be appealed to the next level, a hearing officer, also at the carrier.

At the hearing officer level, claimants could select one of three types of "carrier fair hearings": on-the-record,[4] telephone, or in-person. On-the-record hearings involved evaluations of the written case documentation that did not provide claimants an opportunity to give oral testimony. If claimants chose on-the-record hearings, they could not subsequently request a telephone or in-person hearing. There were no appeal options beyond the carrier level. (See figure I.1 for an illustration of the hearing process in effect until January 1, 1987.)

Part B Appeals Process as of 1987

The legislative change authorizing appeals to an ALJ became effective January 1, 1987. HCFA required that cases go through a carrier fair hearing before being appealed to the ALJ, but HCFA did not change the way appeals were processed within carriers.

In 1988, however, HCFA changed the appeals process within carriers. It required, with some exceptions, that cases go through an on-the-record hearing before being appealed. As before, claimants initially choosing an on-the-record hearing could not subsequently request a telephone or in-person hearing. If disputed amounts were still over $500 after the hearing, claimants could then appeal to an ALJ.

Claimants initially requesting a telephone or in-person hearing, however, now had to go through the on-the-record hearing. After that hearing, for disputed amounts of at least $500, these claimants could either go to the requested telephone or in-person hearing or appeal directly to the ALJ. The on-the-record hearing requirement was phased in by carriers from April to June 1988. Figure I.2 shows the appeals process after the legislative and administrative changes.

HCFA officials state that the mandatory on-the-record hearing was introduced to expedite cases and to reduce costs by directing cases away from the more lengthy and expensive telephone and in-person hearings. Representatives for the National Senior Citizens Law Center testified before the House Judiciary Committee,[5] however, that the on-the-record

[4]HCFA also refers to these as "on-the-record decisions."

[5]Oversight hearing on the adjudicatory procedure of the Department of Health and Human Services, Subcommittee on Administrative Law and Governmental Relations, House Judiciary Committee, June 27, 1989.

hearing step often is a source of confusion about appeal rights and contributes to the overall delay in the review of Part B claims. They also testified regarding concerns about the effect of on-the-record hearings on the rights of claimants not represented by legal counsel. For example, they believed that claimants might erroneously perceive that the on-the-record hearing is the end of the appeals process. The representatives expressed further concern about the possibility of bias in an in-person hearing because the person assigned to review an on-the-record hearing decision may in some way be influenced by knowing that another hearing officer (supposedly at the same level of authority and competency) has already denied the claim.

Objective and Methodology

The objective of our review was to gather information on the changes, if any, in claim volume and outcomes following the addition of the ALJ appeal options and the introduction of mandatory on-the-record hearings to the Medicare Part B appeals process. Specifically, we sought to determine (1) the changes in outcome of cases reviewed by claims processors and hearings officers; (2) the changes after the introduction of mandatory on-the-record hearings in the volume and outcome, by claimant group, of cases reviewed by hearings officers; (3) the expected effect on claim volume and outcomes of lowering the ALJ threshold from $500 to $100, which is the current ALJ threshold for Part A cases; and (4) the congressional intent in establishing the monetary threshold for claimants appealing to an ALJ.

To determine the changes in case outcomes, we obtained quarterly data from HCFA for the period October 1984 to March 1989 for cases at different stages in the appeals process. To determine the changes, by claimant group, after the introduction of mandatory on-the-record hearings in the volume and outcomes of cases reviewed by hearings officers, we obtained individual case data for the period January 1987 to March 1989 from 47 of the 51 Medicare carriers. We categorized claimants into three groups—beneficiaries, physicians, and nonphysicians—and analyzed data obtained from the carriers for cases decided before and after the introduction of mandatory on-the-record hearings. The "before" analysis includes cases reviewed from the introduction of the ALJ hearing option on January 1, 1987, to the time each carrier introduced the mandatory on-the-record hearings (during the period April to June 1988). The "after" analysis includes cases reviewed by each carrier from the time each carrier introduced the mandatory on-the-record hearings to March 1989, the most current data available at the time we collected data from the carriers. (See appendix II for our case-sampling

methodology and appendix III for the survey form sent to the carriers.) We did not assess the extent to which other factors, such as case complexity, case merit, or carrier policy might have affected case volume or outcomes.

Using the data obtained from the carriers, we estimated the potential effect on each claimant group of lowering the ALJ threshold to $100. To do this, we assumed that the pattern of decisions and appeals at a $100 threshold would be the same as it was for the actual cases we reviewed that were subject to the $500 limitation. See appendix IV for a description of this analysis and its results.

We also interviewed HCFA program operation managers and several carriers about recent changes in the Part B appeals process. In addition, we reviewed statutes, regulations, legislative history, and court decisions to determine the congressional intent in establishing the $500 ALJ threshold.

We performed our work between July 1988 and December 1989. We did not verify HCFA or carrier-provided data. With that exception, we performed our work in accordance with generally accepted government auditing standards.

Results in Brief

The results of our review are provided in detail in appendix I. In summary, the percentage of cases receiving a telephone or in-person hearing at the carrier decreased after the introduction of the mandatory on-the-record hearings, while the percentage of cases appealed to ALJs increased. The percentage of hearing-officer decisions that resulted in payments to claimants also decreased after the on-the-record hearing was made mandatory. More specifically:

1. There was little change in the percentage of decisions for or against claimants in initial carrier determinations or carrier reviews by claims processors. (See figs. I.3 and I.4.) However, the percentage of carrier hearing-officer decisions against claimants increased after the introduction of mandatory on-the-record hearings. (See fig. I.5.)

2. Data obtained from Medicare carriers for the period January 1987 through March 1989 show that the largest percentage of cases reviewed before and after the introduction of the mandatory on-the-record hearings involved physicians. (See fig. I.6.) After HCFA introduced mandatory on-the-record hearings:

- The percentage of cases that had such hearings increased from 71 to 100 percent, as expected. Among the claimant groups, cases involving non-physicians had the greatest increase. All claimant groups experienced a decrease in on-the-record hearing decisions resulting in payment to claimants. However, after on-the-record hearings were made mandatory, decisions involving physicians resulted in payments more frequently than did those for the other claimant groups. (See figs. I.7 and I.8.)
- The percentage of cases that had a telephone or in-person hearing decreased from 29 to 6 percent, with the nonphysician claimant group experiencing the greatest decrease (from 38 to 6 percent). The percentage of telephone or in-person hearing decisions resulting in payments to claimants also decreased from 61 to 38 percent. Again, the nonphysician group experienced the greatest decrease (from 70 to 40 percent). (See figs. I.9 and I.10.)
- The percentage of cases appealed to ALJs increased from 11 to 13 percent. Cases involving beneficiaries experienced the greatest increase (from 11 to 16 percent). (See fig. I.11.)

3. Lowering the ALJ threshold to $100 could be expected to increase the number of Part B cases appealed to ALJs to about 21 percent. (See fig. I.12.)

4. The congressional intent in establishing a $500 threshold for ALJ appeals is unclear. Court opinions initially differed on whether the Congress intended such claims to bypass carrier fair hearings. However, a recent federal district court appeal decision concluded that HCFA's instructions requiring claimants with disputed amounts of at least $500 to go through a carrier fair hearing before proceeding to the ALJ were valid.

Conclusions

The revisions to the Part B appeals process have been in effect for a short time and more time is needed to determine if the changes we observed will persist. The revisions appear, however, to be fulfilling their intended purpose of reducing the number of telephone and in-person hearings at the carrier level and providing an opportunity for claimants to appeal beyond the carrier level. If the ALJ threshold was lowered to $100 to correspond with that currently used in the Part A appeals process, the number of cases appealed to ALJs could be expected to increase substantially.

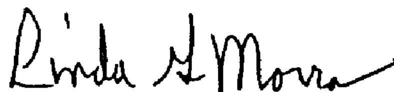
The percentage of carrier hearing decisions resulting in payments to claimants decreased after the introduction of mandatory on-the-record

hearings. Because we did not have case-specific data, we cannot eliminate the possibility that other factors, such as case complexity, case merit, or a change in carrier policy, may have influenced the changes we are observing.

As agreed with your offices, we did not obtain written agency comments on this report. However, we discussed its contents with HCFA officials and incorporated their comments where appropriate.

We are sending copies of this report to the Secretary of Health and Human Services, the Administrator of HCFA, and other interested parties, and we will make copies available to others on request.

Please call me on (202) 275-1655 if you or your staffs have any questions about this report. Other major contributors to this report are listed in appendix V.



Linda G. Morra
Director, Intergovernmental
and Management Issues

Contents

Letter		1
Appendix I Part B Changes Appear to Be Fulfilling Their Purpose		12
	How the Appeals Process Changed	12
	Combined Effect of Changes on Case Outcomes at the Carrier Level	15
	Changes in Cases Reviewed by Hearing Officers After the Introduction of Mandatory On-the-Record Hearings	21
	Expected Appeals to an ALJ if the Threshold Was Lowered	30
	Congressional Intent Regarding Use of Carrier Fair Hearings for Claims Appealed to ALJs	31
Appendix II Case Sampling Methodology		33
Appendix III Survey Form Sent to Medicare Part B Carriers		35
Appendix IV Estimates of the Potential Effect of Lowering the Threshold for Access to an ALJ		40
Appendix V Major Contributors to This Report		47

Tables

Table I.1: Claims Denied in Initial Determinations by Claims Processors, for All Claimants 17
Table I.2: Outcome of Cases Reviewed by Claims Processors, for All Claimants 19
Table I.3: Outcome of Cases Reviewed by Hearing Officers, for All Claimants 21
Table I.4: Hearing Officer Reviews, by Claimant Group 23
Table I.5: On-the-Record Hearings, by Claimant Group 24
Table I.6: On-the-Record Hearing Decisions Favoring Claimants, by Claimant Group 25
Table I.7: Telephone and In-Person Hearings, by Claimant Group 27
Table I.8: Telephone and In-Person Hearing Decisions Favoring Claimants, by Claimant Group 28
Table I.9: Number of Appeals to ALJ, by Claimant Group 29
Table I.10: Expected Appeals to an ALJ at Different Thresholds, by Claimant Group 31
Table II.1: Weights for Sampled Cases in Six Carriers 33

Figures

Figure I.1: Medicare Part B Appeals Process Before January 1, 1987 13
Figure I.2: Medicare Part B Appeals Process After Addition of ALJ and Mandatory On-the-Record Hearings 14
Figure I.3: Claims Denied in Initial Determinations by Claims Processors, for All Claimants 16
Figure I.4: Outcome of Cases Reviewed by Claims Processors, for All Claimants 18
Figure I.5: Outcome of Cases Reviewed by Hearing Officers, for All Claimants 20
Figure I.6: Hearing Officer Reviews, by Claimant Group 22
Figure I.7: On-The-Record Hearings, by Claimant Group 24
Figure I.8: On-the-Record Hearing Decisions Favoring Claimants, by Claimant Group 25
Figure I.9: Telephone and In-Person Hearings, by Claimant Group 26
Figure I.10: Telephone and In-Person Hearing Decisions Favoring Claimants, by Claimant Group 28
Figure I.11: Appeals to an ALJ, by Claimant Group 29
Figure I.12: Expected Appeals to an ALJ at Different Thresholds, by Claimant Group 30

Figure IV.1: Expected Outcomes for Beneficiaries at a $500 ALJ Threshold 41
Figure IV.2: Expected Outcomes for Physicians at a $500 ALJ Threshold 42
Figure IV.3: Expected Outcomes for Nonphysicians at a $500 ALJ Threshold 43
Figure IV.4: Expected Outcomes for Beneficiaries at a $100 ALJ Threshold 44
Figure IV.5: Expected Outcomes for Physicians at a $100 ALJ Threshold 45
Figure IV.6: Expected Outcomes for Nonphysicians at a $100 ALJ Threshold 46

Abbreviations

ALJ	administrative law judge
GAO	General Accounting Office
HCFA	Health Care Financing Administration
SSA	Social Security Administration

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Part B Changes Appear to Be Fulfilling Their Purpose

How the Appeals Process Changed

Medicare Part B claims are submitted to carriers for payment for health care services provided under the program. The initial determination on coverage and amount of payment is made by a carrier claims processor. If a Medicare Part B claimant—an individual beneficiary or a medical provider such as a physician, laboratory, or supplier of medical equipment or services—is dissatisfied with the initial determination, the Medicare program provides specific appeal rights. At the carrier level, claims processors and hearing officers have key roles in the appeals process. As shown in figure I.1, before January 1987, claimants had no options for appeal beyond the carrier level.

Because claimants expressed concerns about the fairness of the process described above and its limited opportunities for appeal two significant legislative and administrative changes were made.

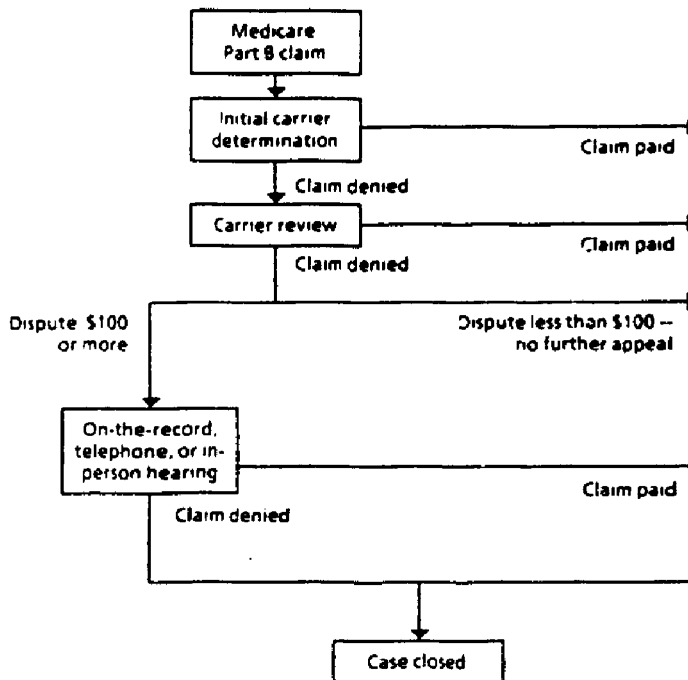
First, effective January 1, 1987, the Congress provided options for claimants to appeal to an ALJ and, ultimately, to the federal courts.[1] Although these options made it possible for cases to be appealed beyond the carrier, the Congress limited access to these levels of review by establishing disputed amount thresholds—$500 for appeal to an ALJ, and $1,000 for appeal to the federal courts. With this change, HCFA required all cases to go through a carrier fair hearing before being appealed.

Second, in 1988, HCFA required that essentially all cases involving $100 or more go through an on-the-record hearing before they became eligible for a telephone or in-person hearing.[2] Implementation of these requirements was phased in by carriers during the period April to June 1988. Figure I.2 shows the appeals process after the changes were made.

[1]The Omnibus Budget Reconciliation Act of 1986 (P.L. 99-509, section 9341), amending the Social Security Act.

[2]Exceptions allowed by HCFA for carriers not conducting on-the-record hearings are when (1) the on-the-record hearing will significantly delay the in-person hearing requested, (2) the facts of the case can only be developed through oral testimony, and (3) a different hearing official is not available to conduct in-person hearings.

Figure I.1: Medicare Part B Appeals Process Before January 1, 1987



Notes

1 A "carrier review" is a review of written case documentation by a claims processor other than the one that made the initial determination

2 Claimants could select one of three types of hearing officer reviews, all of which were referred to as "carrier fair hearings." The choices were "on-the-record," "in-person," or "telephone." The on-the-record hearings were evaluations of the written case documentation, which did not provide claimants with an opportunity to make an oral presentation or give testimony (HCFA also refers to these as "on-the-record decisions.") Further, if claimants selected the on-the-record hearing, they could not subsequently request an in-person or telephone hearing

3 Throughout the process, claims may be dismissed by carriers for procedural reasons, such as missed filing deadlines, or be withdrawn by the claimants.

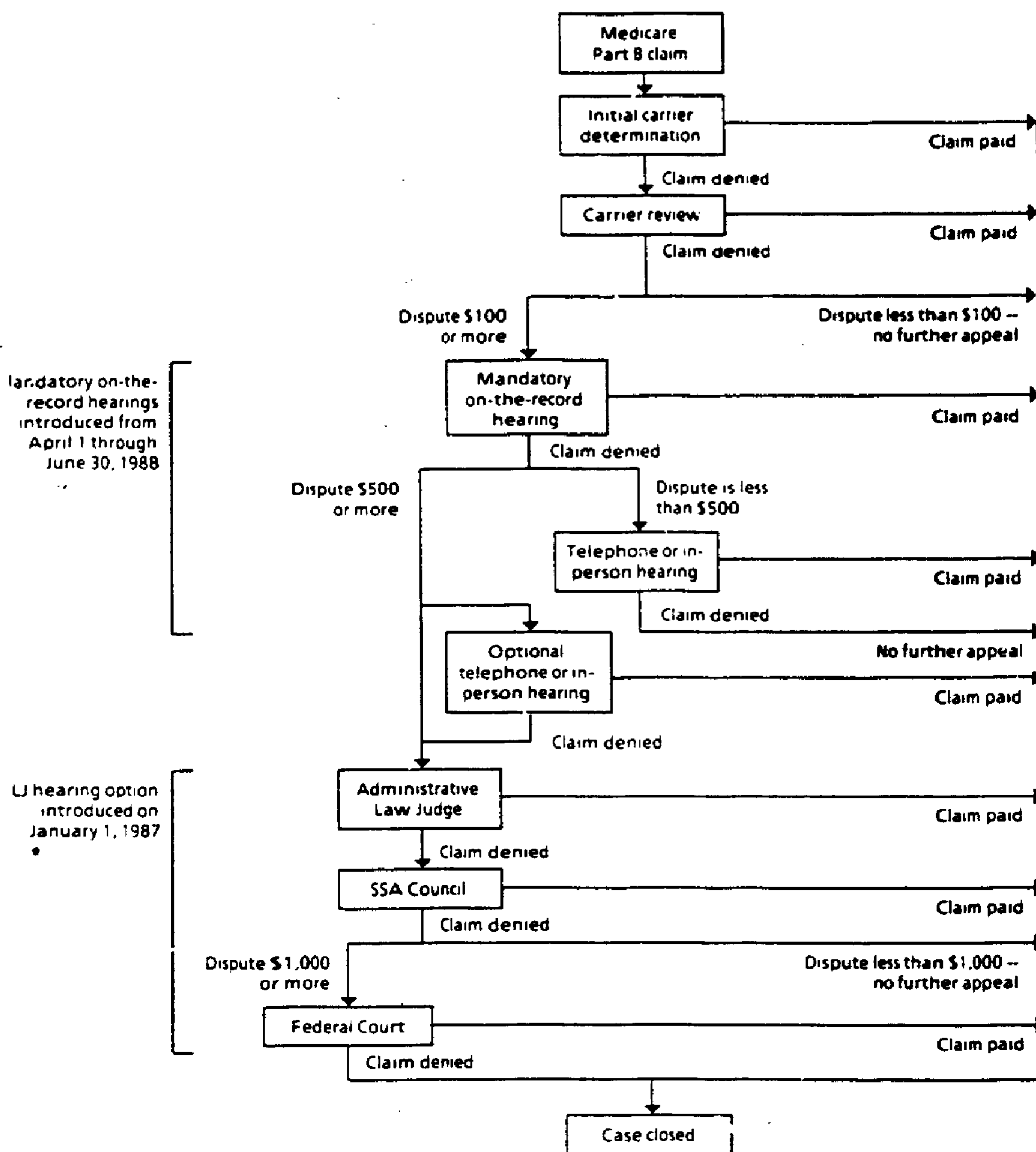
4 A claimant may combine denied claims to meet monetary thresholds

5 At each level of review the determination made at the prior level of review may be affirmed in whole in the carrier's favor (claim denied) or reversed in whole or in part in the claimant's favor (claim paid).

6 "Disputed amount" refers to the difference between the amount billed and the amount allowed less unmet deductible and coinsurance As the case goes through the process the disputed amount may be reduced if decisions result in partial payments of the disputed amount

7 HCFA procedures allow for the reopening of cases under limited circumstances and for the acceptance of appeals filed late where "good cause" is shown

Figure I.2: Medicare Part B Appeals Process After Addition of ALJ and Mandatory On-the-Record Hearings



Notes

1 A "carrier review" is a review of written case documentation by a claims processor other than the one who made the initial determination

2 All cases appealed after the carrier review, with some exceptions are required to go through the on-the-record carrier fair hearing Claimants initially requesting the on-the-record hearing cannot subsequently request a telephone or in-person hearing.

3 Throughout the process, claims may be dismissed by carriers for procedural reasons, such as missed filing deadlines, or be withdrawn by the claimants.

4 A claimant may combine denied claims to meet monetary thresholds

5 At each level of review, the determination made at the prior level of review may be affirmed in whole in the carrier's favor (claim denied) or reversed in whole or in part in the claimant's favor (claim paid)

6 "Disputed amount" refers to the difference between the amount billed and the amount allowed less unmet deductible and coinsurance As the case goes through the process the disputed amount may be reduced if decisions result in partial payments of the disputed amount

7 Any claim appealed to a Social Security Administration (SSA) ALJ can be further appealed to the SSA Appeals Council

8 HCFA procedures allow for the reopening of cases under limited circumstances and for the acceptance of appeals filed late where "good cause" is shown

Combined Effect of Changes on Case Outcomes at the Carrier Level

To detect changes in case outcomes that could be attributed to the introduction of mandatory on-the-record hearings and the addition of an ALJ appeals option to the Medicare Part B appeals process we analyzed HCFA data on cases reviewed and case outcomes for the period October 1984 through March 1989, aggregated by quarter for all claimants. We focused our analysis on three key steps at the carrier level: the initial claims determination, the carrier review of the initial determination, and the hearing officer review. There was little change in the percentage of claims denied in the initial determination by claims processors after introduction of the ALJ appeals option and the mandatory on-the-record hearings.[3] (See fig. I.3 and table I.1.)

[3]Statistical tests to determine if a significant difference in case outcomes existed after the introduction of the ALJ appeals option and mandatory on-the-record carrier fair hearings were found to be inappropriate for the HCFA data because of the few data points available after the changes were made.

Figure I.3: Claims Denied in Initial Determinations by Claims Processors, for All Claimants (Oct. 1984-Mar. 1989)

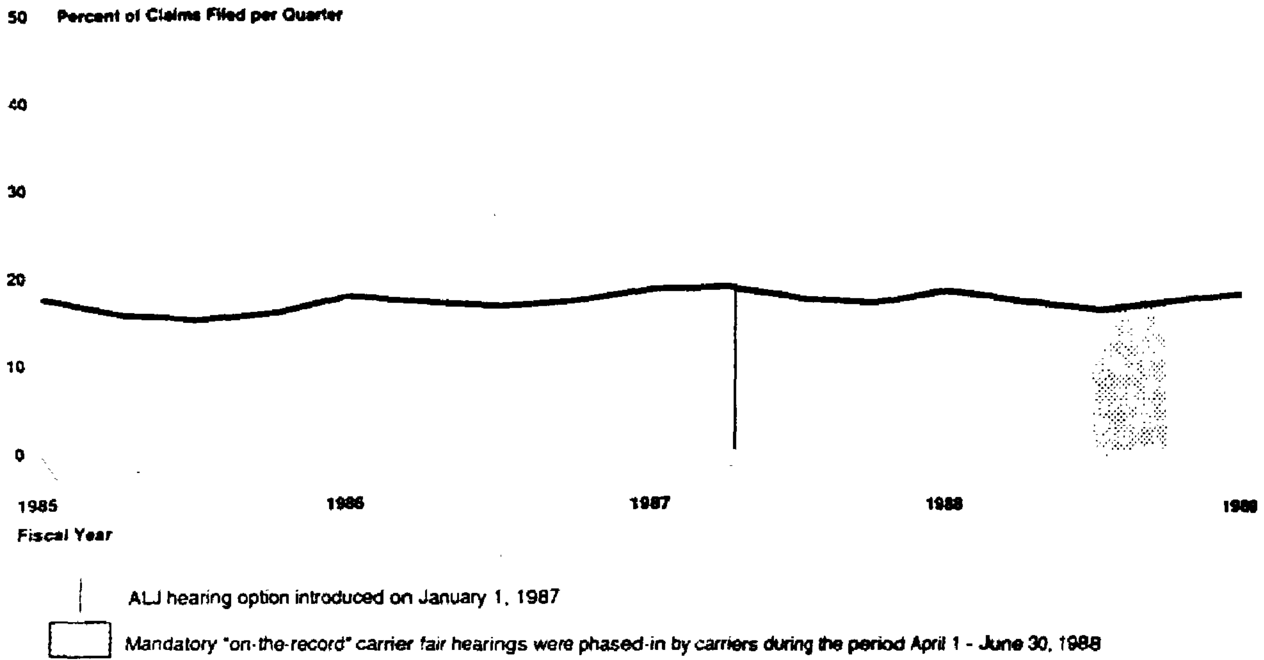


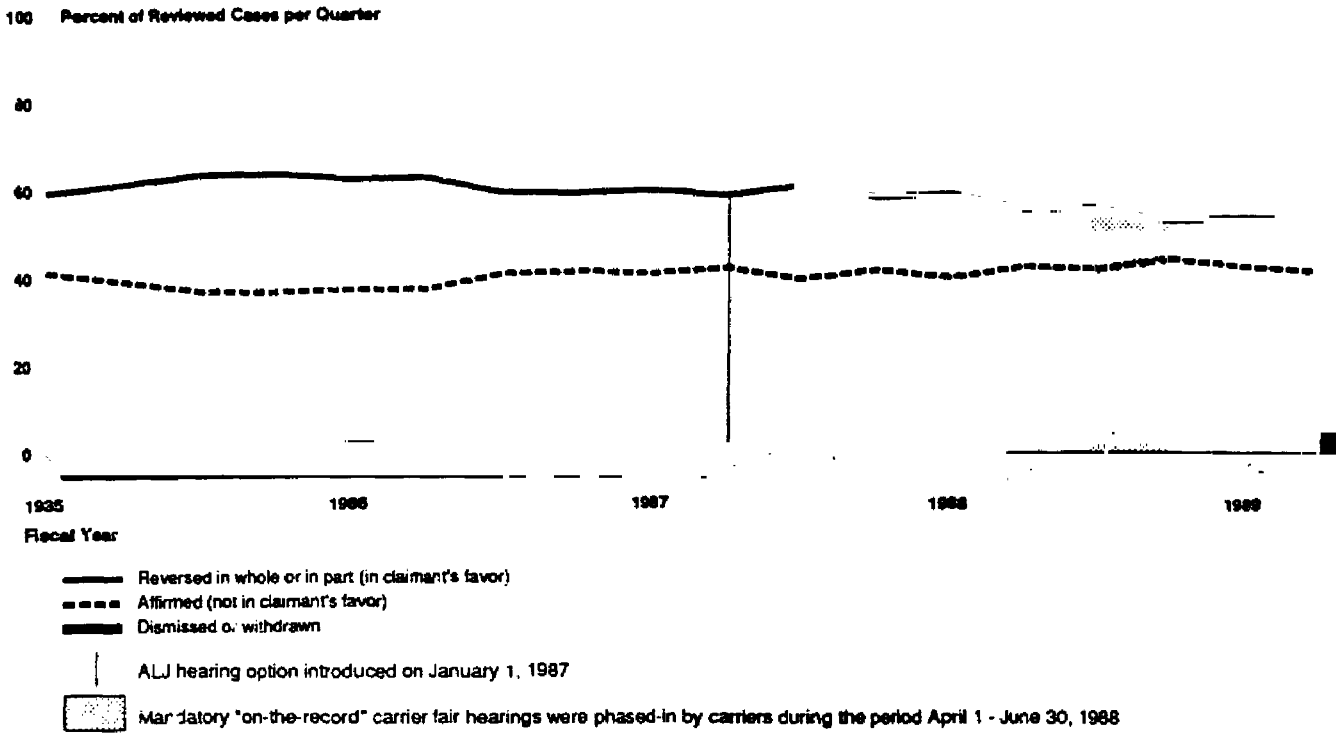
Table I.1: Claims Denied in Initial Determinations by Claims Processors, for All Claimants (Oct. 1984-Mar. 1989)

		Number of claims		
Fiscal year/quarter		**Processed**	**Denied in whole or in part**	**Percent**
1985				
	1st	60,958,980	10,620,677	17.4
	2nd	66,759,955	10,429,709	15.6
	3rd	68,562,820	10,316,489	15.0
	4th	70,935,368	11,122,829	15.7
1986				
	1st	70,766,370	12,487,655	17.6
	2nd	69,624,439	11,792,653	16.9
	3rd	76,337,481	12,508,596	16.4
	4th	82,120,878	13,925,276	17.0
1987				
	1st	77,273,969	14,224,381	18.4
	2nd	84,850,180	15,744,599	18.6
	3rd	87,724,956	15,140,995	17.3
	4th	88,413,489	14,979,330	16.9
1988				
	1st	88,445,920	16,187,746	18.3
	2nd	94,248,452	16,072,492	17.1
	3rd	97,799,881	15,887,506	16.2
	4th	96,422,182	16,591,504	17.2
1989				
	1st	94,607,707	17,133,378	18.1
	2nd	101,917,076	18,381,551	18.0

At the carrier review level, after the legislative and administrative changes were made, the percentage of cases dismissed or withdrawn increased, particularly after the introduction of mandatory on-the-record reviews. However, the data give no indication of a significant change in the percentage of carrier reviews that affirmed or reversed the initial determination.[4] (See fig. I.4 and table I.2.)

[4]Statistical tests to determine if a significant difference in case outcomes existed after the introduction of the ALJ appeals option and on-the-record reviews were found to be inappropriate for the HCFA data because of the few data points available after the changes were made.

Figure I.4: Outcome of Cases Reviewed by Claims Processors, for All Claimants (Oct. 1984-Mar. 1989)



Note: These are administrative reviews of the claimants' paperwork made by a carrier claims processor other than the one who made the initial claims payment or coverage determinations

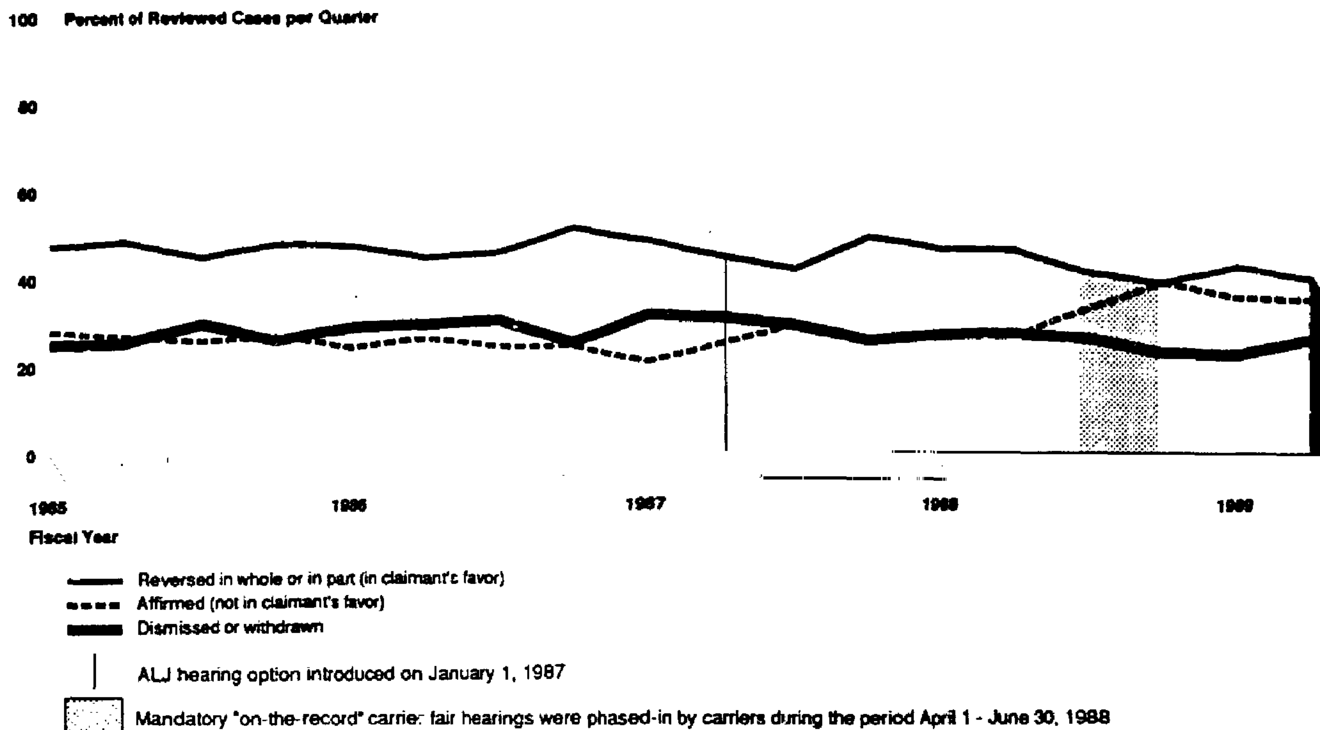
Table I.2: Outcome of Cases Reviewed by Claims Processors, for All Claimants (Oct. 1984-Mar. 1989)

Fiscal year/quarter	Number of reviews	Review decisions					
		Affirmed		Reversed in whole or in part		Dismissed/withdrawn	
		No.	Percent	No.	Percent	No.	Percent
1985							
1st	808,590	329,637	40.8	476,644	59.0	2,309	0.3
2nd	9[illegible]5,333	364,739	38.6	577,109	61.0	3,485	0.4
3rd	979,316	357,491	36.5	618,140	63.1	3,685	0.4
4th	1,002,787	363,718	36.3	633,925	63.2	5,144	0.5
1986							
1st	1,035,263	380,559	36.8	643,115	62.1	11,589	1.1
2nd	1,182,726	436,750	36.9	738,396	62.4	7,580	0.6
3rd	1,119,511	451,818	40.4	658,674	58.8	9,019	0.8
4th	1,230,776	502,773	40.9	722,347	58.7	5,656	0.5
1987							
1st	1,158,441	466,414	40.3	686,655	59.3	5,372	0.5
2nd	1,324,846	550,127	41.5	767,808	58.0	6,911	0.5
3rd	1,455,169	569,124	39.1	878,555	60.4	7,490	0.5
4th	1,538,966	636,058	41.3	888,286	57.8	14,622	1.0
1988							
1st	1,237,490	490,852	39.7	726,457	58.7	20,181	1.6
2nd	1,351,742	571,618	42.3	746,299	55.2	33,825	2.5
3rd	1,519,662	632,225	41.7	845,357	55.6	42,080	2.8
4th	1,596,937	702,986	44.0	841,076	52.7	52,875	3.3
1989							
1st	1,314,340	555,714	42.3	702,759	53.5	55,867	4.3
2nd	1,340,360	550,426	41.1	706,401	52.7	83,533	6.2

At the hearing-officer level, the percentage of cases affirmed by carrier hearing officers increased after the introduction of mandatory on-the-record hearings. (See fig. I.5 and table I.3.)[5]

[5]Statistical tests to determine if a significant difference existed in the percentage of cases affirmed after the introduction of the ALJ appeals option and on-the-record reviews were found to be inappropriate because of the few data points available after the introduction of these changes.

Figure I.5: Outcome of Cases Reviewed by Hearing Officers, for All Claimants (Oct. 1984-Mar. 1989)



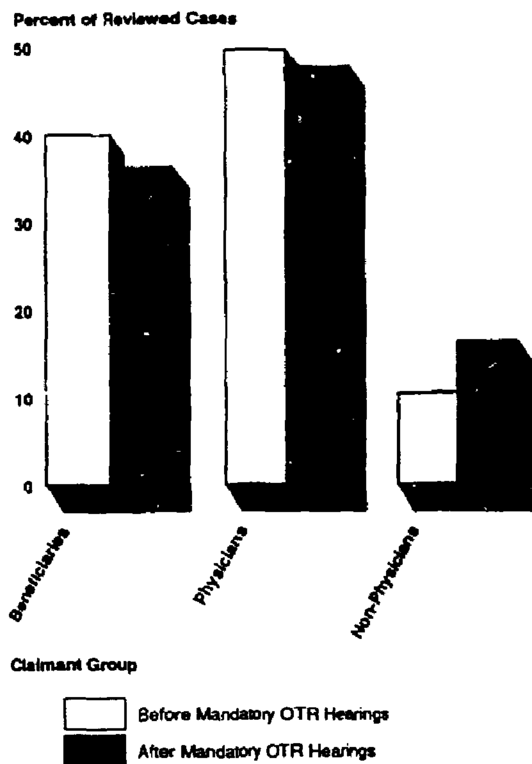
ble I.3: Outcome of Cases Reviewed by Hearing Officers, for All Claimants (Oct 1984-Mar. 1989)

		Review Decisions					
		Affirmed		Reversed in whole or in part		Dismissed/withdrawn	
scal year/quarter	Number of reviews	No.	Percent	No.	Percent	No.	Percent
85							
1st	7,354	2,046	27.8	3,477	47.3	1,831	24.9
2nd	7,650	2,054	26.8	3,699	48.4	1,927	25.2
3rd	8,231	2,107	25.6	3,690	44.8	2,434	29.6
4th	7,271	1,933	26.6	3,467	47.7	1,871	25.7
86							
1st	7,194	1,729	24.0	3,399	47.2	2,066	28.7
2nd	8,287	2,161	26.1	3,695	44.6	2,431	29.3
3rd	9,175	2,219	24.2	4,182	45.6	2,774	30.2
4th	10,606	2,555	24.1	5,405	51.0	2,646	24.9
37							
1st	9,590	1,976	20.6	4,608	48.1	3,006	31.3
2nd	10,288	2,536	24.7	4,590	44.6	3,162	30.7
3rd	13,598	3,976	29.2	5,679	41.8	3,943	29.0
4th	14,890	3,762	25.3	7,312	49.1	3,816	25.6
38							
1st	13,679	3,644	26.6	6,344	46.4	3,691	27.0
2nd	17,277	4,597	26.6	7,979	46.2	4,701	27.2
3rd	17,952	5,890	32.8	7,385	41.1	4,677	26.1
4th	18,724	7,239	38.7	7,223	38.6	4,262	22.8
39							
1st	14,819	5,236	35.3	6,285	42.4	3,298	22.3
2nd	15,873	5,525	34.8	6,274	39.5	4,074	25.7

hanges in Cases eviewed by Hearing fficers After the troduction of andatory On-the-ecord Hearings

Data obtained from 47 Medicare carriers indicate that the majority of cases reviewed by carrier hearing officers before and after the introduction of mandatory on-the-record hearings involved physician claims. However, the percentage of physician and beneficiary claims reviewed decreased after the introduction of the mandatory hearings, while the percentage of claims involving nonphysicians showed the only increase (from 10.4 to 16.2 percent). (See fig. I.6. and table I.4.)

gure I.6: Hearing Officer Reviews, by aimant Group (Jan. 1987-Mar. 1989)



Note. Reviews by carrier hearing officers include "on-the-record," "telephone," and "in-person" carrier fair hearings

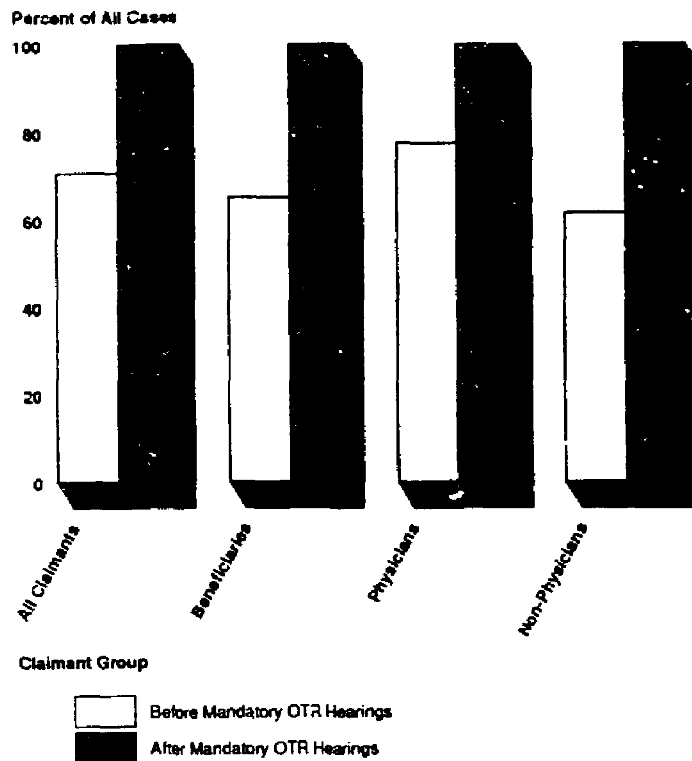
Table I.4: Hearing Officer Reviews, by Claimant Group (Jan 1987-Mar 1989)

Claimant group	Cases reviewed			
	Before		After	
	Number	Percent	Number	Percent
Beneficiaries	10,000	40.0	7,600	36.2
Physicians	12,400	49.6	10,000	47.6
Nonphysicians	2,600	10.4	3,400	16.2
All claimants	**25,000**	**100.0**	**21,000**	**100.0**

Note: These data reflect the number of cases, rounded to the nearest hundred, that were reviewed by hearing officers at the carriers participating in our study. The "before" analysis includes cases reviewed from the introduction of the ALJ appeals option on January 1, 1987, to the time each carrier introduced the mandatory on-the-record hearings (sometime during the period April to June 1988). The "after" analysis includes cases reviewed by each carrier from the time each carrier introduced the mandatory on-the-record hearings to March 1989, the most current data available at the time we collected data from the carriers.

Before the introduction of the mandatory on-the-record hearings, 70.8 percent of all cases had an on-the-record hearing at the carrier level compared with 100 percent when these hearings were made mandatory. While a greater percentage of cases for all claimant groups had an on-the-record hearing after they were made mandatory, cases involving nonphysicians had the greatest increase. (See fig. I.7 and table I.5.)

igure I.7: On-the-Record Hearings, by laimant Group (Jan. 1987-Mar. 1989)



Note: An "on-the-record" carrier fair hearing is an evaluation of written case documentation by a carrier hearing officer

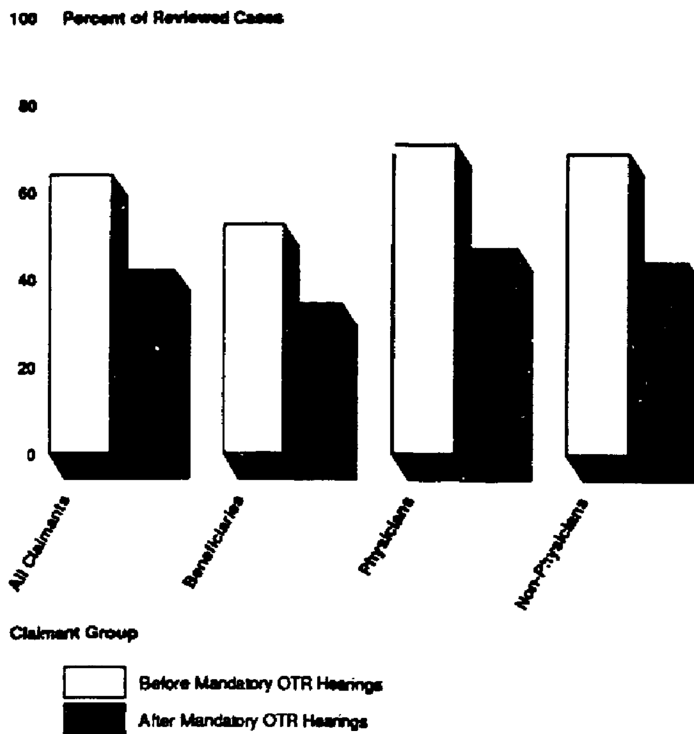
able I.5: On-the-Record Hearings, by laimant Group (Jan. 1987-Mar. 1989)

	Before			After		
Claimant group	**Total cases**	**On-the-record hearings**	**Percent**	**Total cases**	**On-the-record hearings**	**Percent**
Beneficiaries	10,000	6,500	65.0	7,600	7,600	100.0
Physicians	12,400	9,600	77.4	10,000	10,000	100.0
Nonphysicians	2,600	1,600	61.5	3,400	3,400	100.0
All claimants	**25,000**	**17,700**	**70.8**	**21,000**	**21,000**	**100.0**

The percentage of on-the-record hearings that resulted in payments to claimants was greater for all three claimant groups before these hearings were made mandatory. Physicians had the highest percentage of favorable decisions (70.8 percent). After the introduction of mandatory

on-the-record hearings, physicians still had the highest percentage of favorable decisions (47.0 percent) while all claimants had a favorable rate of 41.9 percent. (See fig. I.8 and table I.6.)

Figure I.8: On-the-Record Hearing Decisions Favoring Claimants, by Claimant Group (Jan. 1987-Mar. 1989)



Note: An "on-the-record" carrier fair hearing is an evaluation of written case documentation by a carrier hearing officer

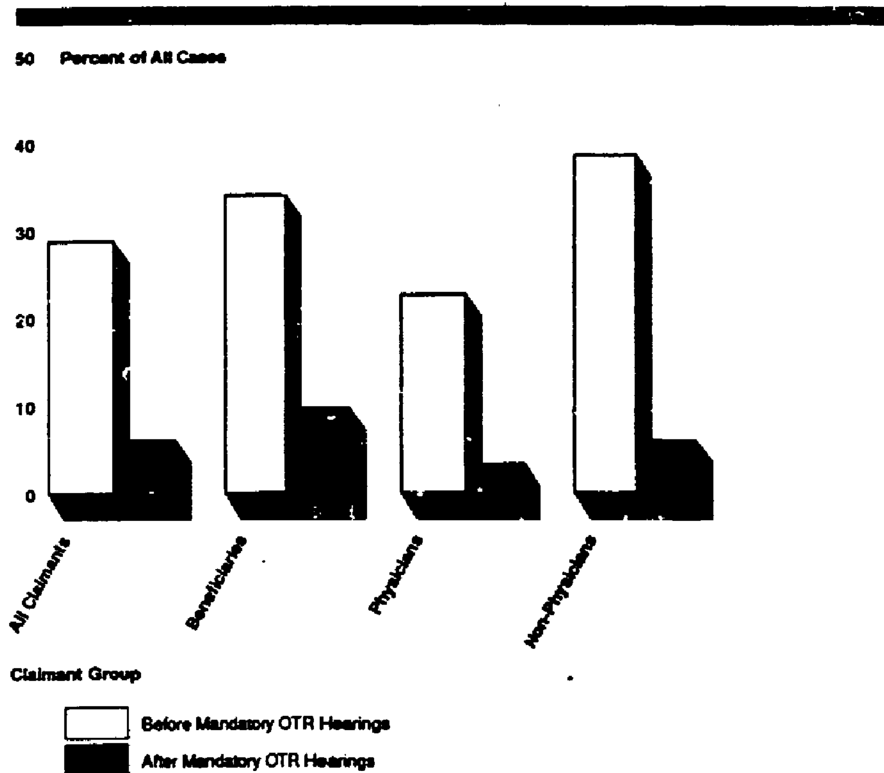
Table I.6: On-the-Record Hearing Decisions Favoring Claimants, by Claimant Group (Jan 1987-Mar 1989)

Claimant group	Before			After		
	Cases reviewed	Favorable decisions	Percent	Cases reviewed	Favorable decisions	Percent
Beneficiaries	6,500	3,400	52.3	7,600	2,600	34.2
Physicians	9,600	6,800	70.8	10,000	4,700	47.0
Nonphysicians	1,600	1,100	68.8	3,400	1,500	44.1
All claimants	**17,700**	**11,300**	**63.8**	**21,000**	**8,800**	**41.9**

Note: For this analysis, a favorable decision is defined as one that reverses, in whole or in part, the carrier's prior decision and results in a payment to the claimant

The percentage of cases that had a telephone or in-person hearing ranged from 22.6 percent for physicians to 38.5 percent for nonphysicians before on-the-record hearings were made mandatory. By comparison, after these hearings were made mandatory, the percentage of cases having a telephone or in-person hearing was significantly lower for all three claimant groups—3.2 percent for physicians, 5.9 percent for nonphysicians, and 9.6 percent for beneficiaries. (See fig. I.9 and table I.7.)

Figure I.9: Telephone and In-Person Hearings, by Claimant Group
(Jan. 1987-Mar. 1989)



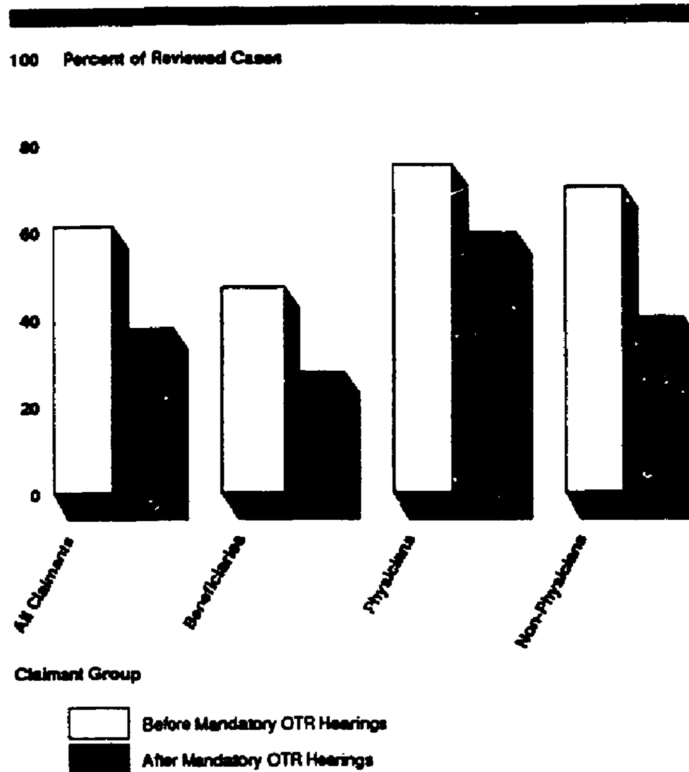
Note "Telephone" and "in-person" carrier fair hearings are conducted by a carrier hearing officer and provide claimants with an opportunity to give oral testimony.

Table I.7: Telephone and In-Person Hearings, by Claimant Group
(Jan. 1987-Mar. 1989)

Claimant group	Before: Total cases	Before: Telephone and in-person hearings	Before: Percent	After: Total cases	After: Telephone and in-person hearings	After: Percent
Beneficiaries	10,000	3,400	34.0	7,600	730	9.6
Physicians	12,400	2,800	22.6	10,000	320	3.2
Nonphysicians	2,600	1,000	38.5	3,400	200	5.9
All claimants	**25,000**	**7,200**	**28.8**	**21,000**	**1,250**	**6.0**

The percentage of telephone and in-person hearing decisions resulting in payments to claimants decreased from 61.1 to 37.6 percent after on-the-record hearings were made mandatory. The greatest change involved cases filed by nonphysicians. Favorable decisions for this group decreased from 70 to 40 percent. (See fig. I.10 and table I.8.)

Figure I.10: Telephone and In-Person Hearing Decisions Favoring Claimants, by Claimant Group (Jan. 1987-Mar. 1989)



Note "Telephone" and "In-person" carrier fair hearings are conducted by a carrier hearing officer and provide claimants with an opportunity to give oral testimony

Table I.8: Telephone and In-Person Hearing Decisions Favoring Claimants, by Claimant Group (Jan. 1987-Mar. 1989)

Claimant group	Before			After		
	Cases reviewed	Favorable decisions	Percent	Cases reviewed	Favorable decisions	Percent
Beneficiaries	3,400	1,600	47.1	730	200	27.4
Physicians	2,800	2,100	75.0	320	190	59.4
Nonphysicians	1,000	700	70.0	200	80	40.0
All claimants	**7,200**	**4,400**	**61.1**	**1,250**	**470**	**37.6**

Note For this analysis a favorable decision is defined as one that reverses, in whole or in part, the carrier's prior decision and results in a payment to the claimant

A higher percentage of cases was appealed to ALJs by all three claimant groups after on-the-record hearings were made mandatory, with optional telephone and in-person hearings at the carrier. The greatest change was in beneficiary cases; about 16 percent were appealed to an

ALJ after on-the-record hearings were made mandatory, compared with 11 percent before. For all claimants, the percentage of cases appealed to ALJs increased from 10.8 to 12.9 percent. (See fig. I.11 and table I.9.)

Figure I.11: Appeals to an ALJ, by Claimant Group (Jan. 1987-Mar. 1989)

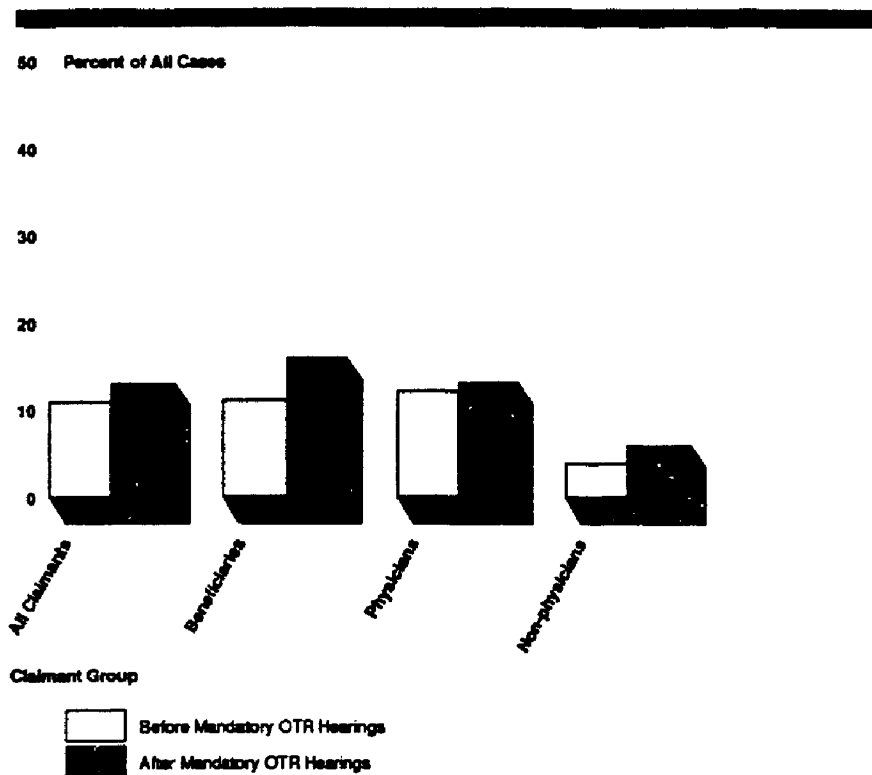


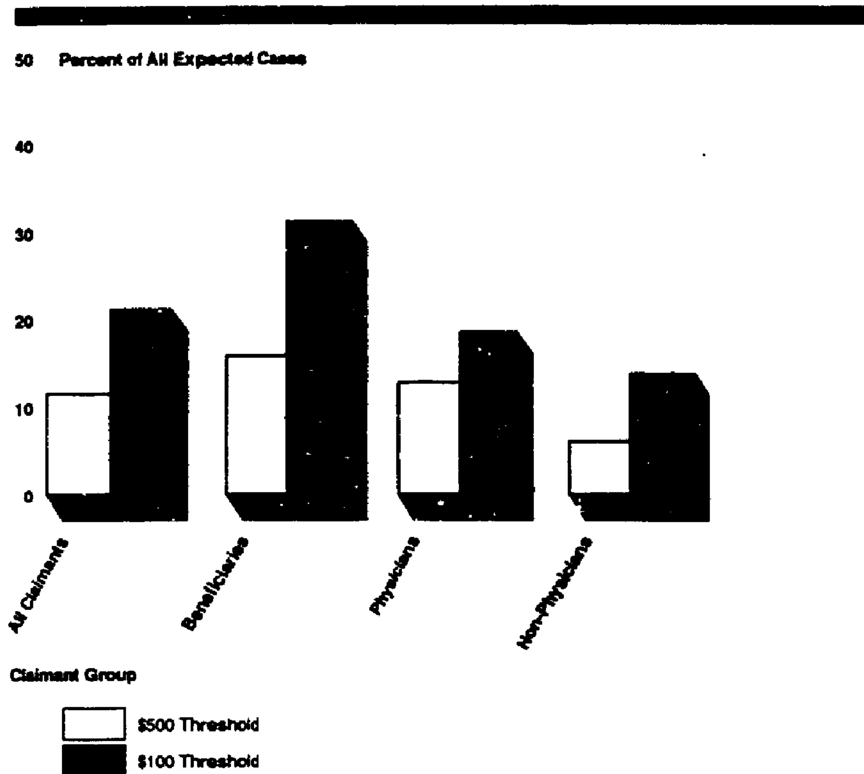
Table I.9: Number of Appeals to ALJ, by Claimant Group (Jan 1987-Mar 1989)

	Before			After		
Claimant group	Total cases	Appeal to an ALJ	Percent	Total cases	Appeal to an ALJ	Percent
Beneficiaries	10,000	1,100	11.0	7,600	1,200	15.8
Physicians	12,400	1,500	12.1	10,000	1,300	13.0
Nonphysicians	2,600	100	3.8	3,400	200	5.9
All claimants	**25,000**	**2,700**	**10.8**	**21,000**	**2,700**	**12.9**

Expected Appeals to an ALJ if the Threshold Was Lowered

The expected percentage of cases appealed to ALJs would be much greater if the Part B ALJ threshold was lowered from $500 to $100 (the threshold used for access to ALJs under Part A). At the $500 threshold, we estimate that 11.5 percent of cases would be appealed to ALJs, while at the $100 threshold, about 21.1 percent of cases would be appealed. (See fig. I.12 and table I.10. Also see figs. IV.1-IV.6.)

Figure I.12: Expected Appeals to an ALJ at Different Thresholds, by Claimant Group



Note: Currently, to appeal to the ALJ under Medicare Part B, the disputed amount must be $500 or more. In contrast, to appeal to the ALJ under Medicare Part A (hospital-related services), the disputed amount must be $100 or more.

Table I.10: Expected Appeals to an ALJ at Different Thresholds, by Claimant Group

	At $500 threshold			At $100 threshold		
Claimant group	Total cases	Expected ALJ appeals	Percent	Total cases	Expected ALJ appeals	Percent
Beneficiaries	10,000	1,579	15.8	10,000	3,123	31.2
Physicians	10,000	1,269	12.7	10,000	1,840	18.4
Nonphysicians	10,000	604	6.0	10,000	1,368	13.7
All claimants	**30,000**	**3,452**	**11.5**	**30,000**	**6,331**	**21.1**

Note: For this analysis, we assumed that the pattern of decisions and appeals for 10,000 cases for each claimant group at a $100 threshold would be the same as it was for the actual cases we reviewed that were subject to the $500 threshold.

Congressional Intent Regarding Use of Carrier Fair Hearings for Claims Appealed to ALJs

Although the Congress originally intended to eliminate carrier fair hearings for claims involving disputed amounts of more than $500, and allow them to proceed directly to an ALJ, subsequent events make it difficult to determine whether that continues to be the congressional intent.

The Omnibus Budget Reconciliation Act of 1986 amended the Social Security Act to give Part B claimants the right to ALJ hearings for disputes where the amount in controversy exceeded $500. After the amendment was enacted, HCFA issued instructions requiring claimants with amounts in controversy of more than $500 to have a carrier fair hearing before proceeding to the ALJ.[6] A federal district court found that the Congress had intended the 1986 amendment to foreclose the use of carrier fair hearings for these claims.[7]

In 1987, the Congress amended that part of the statute which prescribes that carriers must provide a fair hearing for Part B claims between $100 and $500. This was a technical amendment, making no substantive change in the law. However, it was made at a time when the Congress knew of HCFA's interpretation of the carrier fair-hearing requirement and was aware of the litigation. Subsequently, the district court, which had heard the original suit, concluded on rehearing that the 1987 amendment, in effect, ratified the position of HCFA and that the instructions were valid.[8] The decision was based on the fact that the Congress, knowing of the dispute, had refrained from changing the law. The U.S.

[6] Medicare Manual Instructions, para. 1201.5B.

[7] Isaacs v. Bowen, 683 F. Supp. 930, 934 (S.D. N.Y. 1988).

[8] Medicare Manual Instructions, at 935.

Court of Appeals for the Second Circuit, hearing an appeal of the district court decision in 1989, upheld this district court decision.[9]

The Court of Appeals found that the Congress had an opportunity to eliminate the carrier fair-hearing requirement in 1987, when it amended selected aspects of the provision, but did not clearly do so. The court believed that the 1987 act gave an "affirmative, legislative indication" of the Congress' willingness to leave the fair-hearing requirement in place, at least until we completed our study. The court found "a visible expression of congressional approval of the agency's position."

The legislative history and the language of the law provide support for the conclusion that the courts ultimately reached—that the Department of Health and Human Services, and thereby HCFA, may require claimants to have a carrier fair hearing before going to an ALJ—but they do not permit a definitive conclusion about congressional intent. However, even if legislative intent to preclude carrier fair hearings for claims over $500 was clear in 1986, as the courts thought, the Congress' action in 1987 and the Court of Appeals' opinion in 1989 make it difficult to conclude that this remains the legislative intent.

[9] Isaacs v. Bowen, 865 F. 2d 468 (2d Cir. 1989).

Appendix II

Case Sampling Methodology

To determine the changes after the introduction of mandatory on-the-record hearings in case volume and outcomes at the carrier level for each claimant group, we obtained individual case data from 47 of the 51 Medicare carriers for the period January 1987 to March 1989.[1] During this period, the ALJ appeals option was in place and the on-the-record hearings were made mandatory.

We asked carriers to separate cases considered when on-the-record hearings were mandatory from those considered before the carrier implemented HCFA's on-the-record hearing requirement. The carriers entered case data on two forms that we pretested at carriers in New York, Massachusetts, and Maryland. (See appendix III for the data collection forms used to obtain individual case data.)

Of the 47 participating carriers, 6 indicated that they were unable to provide data on all cases for the 2-year period because a large number of cases were involved, they did not have an automated filing and retrieval system, or both. However, these six carriers provided data for a sample of cases randomly selected in accordance with our instructions.

We constructed a final data set consisting of the universe of cases for 41 carriers and a sample of cases for 6. In total, data were collected on about 18,000 individual cases. We weighted the sampled cases from the 6 carriers using the weights shown in table II.1.

Table II.1: Weights for Sampled Cases in Six Carriers

	Sampled case weights	
Carrier	1987	1988
A	100.0	87 0
B	48.9	48.9
C	30.3	59.0
D	[a]	24 2
E	41.7	43 6
F	49.1	49.1

[a]Data for 1987 were not available

The estimates of case outcomes obtained through this analysis are subject to error because of the sampled cases. At the 95-percent confidence

[1] We did not obtain data from three carriers representing Prudential of America because they discontinued participating in the Medicare Part B program in late 1988. We also did not obtain data from one Aetna carrier because of its limited Part B appeals activity.

level, the error range does not exceed plus or minus 4 percent in any of our estimates.

Survey Form Sent to Medicare Part B Carriers

SURVEY OF MEDICARE
PART B HEARING OFFICE CASES
WITH A DATE OF SERVICE ON OR AFTER
JANUARY 01, 1987

INTRODUCTION

This survey is being conducted by the U.S. General Accounting Office (GAO) for the U.S. Congress. The results will be used to help determine the effects of changes in the Medicare Part B hearing appeal process. Your help is needed in order to complete this project successfully. You may wish to consult with the person(s) who track and administer your case load statistics when addressing these data requests.

Before you begin, please check for accuracy purposes, your NAME, TITLE, and ADDRESS on the attached letter introducing our survey and make any corrections in the space provided below:

NAME : ______________________________

TITLE : ______________________________

ADDRESS : ______________________________

CITY : ______________________________

Also, if applicable, please list any other pertinent Carrier officials extensively involved in managing Medicare Part B fair hearing (CFH) appeals:

NAME : ______________________________

TITLE : ______________________________

Please provide a telephone number(s) where you and, if applicable, the other involved manager can be reached, if we have any questions about your responses.

PHONE : ______________________________

PHONE : ______________________________

PLEASE RETURN THIS SHEET WITH THE SURVEY FORMS. THANK YOU

INSTRUCTIONS

Enclosed are two data collection forms i.e., schedules -- each requesting Medicare Part B claimant and Carrier fair hearing information.

The first form: Form A, relates only to those Medicare Part B cases with a 'date of service' (incurred by the claimant) on or after January 01, 1987; but, not beyond the processing date used by Carriers in implementing the Health Care Financing Administration's (HCFA) Part B Interim Guidelines - Hearings and Appeals. The aforementioned guidelines suggested an effective date of no later than May 01, 1988, and instituted a general requirement (with minor exceptions) for conducting a mandatory on-the-record hearing, whether or not an in-person or telephone hearing is requested. In the space provided below, please indicate Carrier implementing date for instituting HCFA's interim guidelines: ________(month) _______(day) _______(year).

The second form: Form B, pertains to only these Medicare Part B cases with a 'date of service' on or after January 01, 1987, and those considered by the Carriers under HCFA's implementing interim guidelines which require mandatory on-the-record reviews, whether or not an in-person or telephone hearing is requested.

For the specific information requested under each column in the two schedules, refer to detailed instructions provided below. Once you have completed the survey forms/schedules, place them in the pre-addressed envelope and mail them as soon as possible, but no later than March 27, 1989. Also, if you have any questions or problems with the survey, call Joe Faley or Claude Hayeck collect at (202) 523-8666.

PLEASE RETURN THIS SHEET WITH THE SURVEY FORMS

THANK YOU FOR YOUR COOPERATION!

SPECIFIC INFORMATION

Refer to designated column title headings. Please note that information below identified by an asterisk (*) only applies to Form B for recording mandatory on-the-record reviews.

Case Reference Number:

Identify by either an in-house control number (preferable identifier) or a number in descending order for those cases listed. Also, depending upon the Carrier, the term "case" is sometimes used interchangeably with the term "claim", use either for your listing purposes, but for whatever definitional reference number terminology used, please identify as such and be consistent in its usage

Type of Claimant:

Identify by a check mark the type of claimant requesting a hearing, i.e., beneficiary and provider with the latter further classified as either physician or non-physician (including durable equipment suppliers, laboratories, etc.)

Number of Claims In Each Case:

Identify the number of claims combined by the claimant to reach the required $100 dollar threshold. Also, refer to "COL #1" discussion on case versus claim terminology.

Original Dollar Amount In Controversy:

Identify the original dollar amount in dispute at the time of the hearing request.

* Mandatory On-The-Record Review Decision:

Identify the on-the-record-review decision as "totally favorable" only if the amount in controversy is totally upheld or decided in the whole amount for the claimant. Likewise, identify any total reversal as "totally unfavorable." For all other claimant rulings involving partial amounts upheld in the favor of the claimant, identify as a "partial" decision. Also, when you pre-determined that a formal hearing was necessary, identify these cases as "exempted" from an on-the record review.

* Dollar Amount In Controversy After The Mandatory On-The Record Review:

Identify the remaining dollar amount in controversy after the on-the-record decision

* **Claimant Continued With Formal CFH Appeal?:**

Identify by a yes or no answer

Type of CFH:

Identify what type of formal hearing the claimant requested. In the situations where mandatory on-the-record reviews were already held, the telephone and in-person formal settings are the only options available to the claimant.

CFH Decision:

Identify the Carrier fair hearing decision as "totally favorable" if the remaining dollar amount in controversy is totally upheld in the favor of the claimant, otherwise, identify any total reversal as "totally unfavorable" and any partial decision as "partial."

Date of CFH Decision

Identify by day, month, and year.

Dollar Amount In Controversy After CFH Decision:

Identify the remaining dollar amount in controversy after the Carrier fair hearing decision.

Appealed To ALJ?:

Identify by a check mark whether, to your knowledge, claimant requested a hearing by an Administrative Law Judge (ALJ).

FORM A

Page 1 of 1

Case #	Type of Claimant (Check Only One)			Number of Claims in Case	Original Dollar Amount in Controversy	Type of CFH (Check One)			CFH Decision (Check One)			Date of CFH Decision	Dollar Amount in Controversy After CFH Decision	Appealed to ALJ? (Check One)	
		Provider													
	Beneficiary	Physician	Non-Physician			On-The-Record	Telephone	In-Person	Totally Favorable	Partial	Totally Unfavorable			Yes	No

FORM B

Page 1 of 2

Case #	Type of Claimaint (Check Only One)			Number of Claims in Case	Original Dollar Amount in Controversy	Mandatory On-The-Record Review Decision (Check Only One)				Dollar Amount in Controversy After Mandatory On-The-Record Decision	Continued With CFH Appeal? (Check One)	
		Provider										
	Beneficiary	Physician	Non-Physician			Totally Favorable	Partial	Totally Unfavorable	Exempted		Yes	No

FORM B (Continued)

Page 2 of 2

Case #	Type of CFH (Check One)		CFH Decision (Check One)			Dollar Amount in Controversy After CFH Decision	Date of CFH Decision	Appealed TO ALJ? (Check One)	
	Telephone	In-Person	Totally Favorable	Partial	Totally Unfavorable			Yes	No

Estimates of the Potential Effect of Lowering the Threshold for Access to an ALJ

Using the data obtained from the carriers, we applied actual conditional probabilities to a hypothetical set of 10,000 cases for each claimant group to assess the potential effect of lowering the ALJ threshold to $100.[1] That means that at each of the 47 Medicare carriers participating in our study, we looked at the actual cases and what happened to them at each point in the appeals process. We then assumed for this analysis that 10,000 cases coming into the appeals process in the future for each claimant group will act in the same way as the actual cases we reviewed; that is, under the same appeals process rules, future cases will have the same patterns of "win," "continue," and "lose" as did the actual cases we reviewed. In these analyses,

- "win" denotes a decision that results in a payment to a claimant.
- "continue" denotes a case in which the claim is totally or partially upheld in the carrier's favor and the disputed amount is equal to or greater than the monetary threshold for appeal to an ALJ, and
- "lose" denotes a case in which the claim is totally or partially upheld in the carrier's favor but the dollar amount remaining in controversy is less than the monetary threshold for appeal to an ALJ.

The results of the conditional probability analyses are shown below for each claimant group for a $500 threshold (figs. IV.1-IV.3) and a $100 threshold (figs. IV.4-IV.6).

[1] Conditional probabilities represent the likelihood that an individual claimant possesses a particular trait or set of traits related to different decisions in the carrier hearing process. For example, a discrete probability would show the likelihood of being a physician (type of claimant) who selected a telephone carrier fair hearing (type of hearing), lost the decision, and decided to appeal that decision to an ALJ. The probability in this example is conditional because it includes or is conditional on all earlier probabilities. That is, the probabilities of being a physician, having a telephone hearing, losing the hearing, and deciding to appeal are multiplied together to obtain the final conditional probability

Figure IV.1: Expected Outcomes for Beneficiaries at a $500 ALJ Threshold

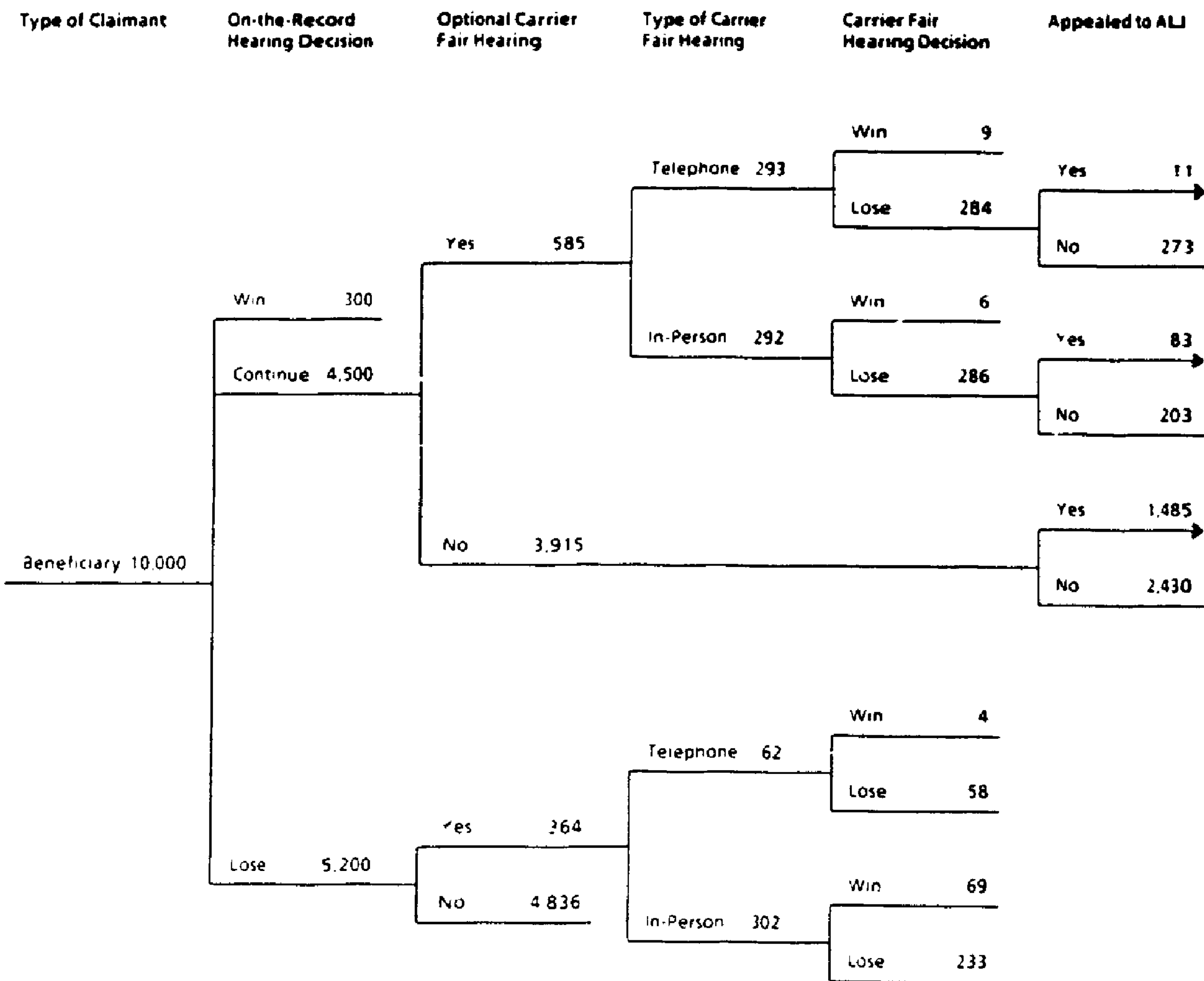


Figure IV.2: Expected Outcomes for Physicians at a $500 ALJ Threshold

Expected Outcomes per 10,000 Claimants

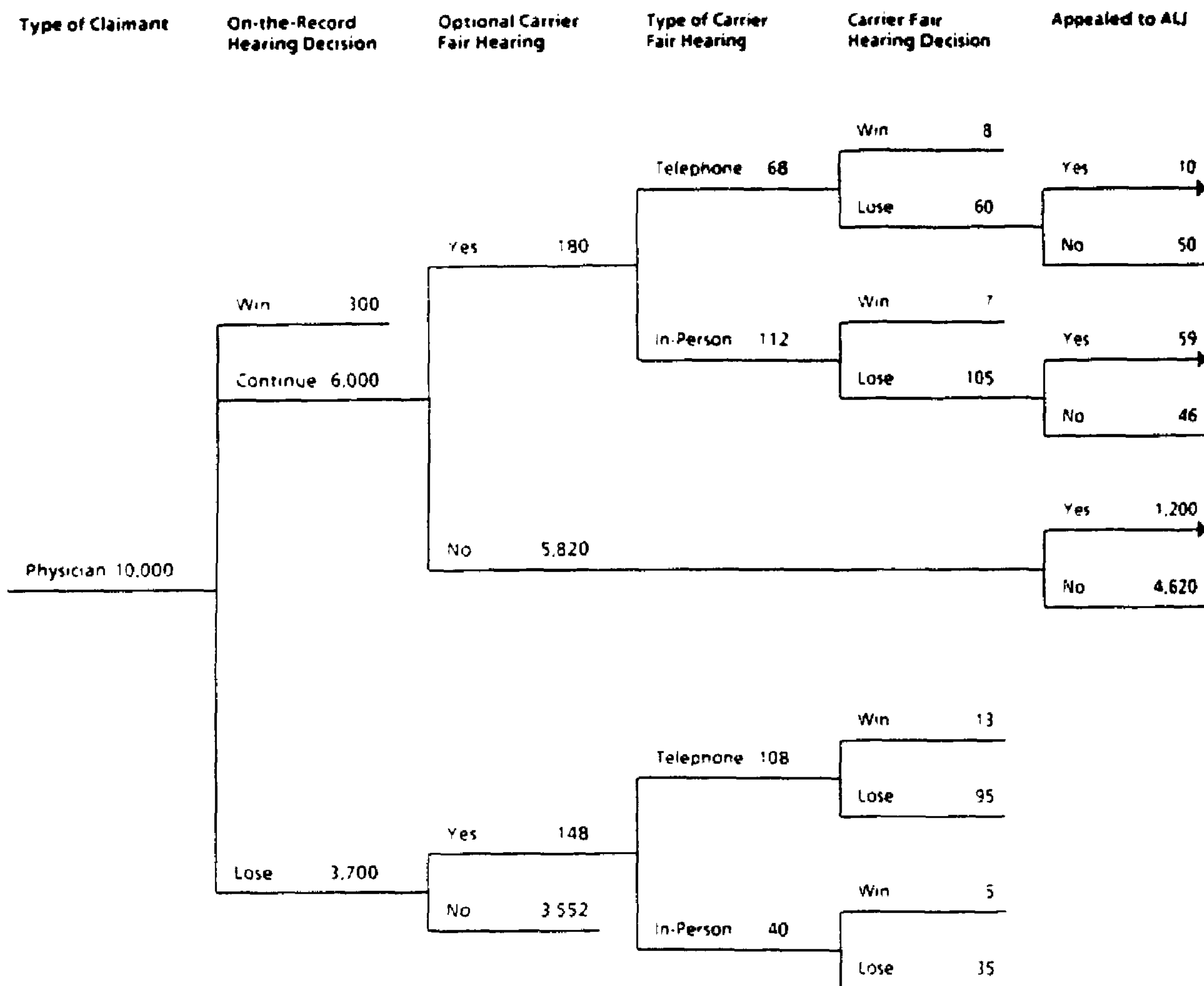


Figure IV.3: Expected Outcomes for Nonphysicians at a $500 ALJ Threshold

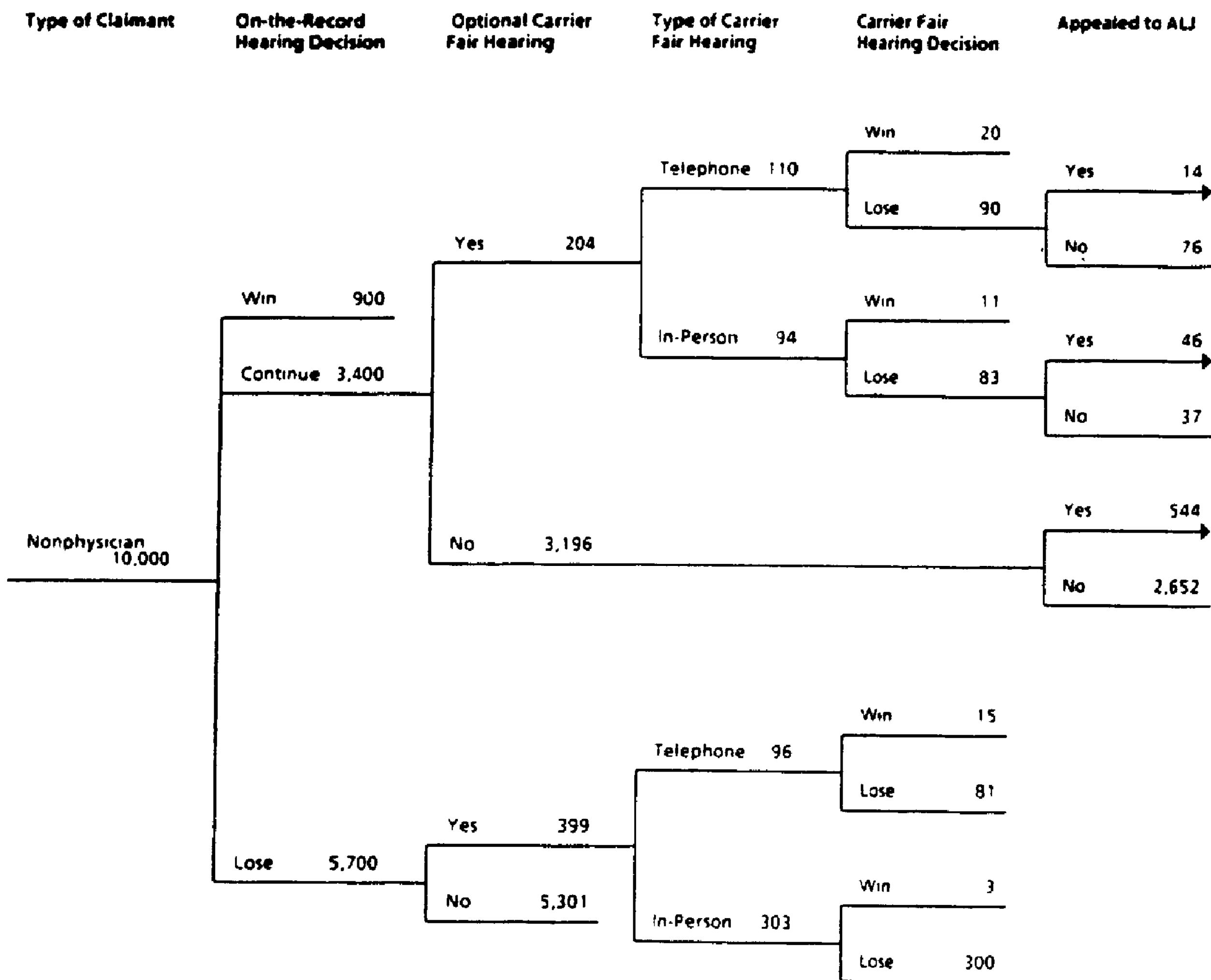


Figure IV.4: Expected Outcomes for Beneficiaries at a $100 ALJ Threshold

Expected Outcomes per 10,000 Claimants

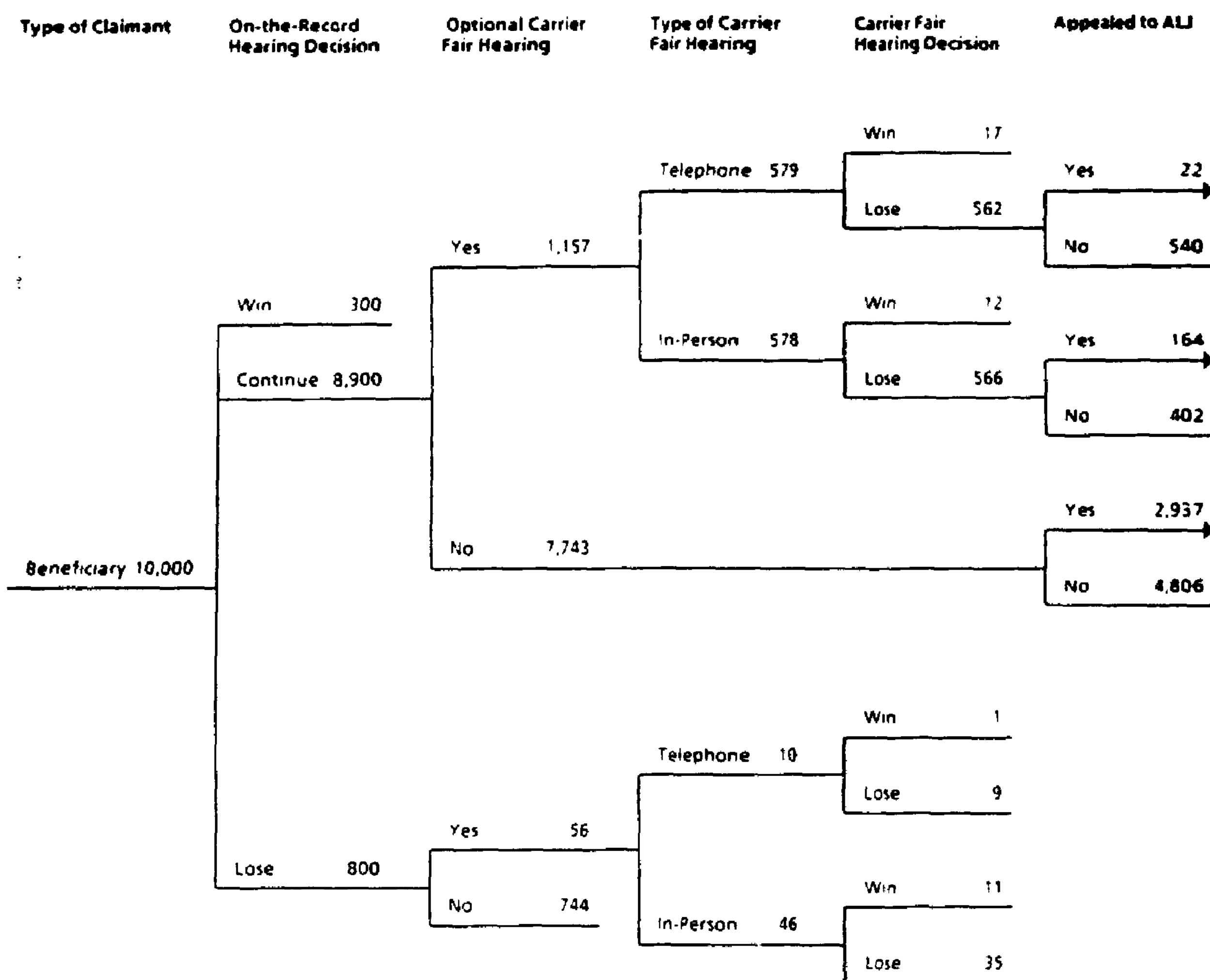


Figure IV.5: Expected Outcomes for Physicians at a $100 ALJ Threshold

Expected Outcomes per 10,000 Claimants

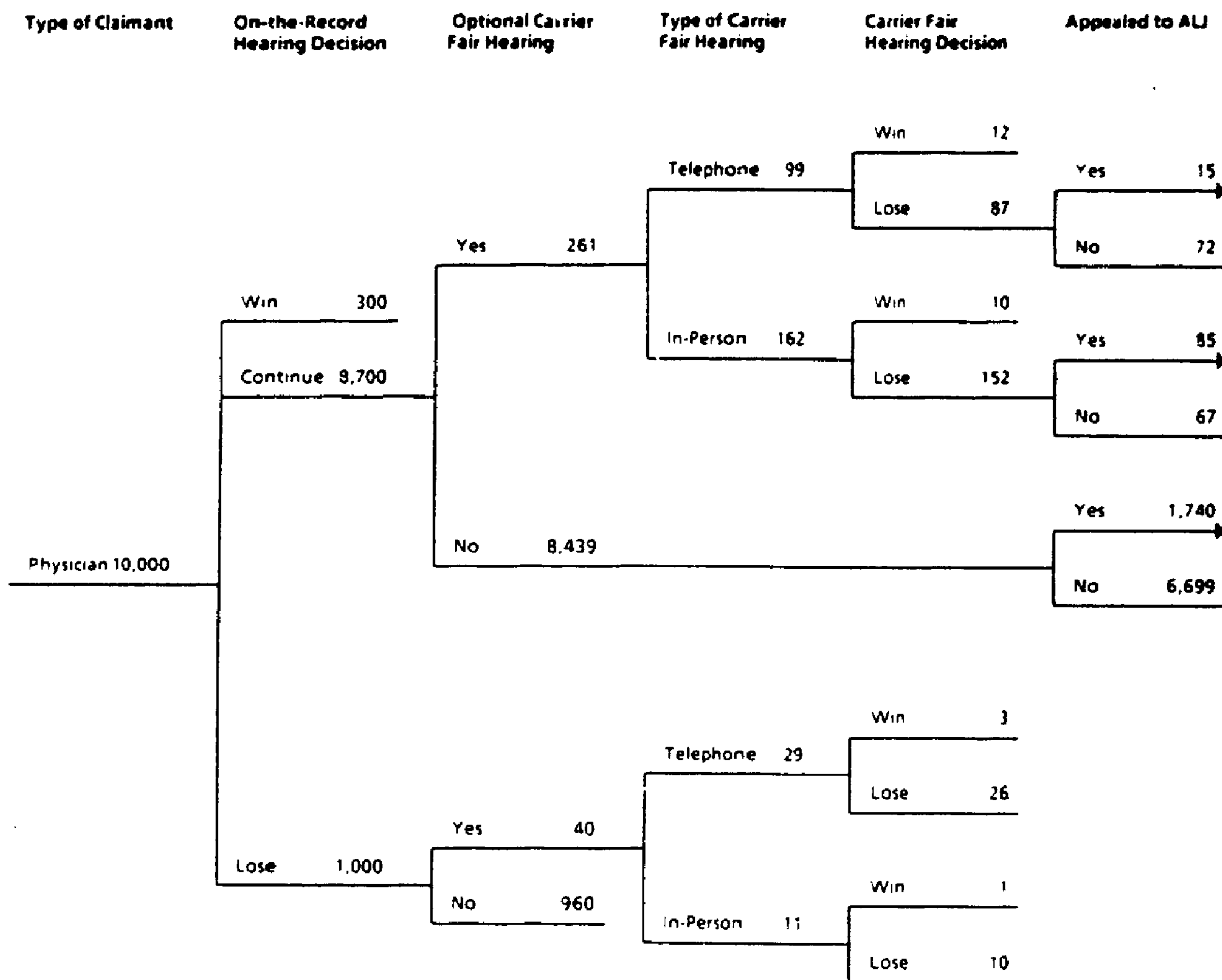
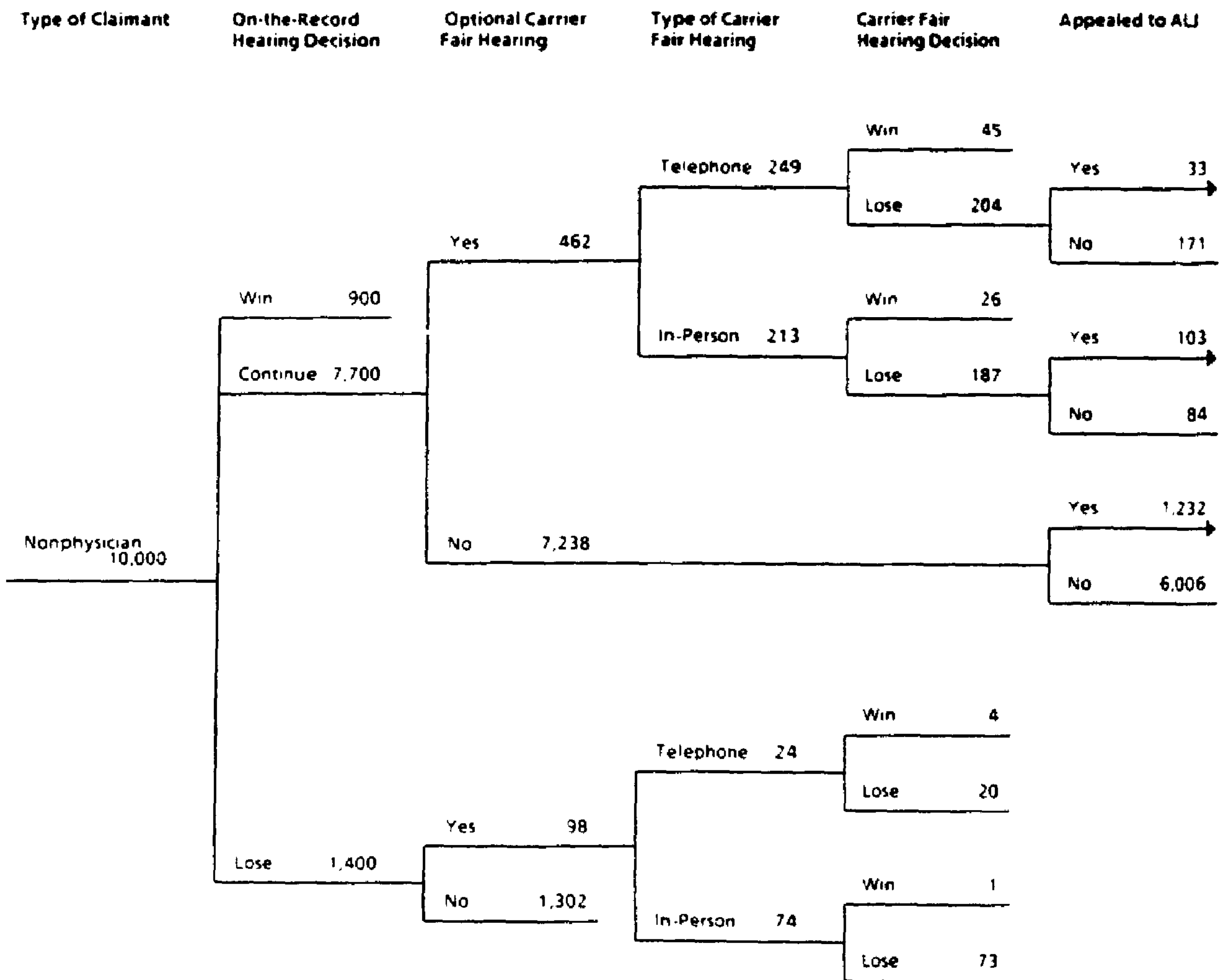


Figure IV.6: Expected Outcomes for Nonphysicians at a $100 ALJ Threshold

Expected Outcomes per 10,000 Claimants



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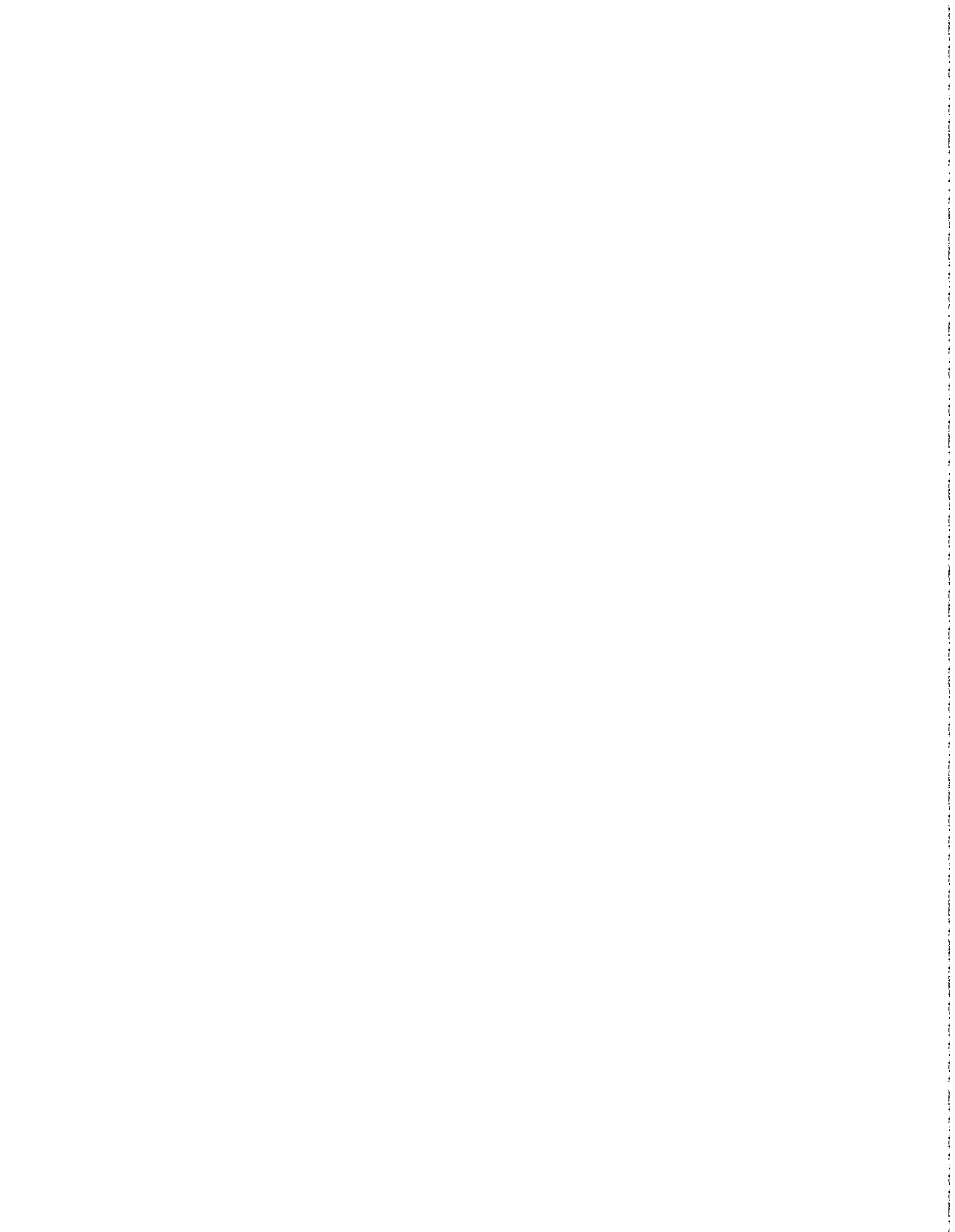


United States
General Accounting Office
Washington, D.C. 20548

Human Resources Division

B-234417

July 16, 1990

The Honorable Lloyd Bentsen
Chairman, Committee on Finance
United States Senate

The Honorable John D. Rockefeller, IV
Chairman, Subcommittee on Medicare and
Long Term Care
Committee on Finance
United States Senate

The Honorable Dan Rostenkowski
Chairman, Committee on Ways and Means
House of Representatives

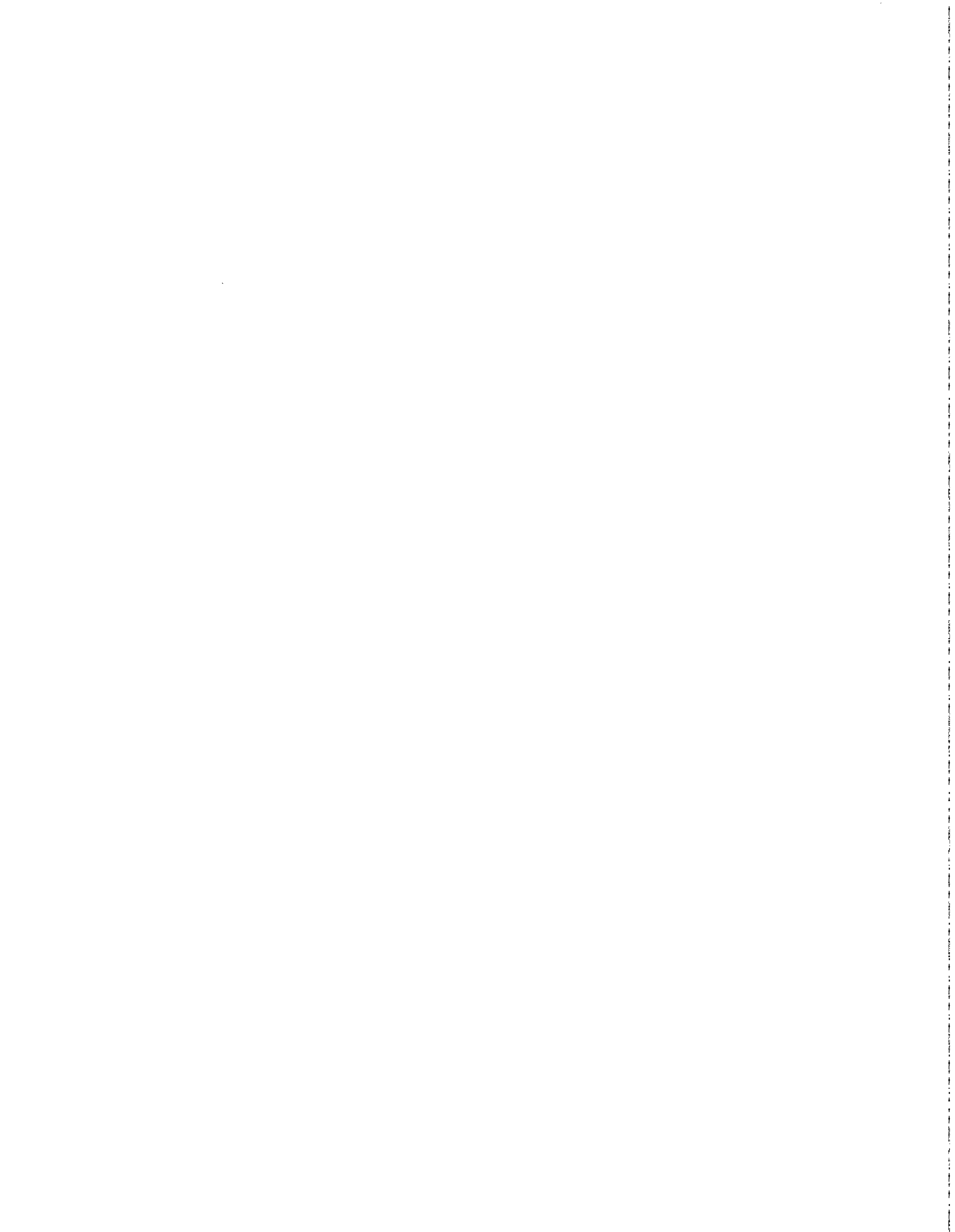
The Honorable Pete Stark
Chairman, Subcommittee on Health
Committee on Ways and Means
House of Representatives

As agreed with your offices, this study provides information on the changes in claim volume and outcomes at the carrier level following recent changes in the Medicare Part B appeals process.[1] This report also provides information regarding the requirement that a claimant appeal an adverse decision to the carrier before being permitted to appeal to a federal administrative law judge (ALJ) when the disputed amount is more than $500. Further, it assesses the potential change in the ALJ caseload if the disputed amount threshold was lowered.

This report also fulfills our mandate under the Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203, section 4082 (d)). The act directed us to study the cost effectiveness of the Health Care Financing Administration's (HCFA's) requirement that Part B cases go through a hearing at the carrier level before they are appealed to an ALJ.[2]

[1] The initial determinations about coverage for particular services and the amount of payment for Part B claims are made by carriers, such as Blue Cross/Blue Shield or other commercial insurance companies, which are generally performing this function under contract to the Health Care Financing Administration.

[2] A separate report provided statistical information on the ALJ hearings process, including the number and status of ALJ cases filed, the outcome of cases by type of hearing, and the time required to complete the hearing process. See Statistics on the Part B Administrative Law Judge Hearings Process (GAO/HRD-90-18, Nov. 28, 1989).



Background

Title XVIII of the Social Security Act authorizes the Medicare Part B program to provide supplemental medical insurance coverage for most individuals age 65 and older. HCFA, within the Department of Health and Human Services, administers the Medicare program. In fiscal year 1989, Part B covered approximately 32.4 million enrollees and paid benefits of about $38.7 billion.

The Medicare program provides specific appeal rights for Part B claimants. These are the individual beneficiary or a medical provider such as a physician, laboratory, or supplier of medical equipment or services. At the inception of the program, Part B claims were not accorded the same appeal rights as Part A claims (the hospital insurance portion) because they were expected to be for substantially smaller amounts than Part A claims. In addition, Part B claims are far more numerous than Part A claims and this posed the possibility of a substantial workload if judicial review was accorded to all of them.

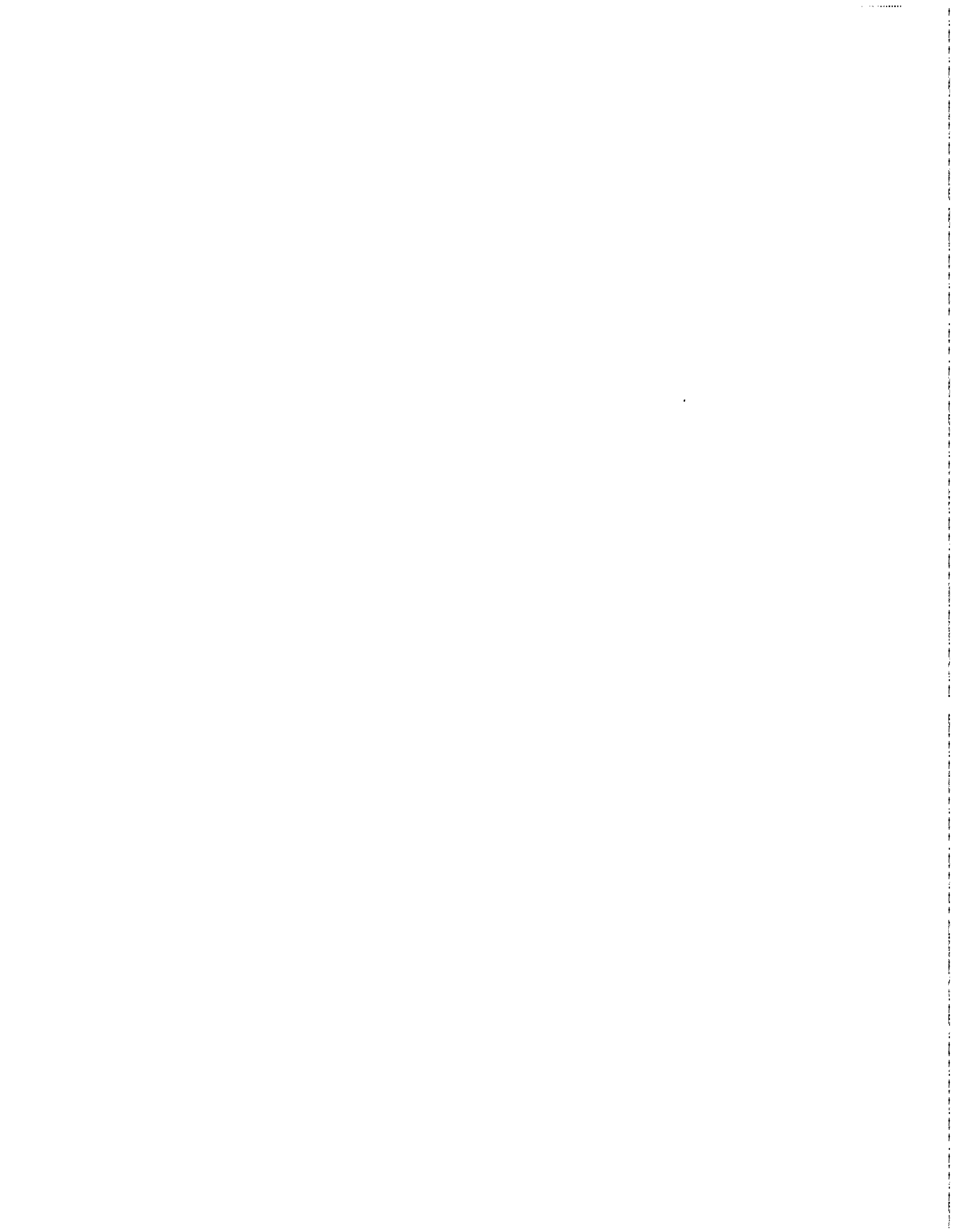
Recent legislative and administrative changes were made in the appeals process because claimants expressed concerns about the fairness and adequacy of the Part B appeals process. For example, claimants were concerned that the hearing officers at the carrier level were not objective because their continued employment may depend on the carriers' being satisfied with the decisions they render. To attempt to resolve claimants' concerns about the Part B process, the Congress changed the process to make it more like Part A by adding appeal options beyond the carrier. Review of Part B claims by an ALJ is now available if the disputed amount is $500 or more and judicial review is available if the disputed amount is $1,000 or more.[3] A claimant can combine denied claims to meet these limitations.

The 1987 legislative change and the need for program economies prompted HCFA to revise the way carriers processed appeals.

Part B Appeals Process Before 1987

Before 1987, the appeals process worked as follows. First, the claim underwent a "carrier review," which is a review of written case documentation by a claims processor other than the one that made the "initial claim determination." If the carrier review decision agreed with the initial determination and the amount in dispute was at least $100, the

[3]The Omnibus Budget Reconciliation Act of 1986 (P.L. 99-509, section 9341), amending the Social Security Act. The change was effective January 1, 1987



case could be appealed to the next level, a hearing officer, also at the carrier.

At the hearing officer level, claimants could select one of three types of "carrier fair hearings": on-the-record,[4] telephone, or in-person. On-the-record hearings involved evaluations of the written case documentation that did not provide claimants an opportunity to give oral testimony. If claimants chose on-the-record hearings, they could not subsequently request a telephone or in-person hearing. There were no appeal options beyond the carrier level. (See figure I.1 for an illustration of the hearing process in effect until January 1, 1987.)

Part B Appeals Process as of 1987

The legislative change authorizing appeals to an ALJ became effective January 1, 1987. HCFA required that cases go through a carrier fair hearing before being appealed to the ALJ, but HCFA did not change the way appeals were processed within carriers.

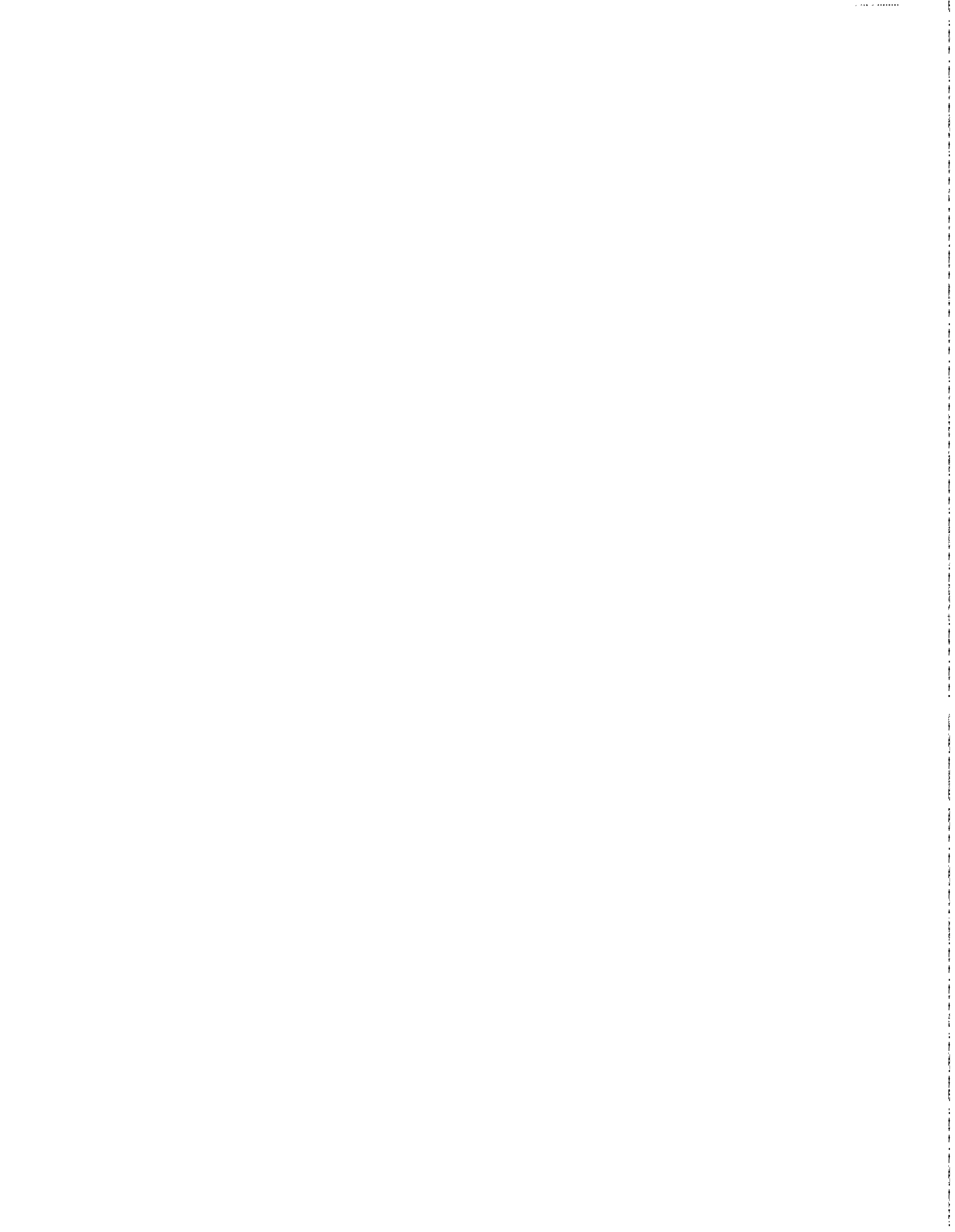
In 1988, however, HCFA changed the appeals process within carriers. It required, with some exceptions, that cases go through an on-the-record hearing before being appealed. As before, claimants initially choosing an on-the-record hearing could not subsequently request a telephone or in-person hearing. If disputed amounts were still over $500 after the hearing, claimants could then appeal to an ALJ.

Claimants initially requesting a telephone or in-person hearing, however, now had to go through the on-the-record hearing. After that hearing, for disputed amounts of at least $500, these claimants could either go to the requested telephone or in-person hearing or appeal directly to the ALJ. The on-the-record hearing requirement was phased in by carriers from April to June 1988. Figure I.2 shows the appeals process after the legislative and administrative changes.

HCFA officials state that the mandatory on-the-record hearing was introduced to expedite cases and to reduce costs by directing cases away from the more lengthy and expensive telephone and in-person hearings. Representatives for the National Senior Citizens Law Center testified before the House Judiciary Committee,[5] however, that the on-the-record

[4] HCFA also refers to these as "on-the-record decisions."

[5] Oversight hearing on the adjudicatory procedure of the Department of Health and Human Services, Subcommittee on Administrative Law and Governmental Relations, House Judiciary Committee, June 27, 1989.

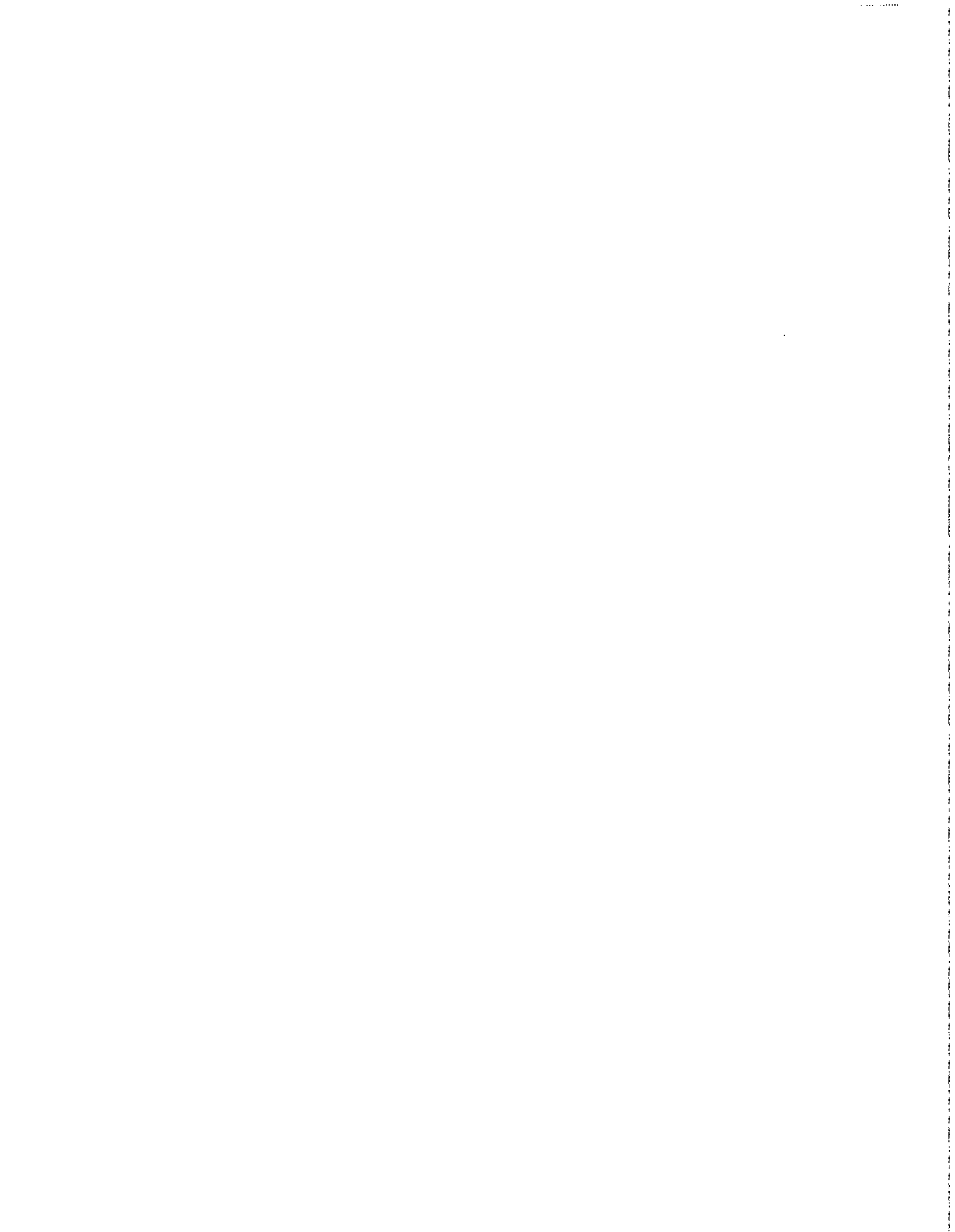


hearing step often is a source of confusion about appeal rights and contributes to the overall delay in the review of Part B claims. They also testified regarding concerns about the effect of on-the-record hearings on the rights of claimants not represented by legal counsel. For example, they believed that claimants might erroneously perceive that the on-the-record hearing is the end of the appeals process. The representatives expressed further concern about the possibility of bias in an in-person hearing because the person assigned to review an on-the-record hearing decision may in some way be influenced by knowing that another hearing officer (supposedly at the same level of authority and competency) has already denied the claim.

Objective and Methodology

The objective of our review was to gather information on the changes, if any, in claim volume and outcomes following the addition of the ALJ appeal options and the introduction of mandatory on-the-record hearings to the Medicare Part B appeals process. Specifically, we sought to determine (1) the changes in outcome of cases reviewed by claims processors and hearings officers; (2) the changes after the introduction of mandatory on-the-record hearings in the volume and outcome, by claimant group, of cases reviewed by hearings officers; (3) the expected effect on claim volume and outcomes of lowering the ALJ threshold from $500 to $100, which is the current ALJ threshold for Part A cases; and (4) the congressional intent in establishing the monetary threshold for claimants appealing to an ALJ.

To determine the changes in case outcomes, we obtained quarterly data from HCFA for the period October 1984 to March 1989 for cases at different stages in the appeals process. To determine the changes, by claimant group, after the introduction of mandatory on-the-record hearings in the volume and outcomes of cases reviewed by hearings officers, we obtained individual case data for the period January 1987 to March 1989 from 47 of the 51 Medicare carriers. We categorized claimants into three groups—beneficiaries, physicians, and nonphysicians—and analyzed data obtained from the carriers for cases decided before and after the introduction of mandatory on-the-record hearings. The "before" analysis includes cases reviewed from the introduction of the ALJ hearing option on January 1, 1987, to the time each carrier introduced the mandatory on-the-record hearings (during the period April to June 1988). The "after" analysis includes cases reviewed by each carrier from the time each carrier introduced the mandatory on-the-record hearings to March 1989, the most current data available at the time we collected data from the carriers. (See appendix II for our case-sampling



methodology and appendix III for the survey form sent to the carriers.) We did not assess the extent to which other factors, such as case complexity, case merit, or carrier policy might have affected case volume or outcomes.

Using the data obtained from the carriers, we estimated the potential effect on each claimant group of lowering the ALJ threshold to $100. To do this, we assumed that the pattern of decisions and appeals at a $100 threshold would be the same as it was for the actual cases we reviewed that were subject to the $500 limitation. See appendix IV for a description of this analysis and its results.

We also interviewed HCFA program operation managers and several carriers about recent changes in the Part B appeals process. In addition, we reviewed statutes, regulations, legislative history, and court decisions to determine the congressional intent in establishing the $500 ALJ threshold.

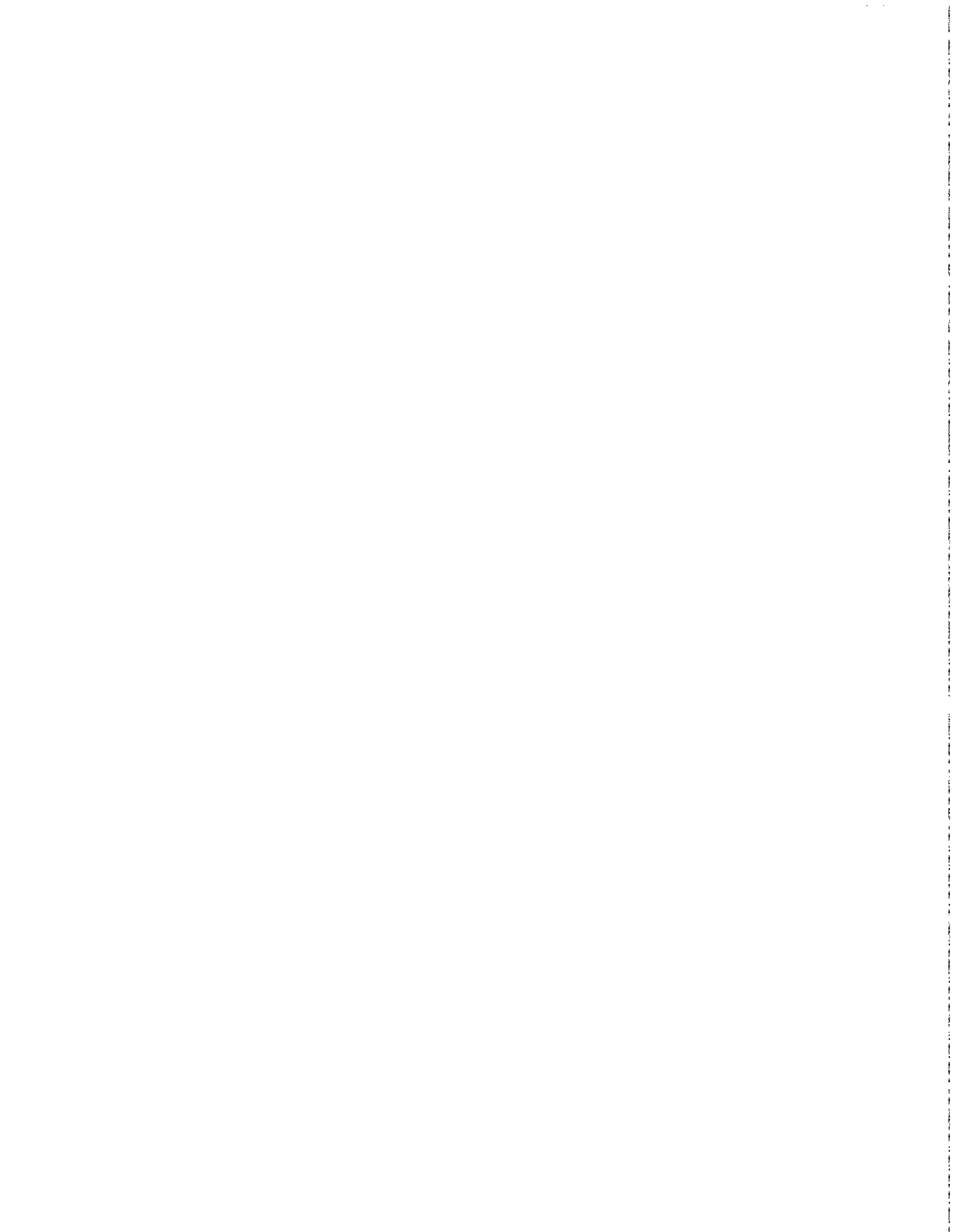
We performed our work between July 1988 and December 1989. We did not verify HCFA or carrier-provided data. With that exception, we performed our work in accordance with generally accepted government auditing standards.

Results in Brief

The results of our review are provided in detail in appendix I. In summary, the percentage of cases receiving a telephone or in-person hearing at the carrier decreased after the introduction of the mandatory on-the-record hearings, while the percentage of cases appealed to ALJs increased. The percentage of hearing-officer decisions that resulted in payments to claimants also decreased after the on-the-record hearing was made mandatory. More specifically:

1. There was little change in the percentage of decisions for or against claimants in initial carrier determinations or carrier reviews by claims processors. (See figs. I.3 and I.4.) However, the percentage of carrier hearing-officer decisions against claimants increased after the introduction of mandatory on-the-record hearings. (See fig. I.5.)

2. Data obtained from Medicare carriers for the period January 1987 through March 1989 show that the largest percentage of cases reviewed before and after the introduction of the mandatory on-the-record hearings involved physicians. (See fig. I.6.) After HCFA introduced mandatory on-the-record hearings:



- The percentage of cases that had such hearings increased from 71 to 100 percent, as expected. Among the claimant groups, cases involving nonphysicians had the greatest increase. All claimant groups experienced a decrease in on-the-record hearing decisions resulting in payment to claimants. However, after on-the-record hearings were made mandatory, decisions involving physicians resulted in payments more frequently than did those for the other claimant groups. (See figs. I.7 and I.8.)
- The percentage of cases that had a telephone or in-person hearing decreased from 29 to 6 percent, with the nonphysician claimant group experiencing the greatest decrease (from 38 to 6 percent). The percentage of telephone or in-person hearing decisions resulting in payments to claimants also decreased from 61 to 38 percent. Again, the nonphysician group experienced the greatest decrease (from 70 to 40 percent). (See figs. I.9 and I.10.)
- The percentage of cases appealed to ALJs increased from 11 to 13 percent. Cases involving beneficiaries experienced the greatest increase (from 11 to 16 percent). (See fig. I.11.)

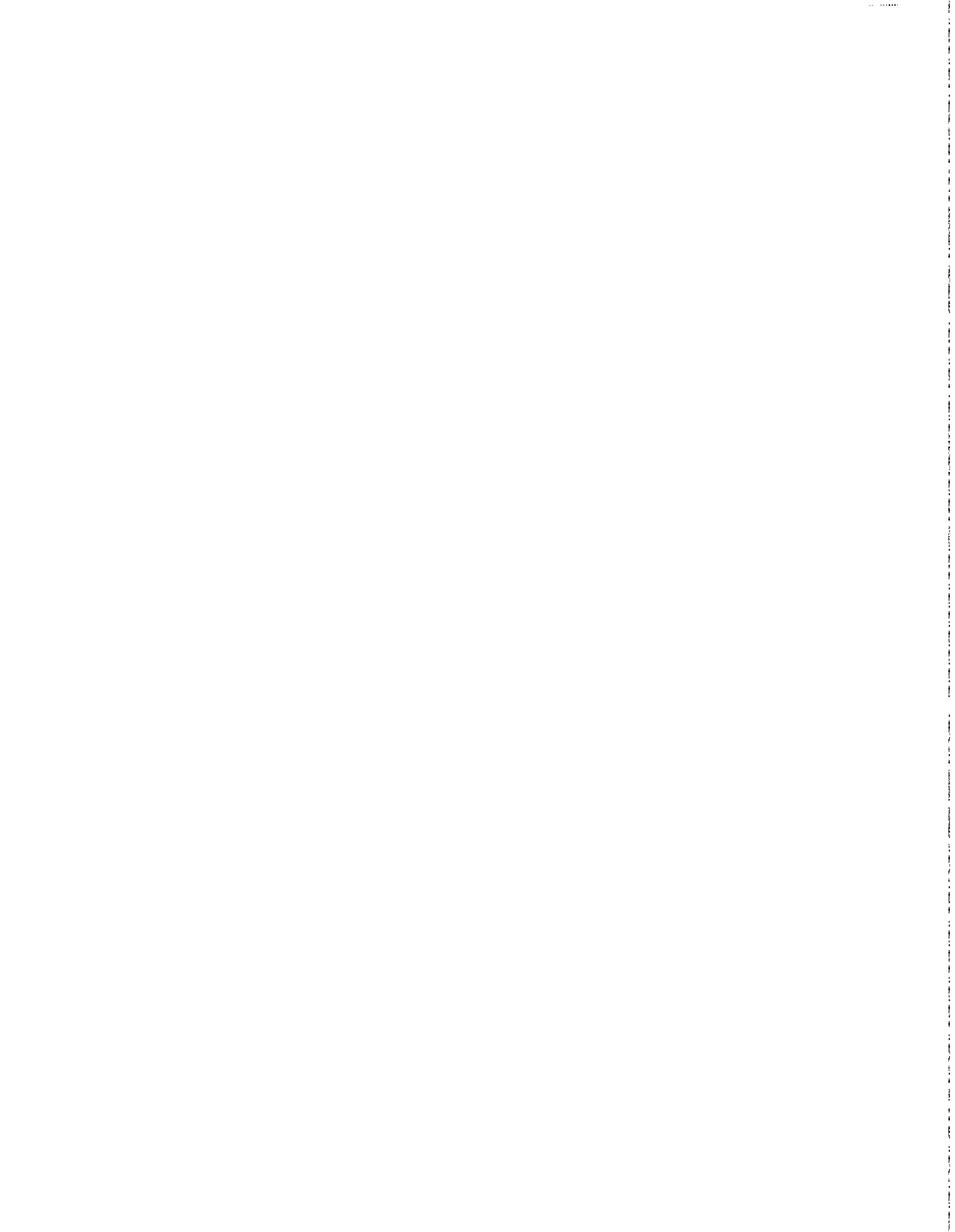
3. Lowering the ALJ threshold to $100 could be expected to increase the number of Part B cases appealed to ALJs to about 21 percent. (See fig. I.12.)

4. The congressional intent in establishing a $500 threshold for ALJ appeals is unclear. Court opinions initially differed on whether the Congress intended such claims to bypass carrier fair hearings. However, a recent federal district court appeal decision concluded that HCFA's instructions requiring claimants with disputed amounts of at least $500 to go through a carrier fair hearing before proceeding to the ALJ were valid.

Conclusions

The revisions to the Part B appeals process have been in effect for a short time and more time is needed to determine if the changes we observed will persist. The revisions appear, however, to be fulfilling their intended purpose of reducing the number of telephone and in-person hearings at the carrier level and providing an opportunity for claimants to appeal beyond the carrier level. If the ALJ threshold was lowered to $100 to correspond with that currently used in the Part A appeals process, the number of cases appealed to ALJs could be expected to increase substantially.

The percentage of carrier hearing decisions resulting in payments to claimants decreased after the introduction of mandatory on-the-record



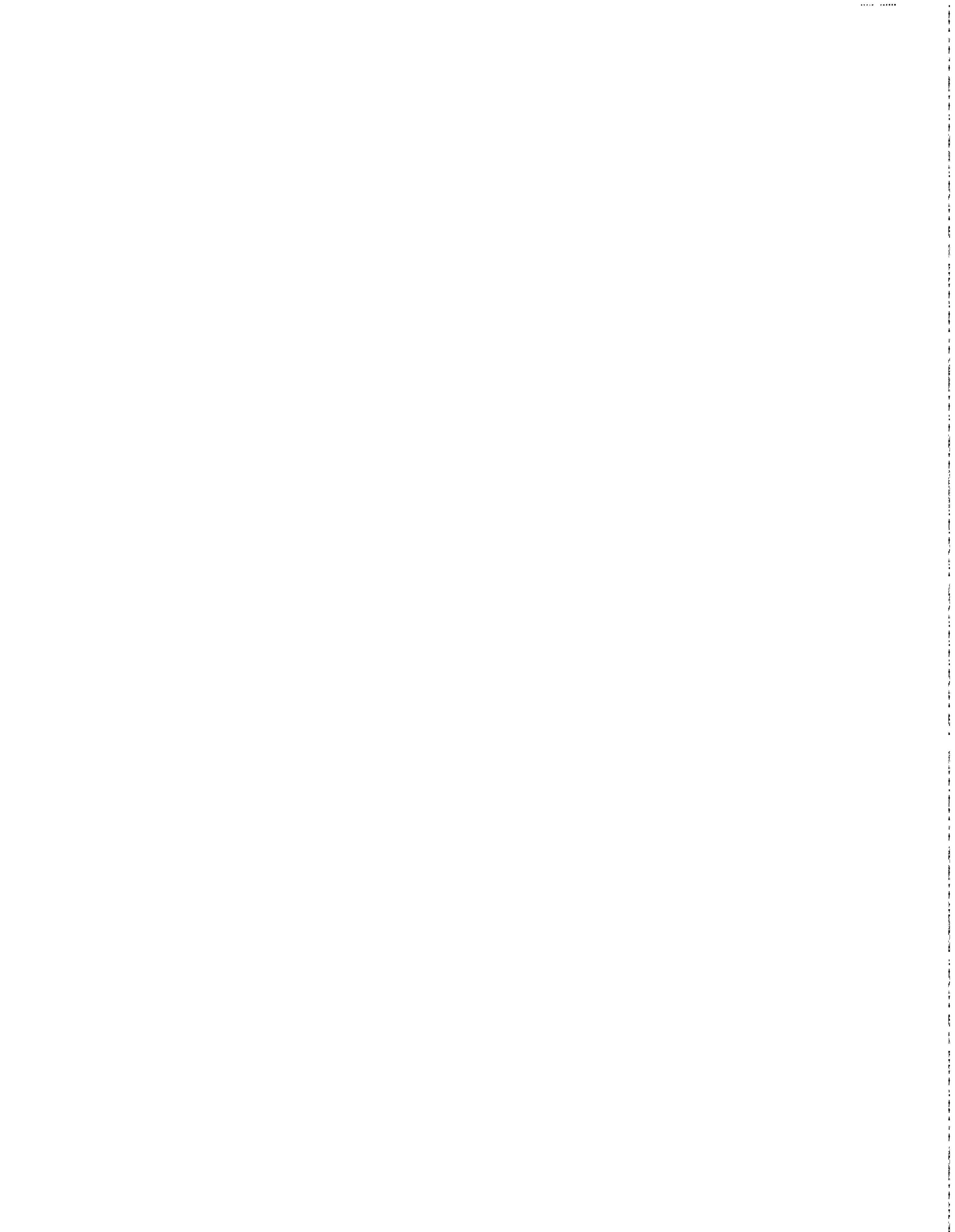
hearings. Because we did not have case-specific data, we cannot eliminate the possibility that other factors, such as case complexity, case merit, or a change in carrier policy, may have influenced the changes we are observing.

As agreed with your offices, we did not obtain written agency comments on this report. However, we discussed its contents with HCFA officials and incorporated their comments where appropriate.

We are sending copies of this report to the Secretary of Health and Human Services, the Administrator of HCFA, and other interested parties, and we will make copies available to others on request.

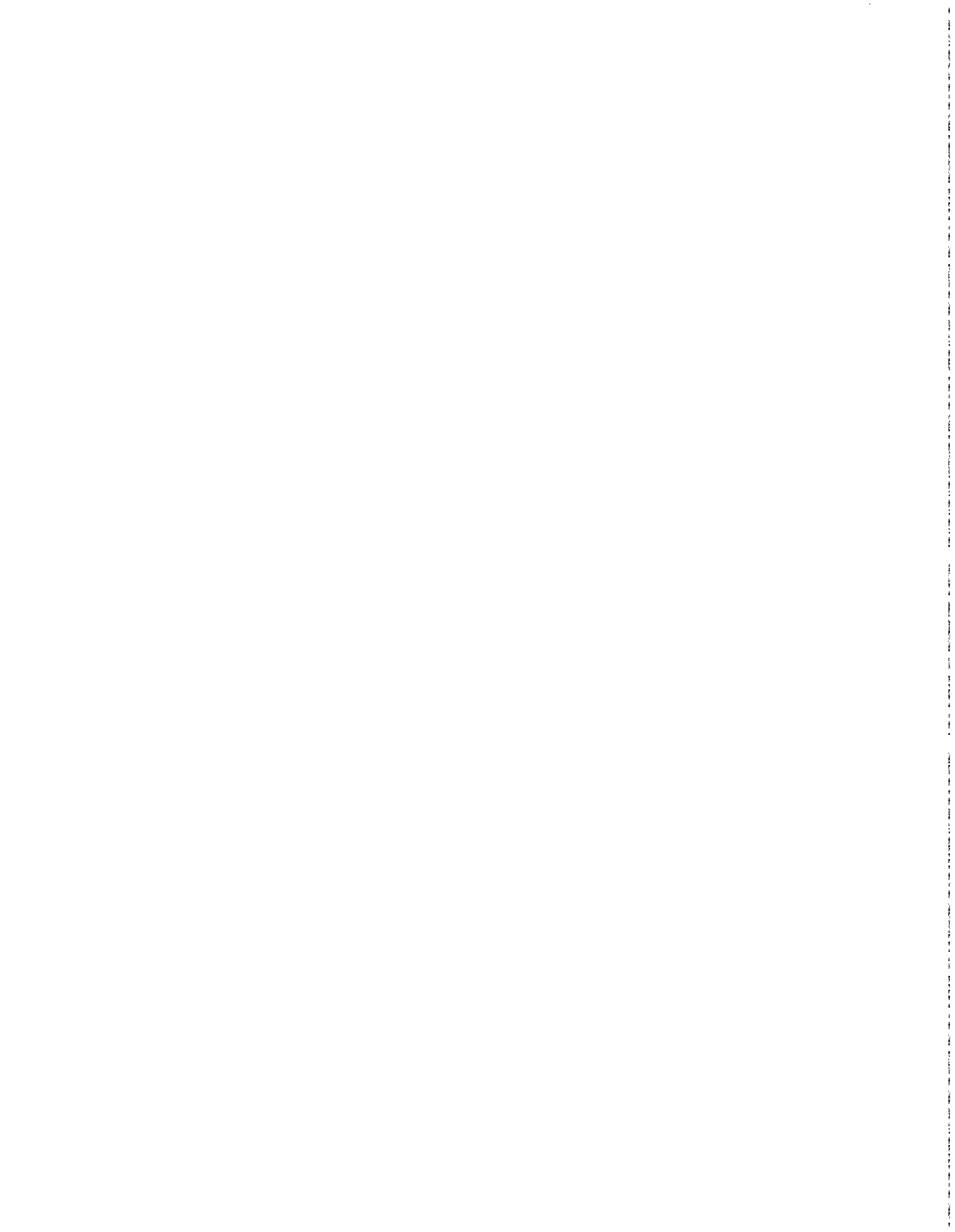
Please call me on (202) 275-1655 if you or your staffs have any questions about this report. Other major contributors to this report are listed in appendix V.

Linda G. Morra
Director, Intergovernmental
and Management Issues



Contents

Letter		1
Appendix I Part B Changes Appear to Be Fulfilling Their Purpose		12
	How the Appeals Process Changed	12
	Combined Effect of Changes on Case Outcomes at the Carrier Level	15
	Changes in Cases Reviewed by Hearing Officers After the Introduction of Mandatory On-the-Record Hearings	21
	Expected Appeals to an ALJ if the Threshold Was Lowered	30
	Congressional Intent Regarding Use of Carrier Fair Hearings for Claims Appealed to ALJs	31
Appendix II Case Sampling Methodology		33
Appendix III Survey Form Sent to Medicare Part B Carriers		35
Appendix IV Estimates of the Potential Effect of Lowering the Threshold for Access to an ALJ		40
Appendix V Major Contributors to This Report		47



Tables

Table I.1: Claims Denied in Initial Determinations by Claims Processors, for All Claimants 17
Table I.2: Outcome of Cases Reviewed by Claims Processors, for All Claimants 19
Table I.3: Outcome of Cases Reviewed by Hearing Officers, for All Claimants 21
Table I.4: Hearing Officer Reviews, by Claimant Group 23
Table I.5: On-the-Record Hearings, by Claimant Group 24
Table I.6: On-the-Record Hearing Decisions Favoring Claimants, by Claimant Group 25
Table I.7: Telephone and In-Person Hearings, by Claimant Group 27
Table I.8: Telephone and In-Person Hearing Decisions Favoring Claimants, by Claimant Group 28
Table I.9: Number of Appeals to ALJ, by Claimant Group 29
Table I.10: Expected Appeals to an ALJ at Different Thresholds, by Claimant Group 31
Table II.1: Weights for Sampled Cases in Six Carriers 33

Figures

Figure I.1: Medicare Part B Appeals Process Before January 1, 1987 13
Figure I.2: Medicare Part B Appeals Process After Addition of ALJ and Mandatory On-the-Record Hearings 14
Figure I.3: Claims Denied in Initial Determinations by Claims Processors, for All Claimants 16
Figure I.4: Outcome of Cases Reviewed by Claims Processors, for All Claimants 18
Figure I.5: Outcome of Cases Reviewed by Hearing Officers, for All Claimants 20
Figure I.6: Hearing Officer Reviews, by Claimant Group 22
Figure I.7: On-The-Record Hearings, by Claimant Group 24
Figure I.8: On-the-Record Hearing Decisions Favoring Claimants, by Claimant Group 25
Figure I.9: Telephone and In-Person Hearings, by Claimant Group 26
Figure I.10: Telephone and In-Person Hearing Decisions Favoring Claimants, by Claimant Group 28
Figure I.11: Appeals to an ALJ, by Claimant Group 29
Figure I.12: Expected Appeals to an ALJ at Different Thresholds, by Claimant Group 30

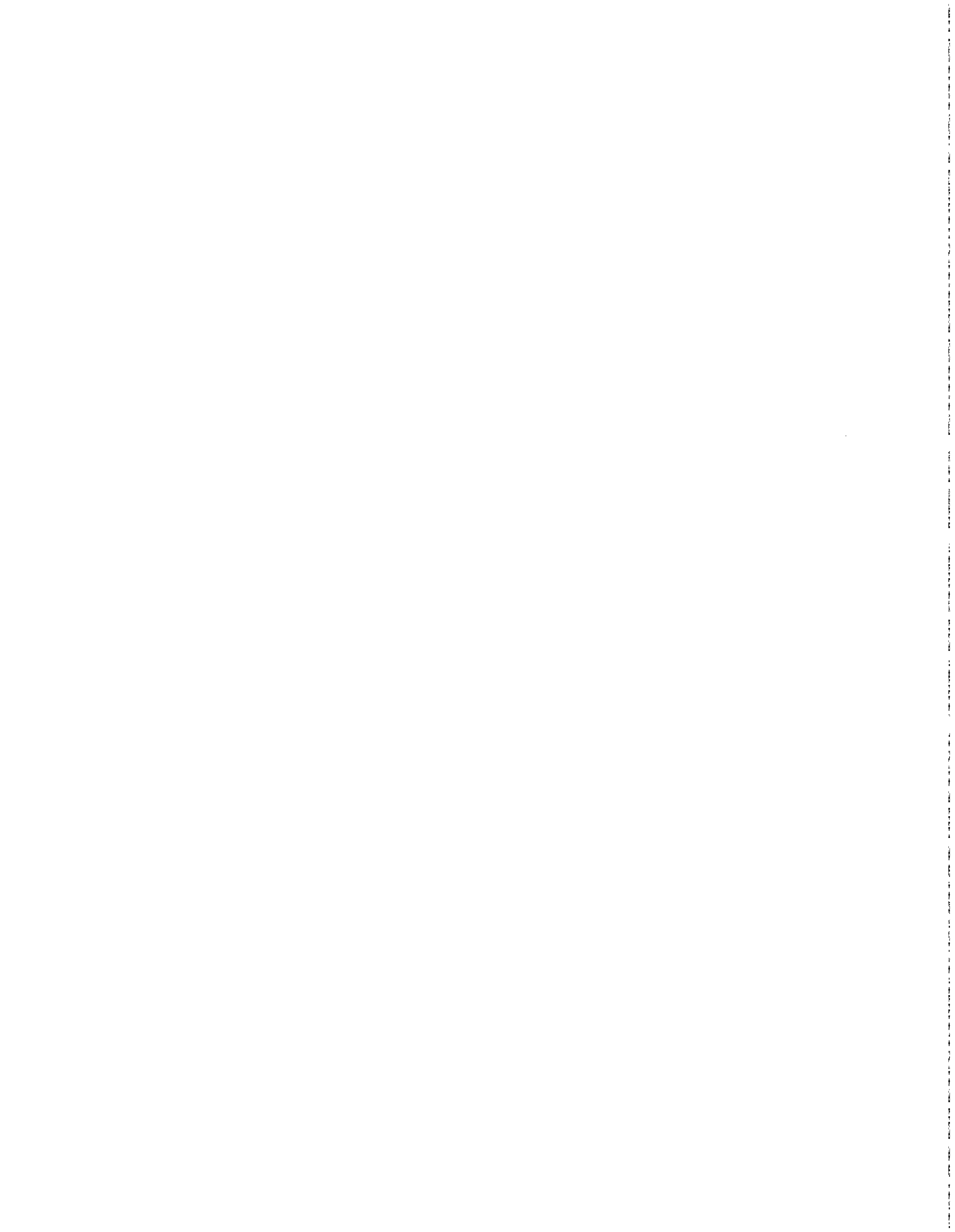


Figure IV.1: Expected Outcomes for Beneficiaries at a $500 ALJ Threshold 41
Figure IV.2: Expected Outcomes for Physicians at a $500 ALJ Threshold 42
Figure IV.3: Expected Outcomes for Nonphysicians at a $500 ALJ Threshold 43
Figure IV.4: Expected Outcomes for Beneficiaries at a $100 ALJ Threshold 44
Figure IV.5: Expected Outcomes for Physicians at a $100 ALJ Threshold 45
Figure IV.6: Expected Outcomes for Nonphysicians at a $100 ALJ Threshold 46

Abbreviations

ALJ	administrative law judge
GAO	General Accounting Office
HCFA	Health Care Financing Administration
SSA	Social Security Administration

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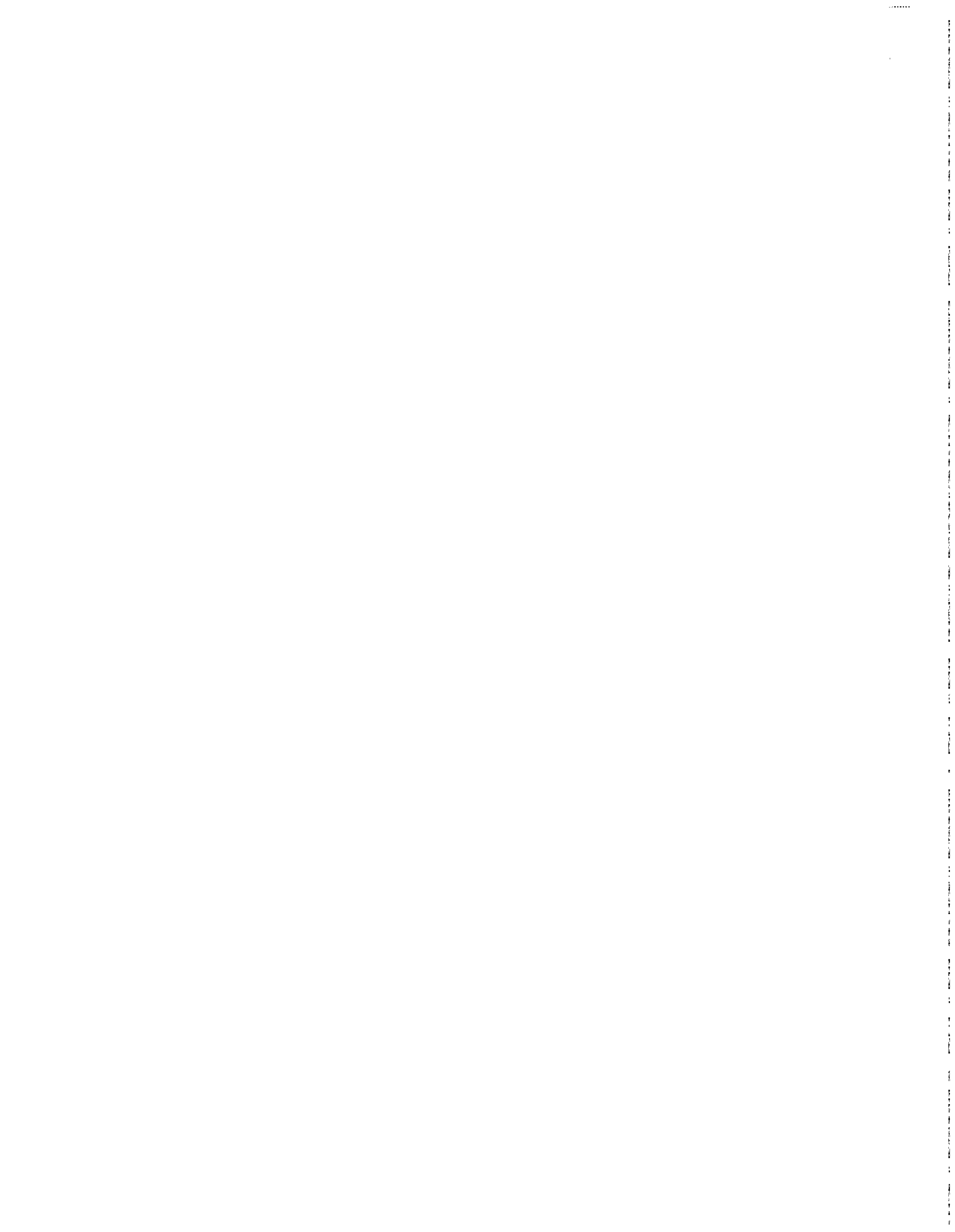


Appendix I

Part B Changes Appear to Be Fulfilling Their Purpose

How the Appeals Process Changed

Medicare Part B claims are submitted to carriers for payment for health care services provided under the program. The initial determination on coverage and amount of payment is made by a carrier claims processor. If a Medicare Part B claimant—an individual beneficiary or a medical provider such as a physician, laboratory, or supplier of medical equipment or services—is dissatisfied with the initial determination, the Medicare program provides specific appeal rights. At the carrier level, claims processors and hearing officers have key roles in the appeals process. As shown in figure I.1, before January 1987, claimants had no options for appeal beyond the carrier level.

Because claimants expressed concerns about the fairness of the process described above and its limited opportunities for appeal two significant legislative and administrative changes were made.

First, effective January 1, 1987, the Congress provided options for claimants to appeal to an ALJ and, ultimately, to the federal courts.[1] Although these options made it possible for cases to be appealed beyond the carrier, the Congress limited access to these levels of review by establishing disputed amount thresholds—$500 for appeal to an ALJ, and $1,000 for appeal to the federal courts. With this change, HCFA required all cases to go through a carrier fair hearing before being appealed.

Second, in 1988, HCFA required that essentially all cases involving $100 or more go through an on-the-record hearing before they became eligible for a telephone or in-person hearing.[2] Implementation of these requirements was phased in by carriers during the period April to June 1988. Figure I.2 shows the appeals process after the changes were made.

[1]The Omnibus Budget Reconciliation Act of 1986 (P.L. 99-509, section 9341), amending the Social Security Act

[2]Exceptions allowed by HCFA for carriers not conducting on-the-record hearings are when (1) the on-the-record hearing will significantly delay the in-person hearing requested, (2) the facts of the case can only be developed through oral testimony, and (3) a different hearing official is not available to conduct in-person hearings.

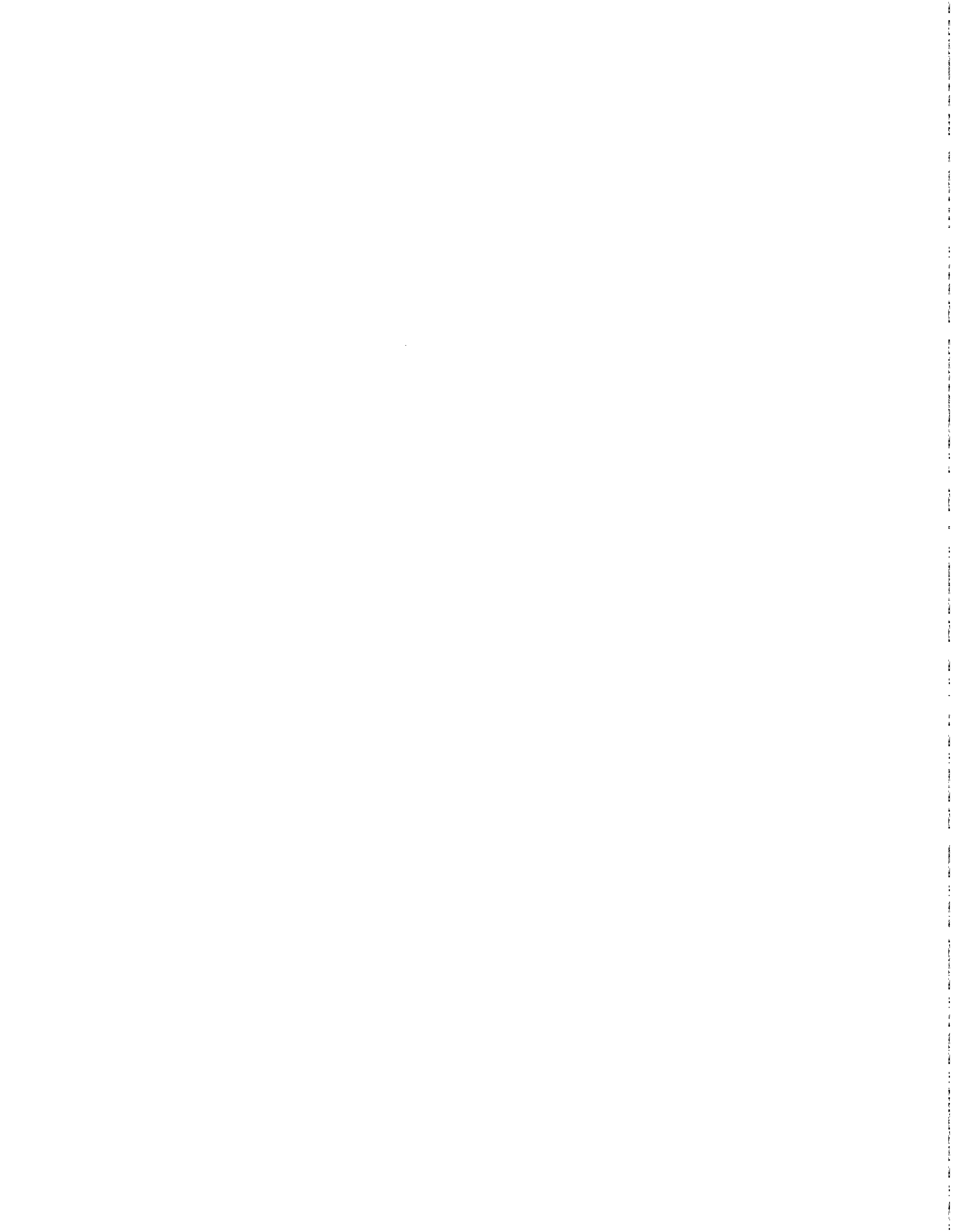
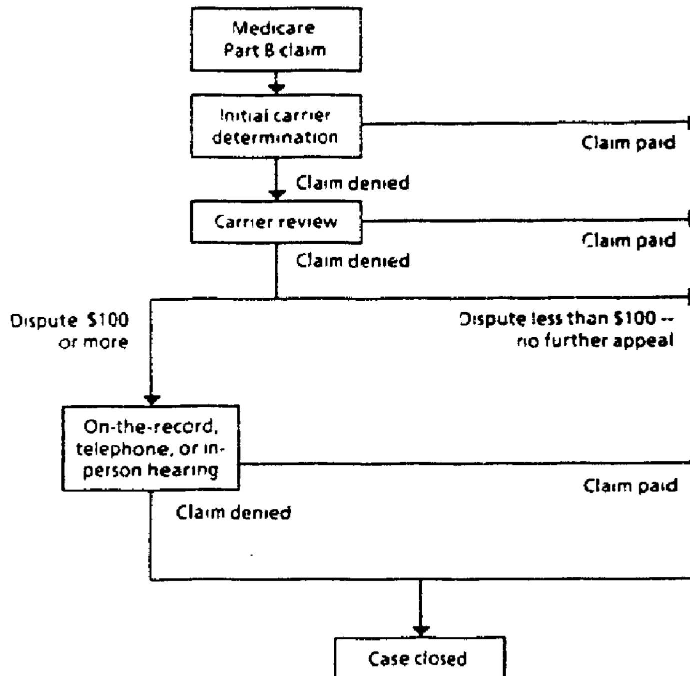


Figure I.1: Medicare Part B Appeals Process Before January 1, 1987



Notes

1 A "carrier review" is a review of written case documentation by a claims processor other than the one that made the initial determination

2 Claimants could select one of three types of hearing officer reviews all of which were referred to as "carrier fair hearings" The choices were "on-the-record," "in-person," or "telephone" The on-the-record hearings were evaluations of the written case documentation, which did not provide claimants with an opportunity to make an oral presentation or give testimony (HCFA also refers to these as "on-the record decisions") Further, if claimants selected the on-the-record hearing, they could not subsequently request an in-person or telephone hearing

3 Throughout the process, claims may be dismissed by carriers for procedural reasons, such as missed filing deadlines, or be withdrawn by the claimants.

4 A claimant may combine denied claims to meet monetary thresholds

5 At each level of review the determination made at the prior level of review may be affirmed in whole in the carrier's favor (claim denied) or reversed in whole or in part in the claimant's favor (claim paid).

6 "Disputed amount" refers to the difference between the amount billed and the amount allowed less unmet deductible and coinsurance As the case goes through the process the disputed amount may be reduced if decisions result in partial payments of the disputed amount

7 HCFA procedures allow for the reopening of cases under limited circumstances and for the acceptance of appeals filed late where "good cause" is shown

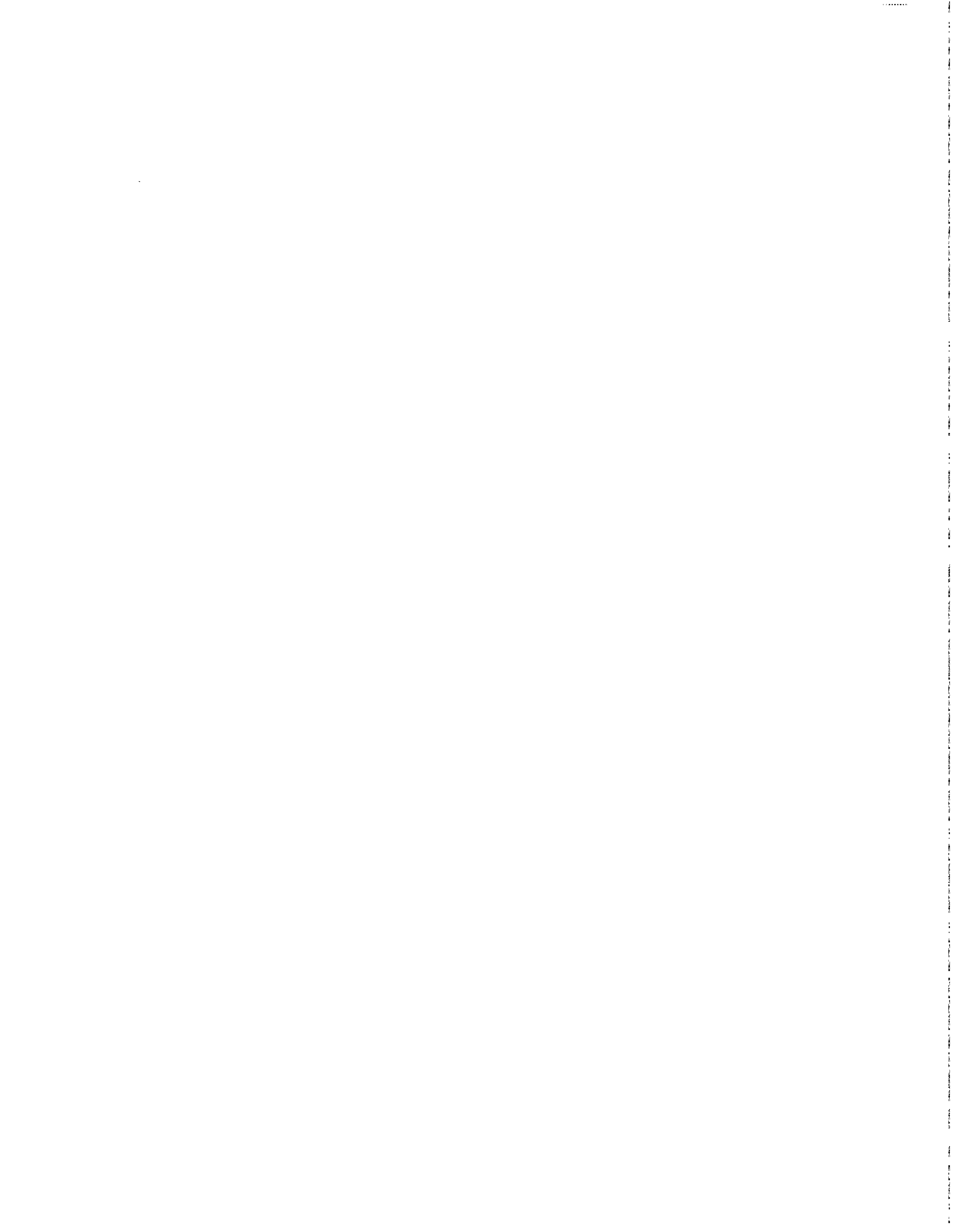
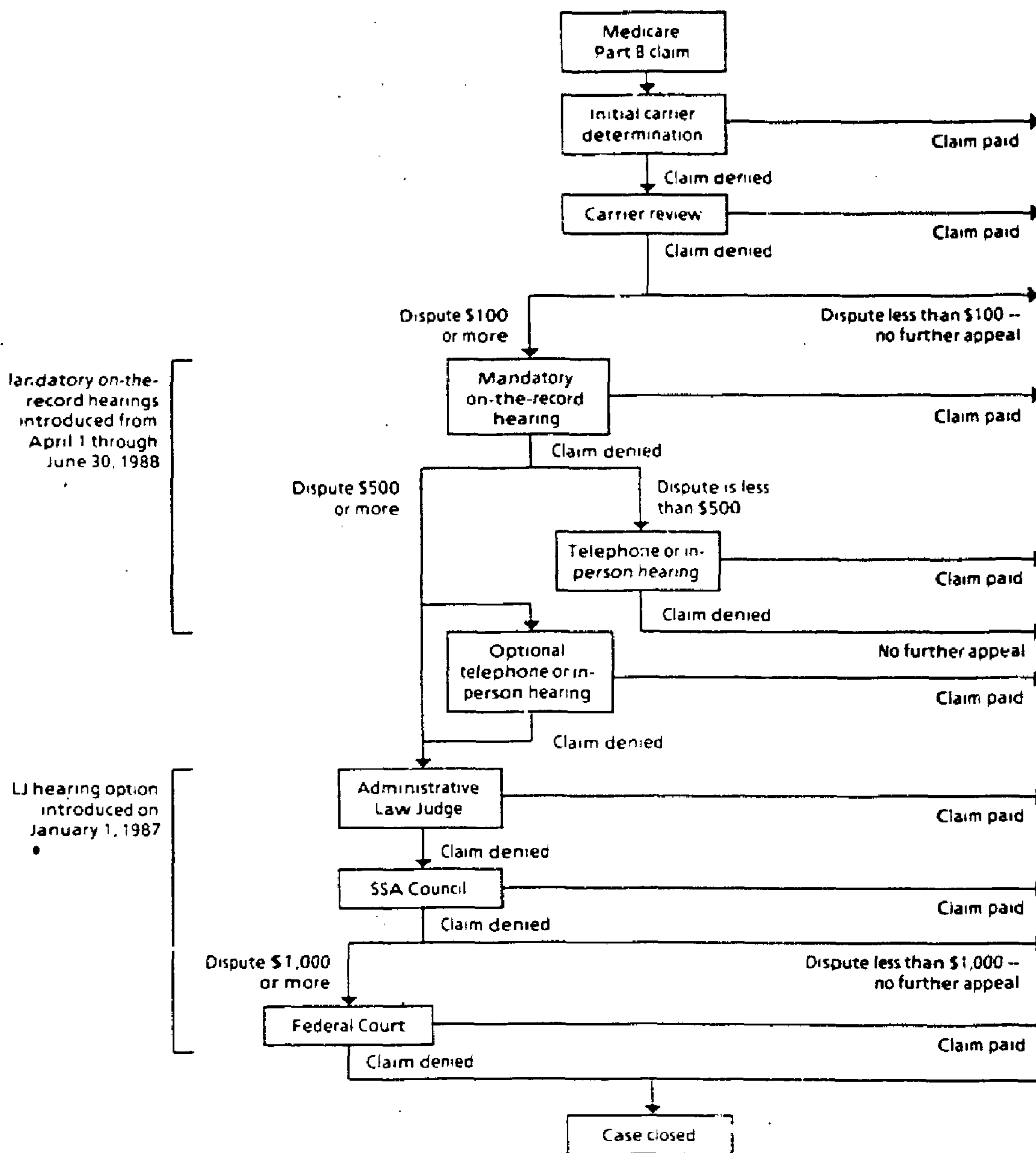


Figure I.2: Medicare Part B Appeals Process After Addition of ALJ and Mandatory On-the-Record Hearings



Notes

1 A "carrier review" is a review of written case documentation by a claims processor other than the one who made the initial determination

2 All cases appealed after the carrier review, with some exceptions are required to go through the on-the-record carrier fair hearing Claimants initially requesting the on-the-record hearing cannot subsequently request a telephone or in-person hearing

3 Throughout the process, claims may be dismissed by carriers for procedural reasons, such as missed filing deadlines or be withdrawn by the claimants

4 A claimant may combine denied claims to meet monetary thresholds

5 At each level of review, the determination made at the prior level of review may be affirmed in whole in the carrier's favor (claim denied) or reversed in whole or in part in the claimant's favor (claim paid)

6 "Disputed amount" refers to the difference between the amount billed and the amount allowed less unmet deductible and coinsurance As the case goes through the process the disputed amount may be reduced if decisions result in partial payments of the disputed amount

7 Any claim appealed to a Social Security Administration (SSA) ALJ can be further appealed to the SSA Appeals Council

8 HCFA procedures allow for the reopening of cases under limited circumstances and for the acceptance of appeals filed late where "good cause" is shown

Combined Effect of Changes on Case Outcomes at the Carrier Level

To detect changes in case outcomes that could be attributed to the introduction of mandatory on-the-record hearings and the addition of an ALJ appeals option to the Medicare Part B appeals process we analyzed HCFA data on cases reviewed and case outcomes for the period October 1984 through March 1989, aggregated by quarter for all claimants. We focused our analysis on three key steps at the carrier level: the initial claims determination, the carrier review of the initial determination, and the hearing officer review. There was little change in the percentage of claims denied in the initial determination by claims processors after introduction of the ALJ appeals option and the mandatory on-the-record hearings.[3] (See fig. I.3 and table I.1.)

[3]Statistical tests to determine if a significant difference in case outcomes existed after the introduction of the ALJ appeals option and mandatory on-the-record carrier fair hearings were found to be inappropriate for the HCFA data because of the few data points available after the changes were made

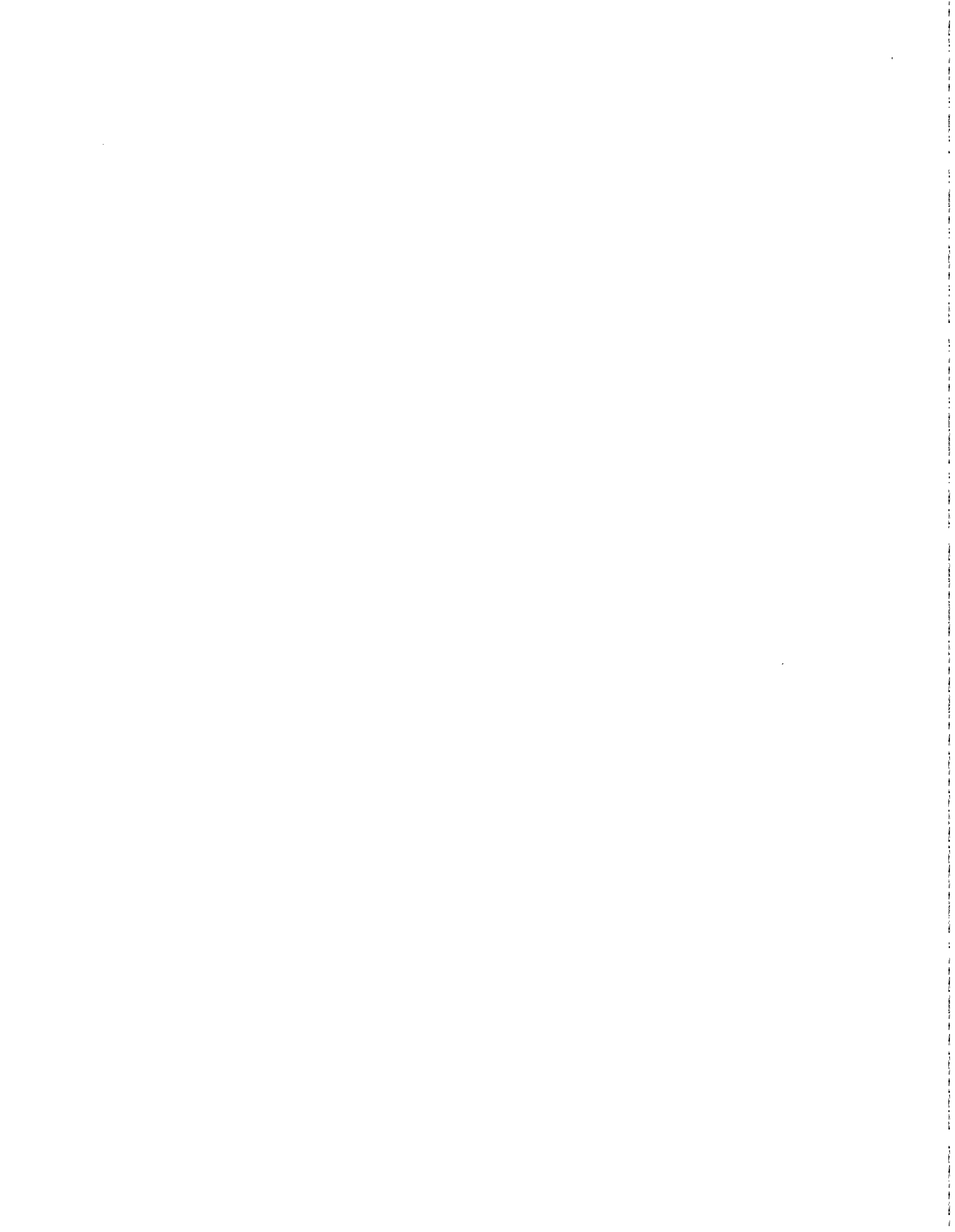
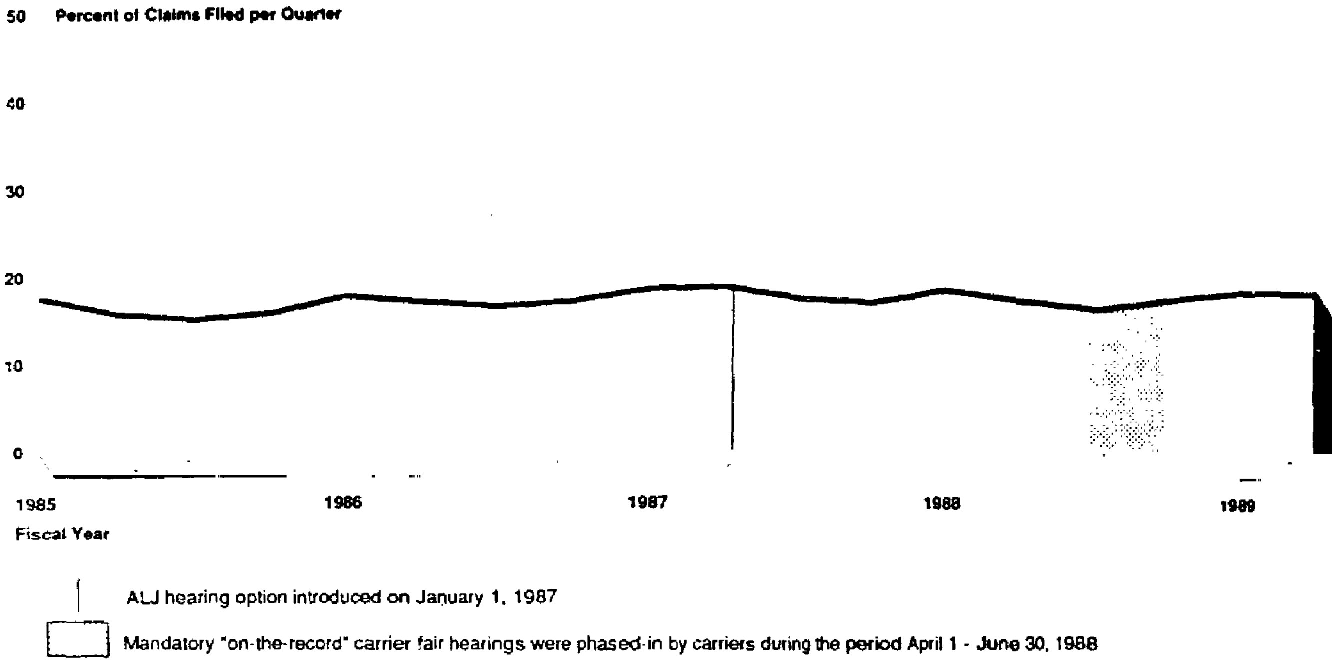


Figure I.3: Claims Denied in Initial Determinations by Claims Processors, for All Claimants (Oct 1984-Mar 1989)



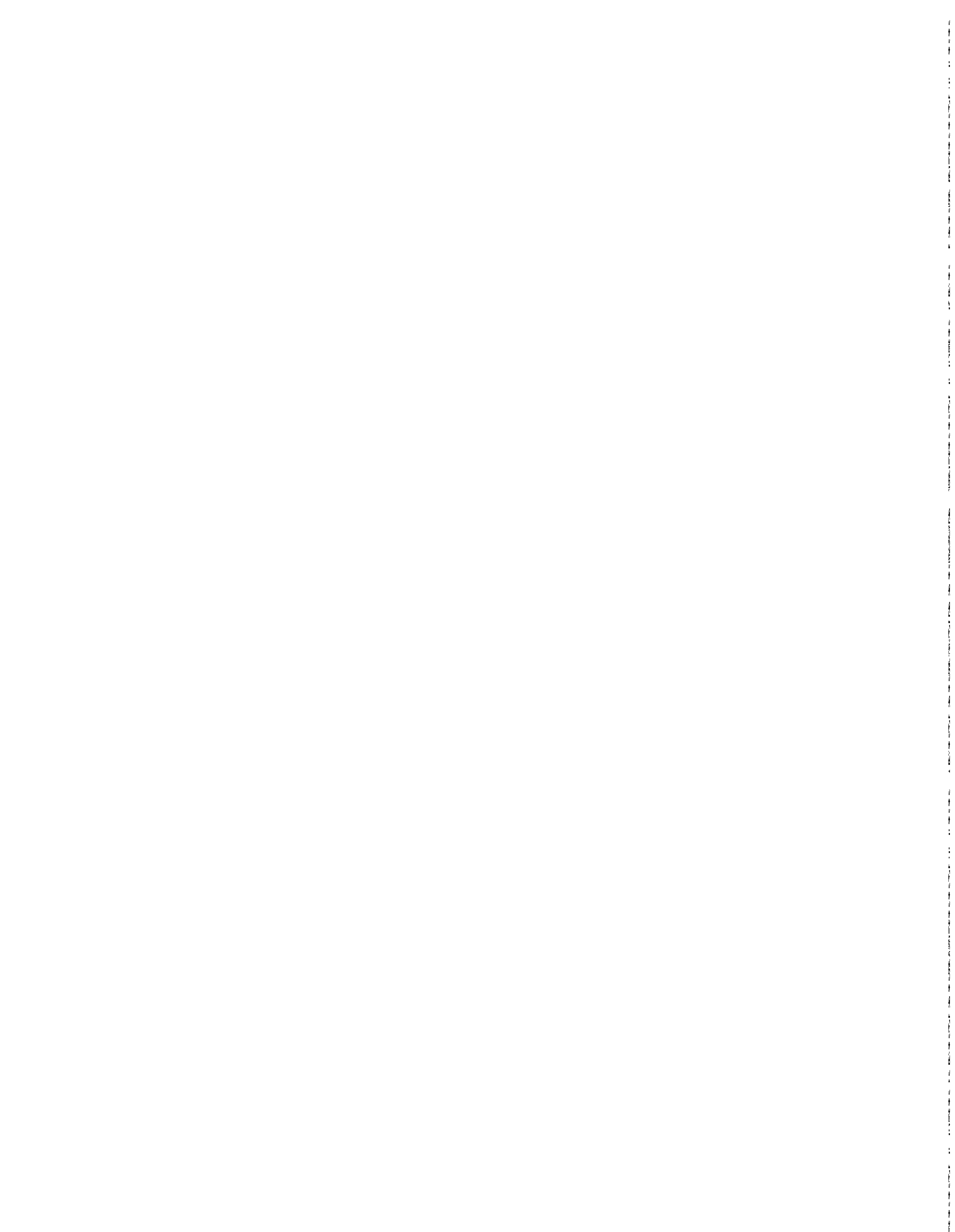


Table I.1: Claims Denied in Initial Determinations by Claims Processors, for All Claimants (Oct 1984-Mar 1989)

Fiscal year/quarter		Number of claims		
		Processed	Denied in whole or in part	Percent
1985				
	1st	60,958,980	10,620,677	17.4
	2nd	66,759,955	10,429,709	15.6
	3rd	68,562,820	10,316,489	15.0
	4th	70,935,968	11,122,829	15.7
1986				
	1st	70,766,370	12,487,655	17.6
	2nd	69,624,439	11,792,653	16.9
	3rd	76,337,481	12,508,596	16.4
	4th	82,120,878	13,925,276	17.0
1987				
	1st	77,273,969	14,224,381	18.4
	2nd	84,850,180	15,744,599	18.6
	3rd	87,724,956	15,140,995	17.3
	4th	88,413,489	14,979,330	16.9
1988				
	1st	88,445,920	16,187,746	18.3
	2nd	94,248,452	16,072,492	17.1
	3rd	97,799,881	15,887,506	16.2
	4th	96,422,182	16,591,504	17.2
1989				
	1st	94,607,707	17,133,378	18.1
	2nd	101,917,076	18,381,551	18.0

At the carrier review level, after the legislative and administrative changes were made, the percentage of cases dismissed or withdrawn increased, particularly after the introduction of mandatory on-the-record reviews. However, the data give no indication of a significant change in the percentage of carrier reviews that affirmed or reversed the initial determination.[4] (See fig. I.4 and table I.2.)

[4] Statistical tests to determine if a significant difference in case outcomes existed after the introduction of the ALJ appeals option and on-the-record reviews were found to be inappropriate for the HCFA data because of the few data points available after the changes were made.

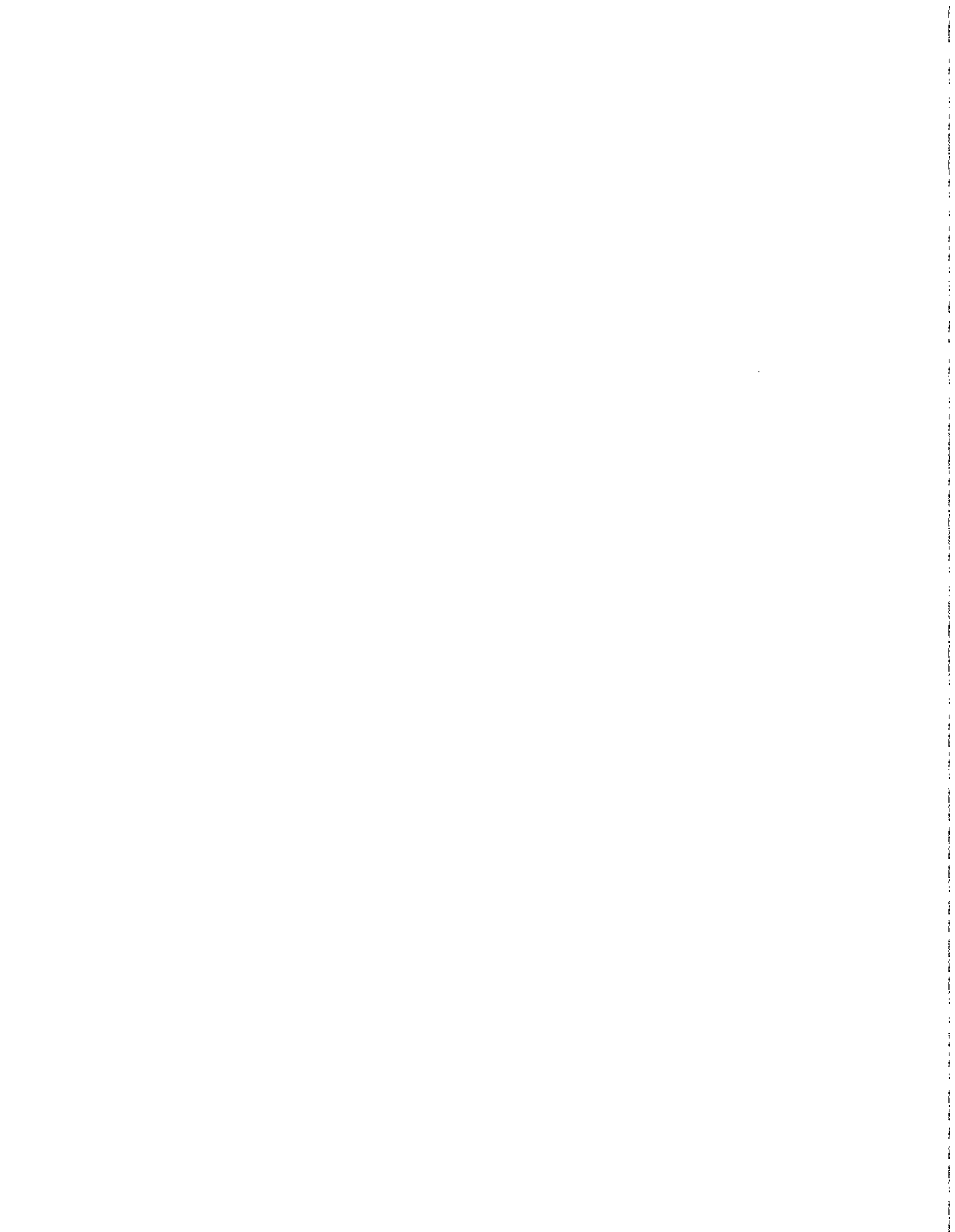
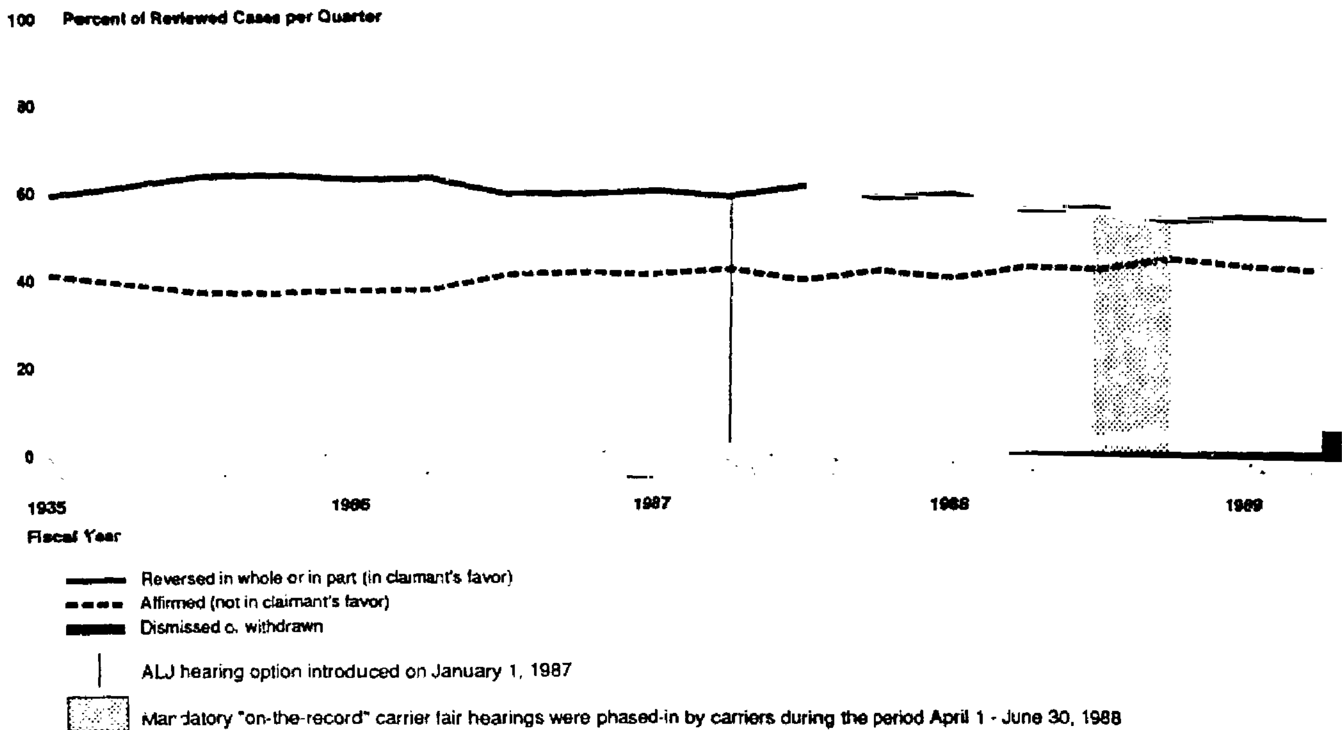


Figure I.4: Outcome of Cases Reviewed by Claims Processors, for All Claimants (Oct. 1984-Mar. 1989)



Note These are administrative reviews of the claimants paperwork made by a carrier claims processor other than the one who made the initial claims payment or coverage determinations.

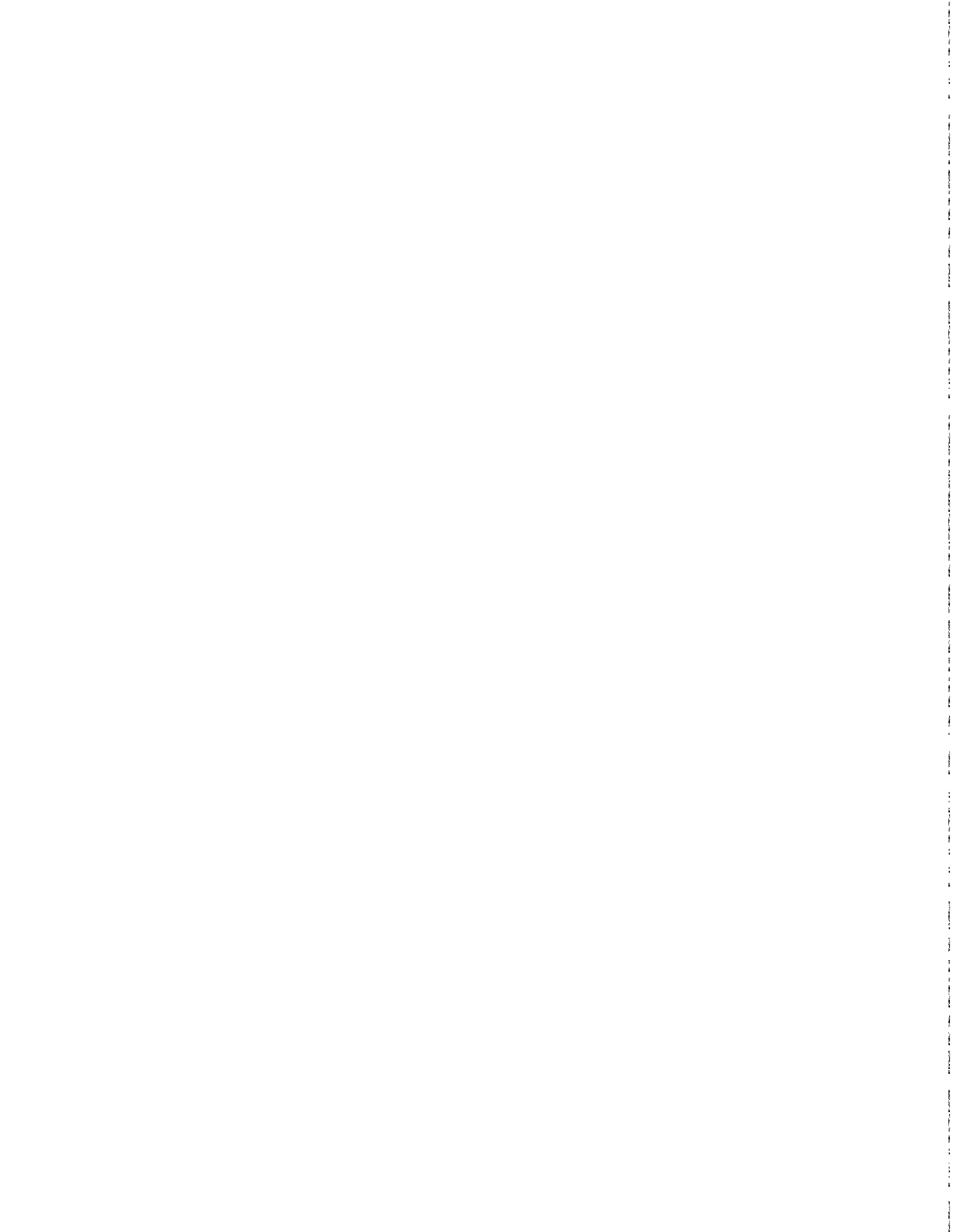


Table I.2: Outcome of Cases Reviewed by Claims Processors, for All Claimants (Oct. 1984-Mar. 1989)

Fiscal year/quarter	Number of reviews	Review decisions: Affirmed No.	Affirmed Percent	Reversed in whole or in part No.	Reversed in whole or in part Percent	Dismissed/withdrawn No.	Dismissed/withdrawn Percent
1985							
1st	808,590	329,637	40 8	476,644	59.0	2,309	0 3
2nd	9[illegible]5.333	364,739	38 6	577,109	61.0	3,485	0.4
3rd	979.316	357,491	36 5	618,140	63.1	3,685	0.4
4th	1.002,787	363,718	36 3	633,925	63.2	5,144	0.5
1986							
1st	1,035,263	380,559	36 8	643,115	62.1	11,589	1 1
2nd	1,182,726	436,750	36 9	738,396	62.4	7,580	0 6
3rd	1,119,511	451,818	40 4	658,674	58.8	9,019	0.8
4th	1,230,776	502,77[illegible]	40 9	722,347	58.7	5,656	0.5
1987							
1st	1,158,441	466,414	40 3	686,655	59.3	5,372	0.5
2nd	1,324,846	550,127	41 5	767,808	58.0	6,911	0.5
3rd	1,455,169	569,124	39 1	878,555	60.4	7,490	0.5
4th	1,538,966	636,058	41 3	888,286	57.8	14,622	1.0
1988							
1st	1,237,490	490,852	39 7	726,457	58.7	20,181	1.6
2nd	1,351,742	571,618	42 3	746,299	55.2	33,825	2.5
3rd	1 519,662	632,225	41 7	845,357	55 6	42,080	2.8
4th	1,596,937	702,986	44 0	841,076	52 7	52,875	3.3
1989							
1st	1,314,340	555,714	42 3	702,759	53.5	55,867	4.3
2nd	1,34[illegible],360	550,426	41 1	706,401	52.7	83,533	6.2

At the hearing-officer level, the percentage of cases affirmed by carrier hearing officers increased after the introduction of mandatory on-the-record hearings. (See fig. I.5 and table I.3.)[5]

[5]Statistical tests to determine if a significant difference existed in the percentage of cases affirmed after the introduction of the ALJ appeals option and on-the-record reviews were found to be inappropriate because of the few data points available after the introduction of these changes.

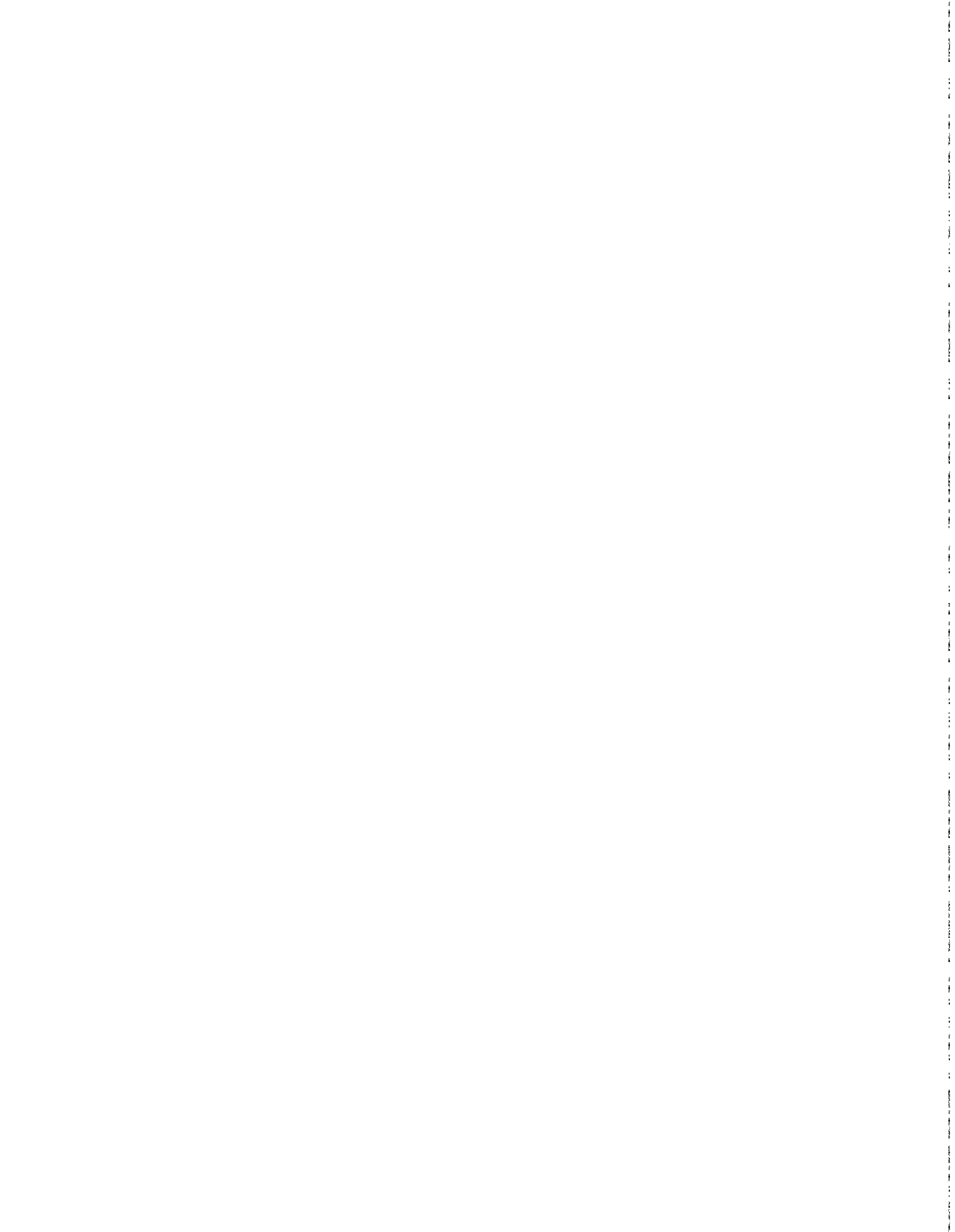
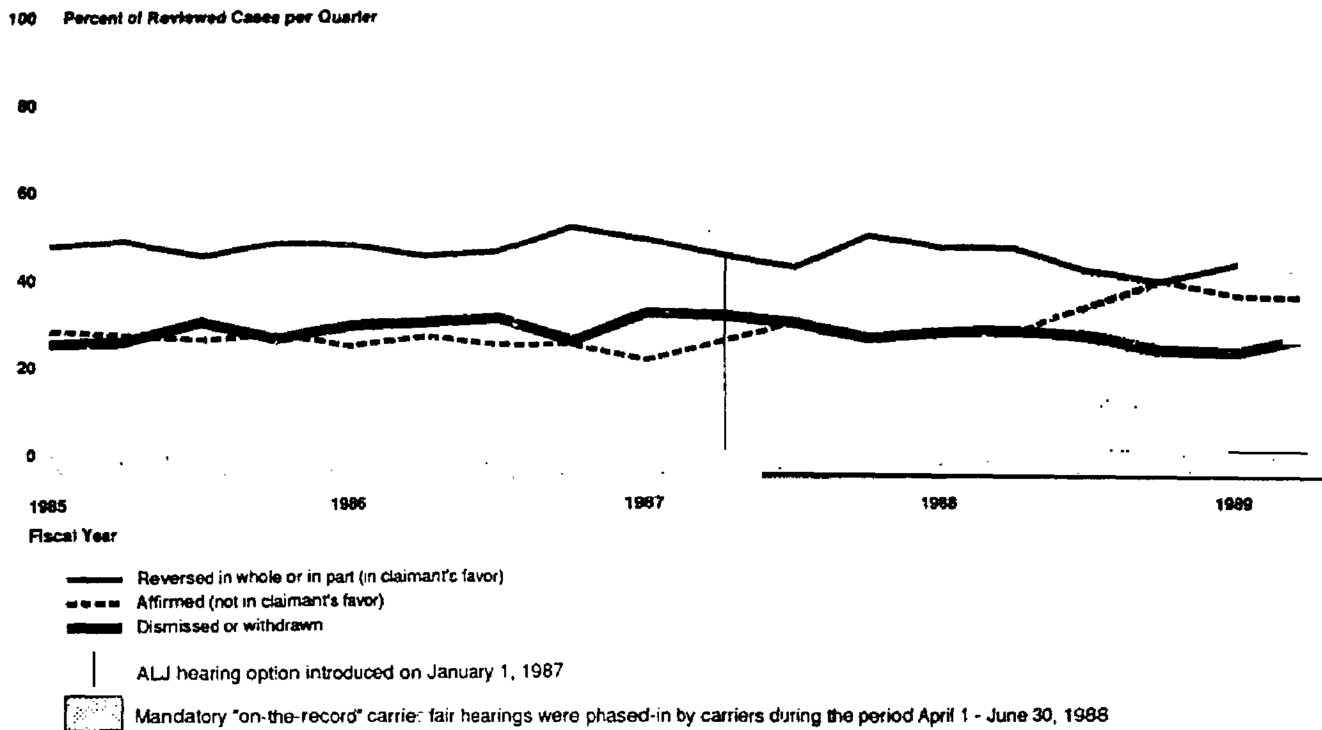
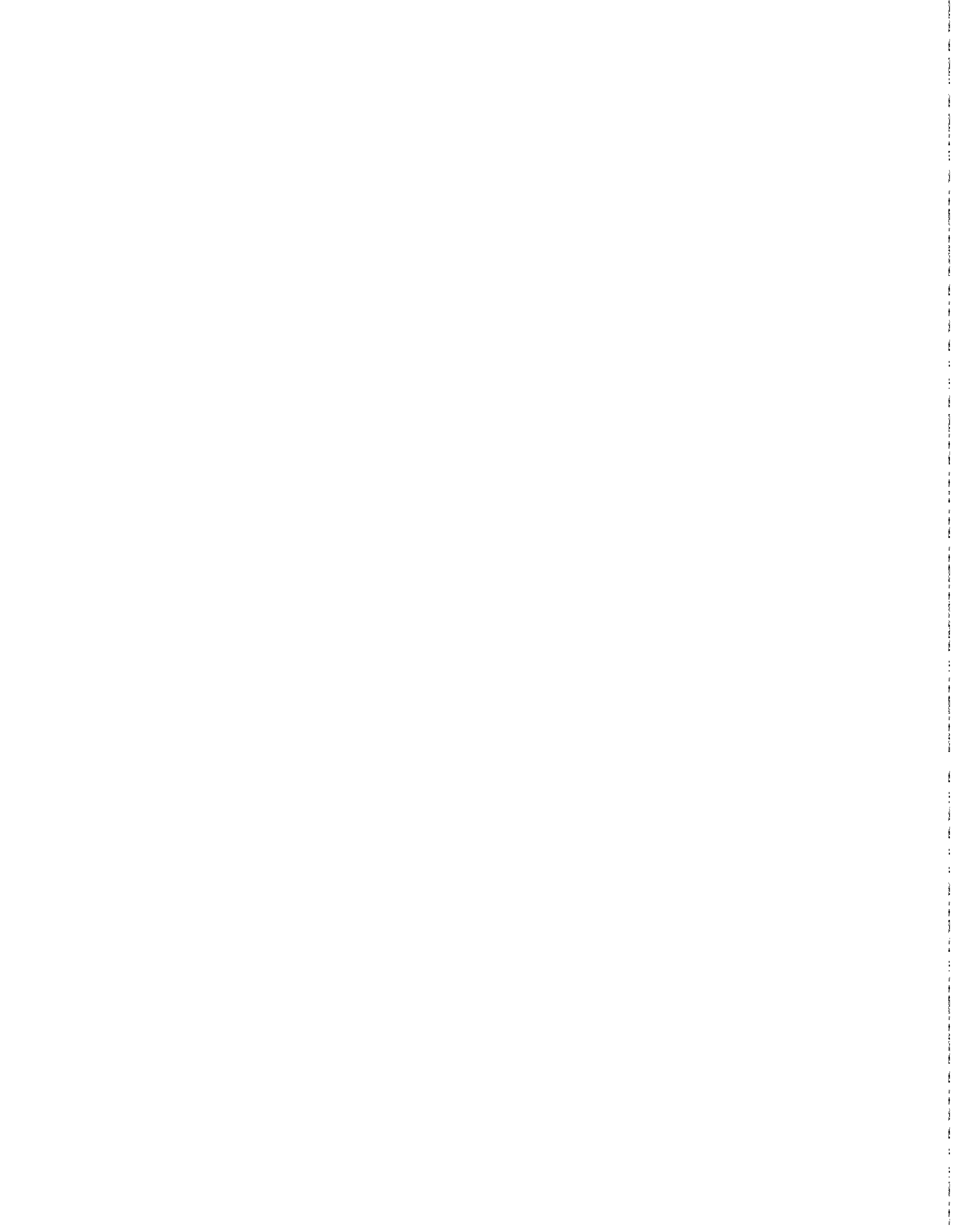


Figure I.5: Outcome of Cases Reviewed by Hearing Officers, for All Claimants (Oct. 1984-Mar. 1989)



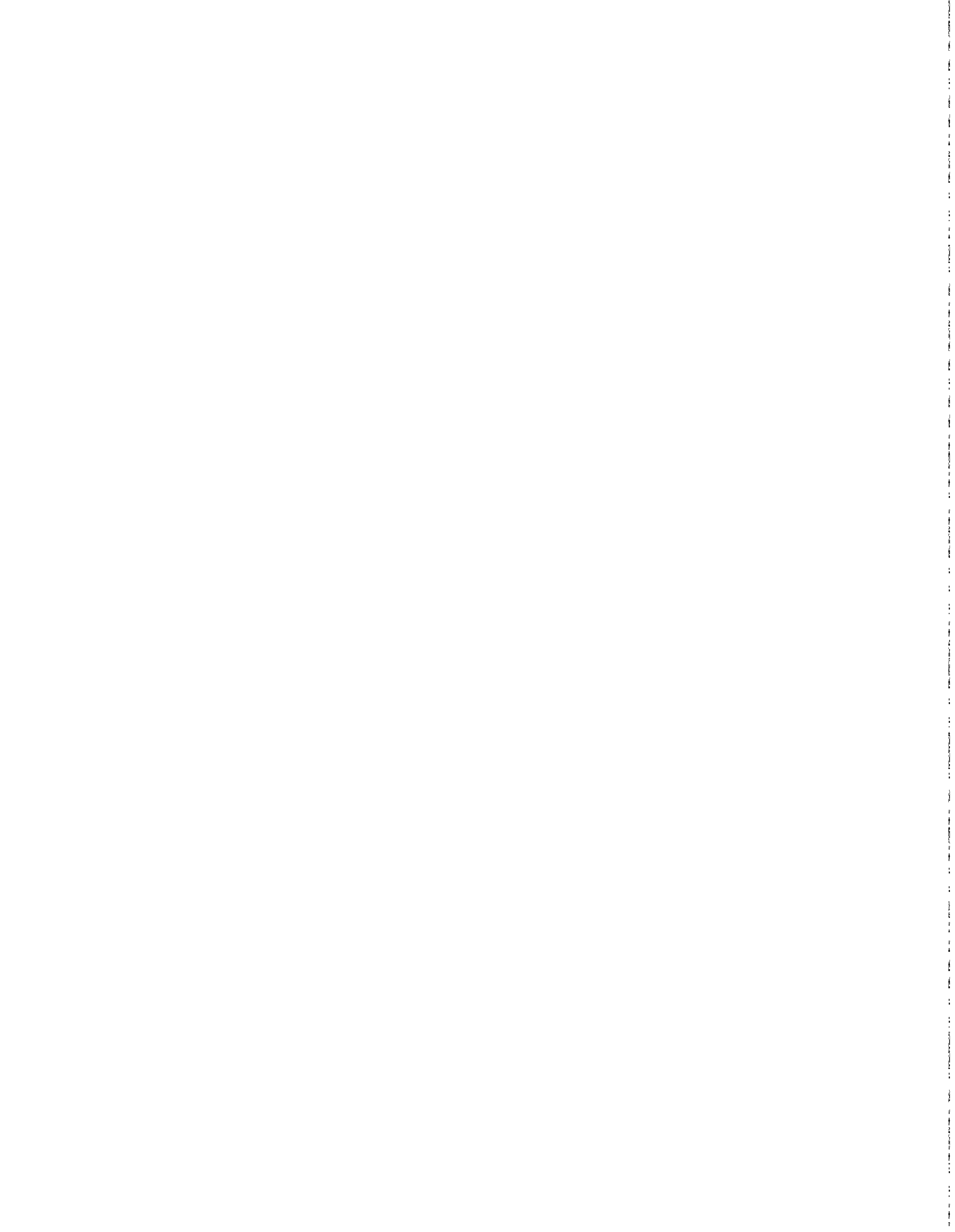


ble I.3: Outcome of Cases Reviewed by Hearing Officers, for All Claimants (Oct 1984-Mar 1989)

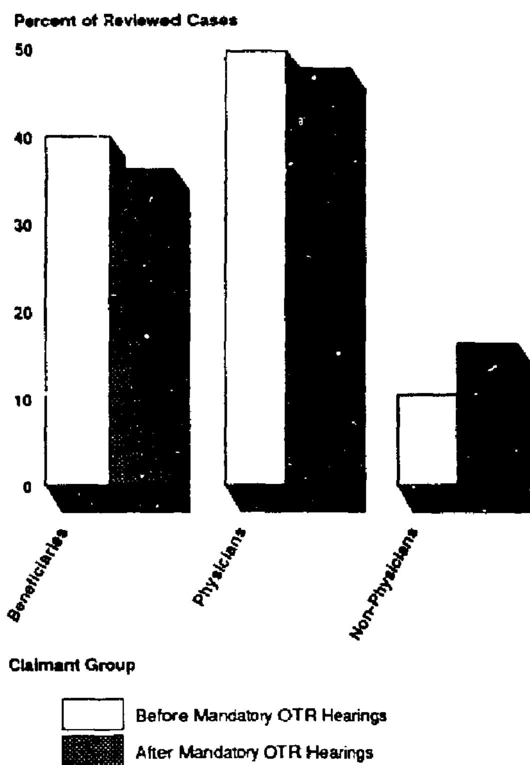
		Review Decisions					
	Number of reviews	Affirmed		Reversed in whole or in part		Dismissed/withdrawn	
scal year/quarter		No.	Percent	No.	Percent	No.	Percent
85							
1st	7,354	2,046	27.8	3,477	47.3	1,831	24.9
2nd	7,650	2,054	26.8	3,699	48.4	1,927	25.2
3rd	8,231	2,107	25.6	3,690	44.8	2,434	29.6
4th	7,271	1,933	26.6	3,467	47.7	1,871	25.7
86							
1st	7,194	1,729	24.0	3,399	47.2	2,066	28.7
2nd	8,287	2,161	26.1	3,695	44.6	2,431	29.3
3rd	9,175	2,219	24.2	4,182	45.6	2,774	30.2
4th	10,606	2,555	24.1	5,405	51.0	2,646	24.9
87							
1st	9,590	1,976	20.6	4,608	48.1	3,006	31.3
2nd	10,288	2,536	24.7	4,590	44.6	3,162	30.7
3rd	13,598	3,976	29.2	5,679	41.8	3,943	29.0
4th	14,890	3,762	25.3	7,312	49.1	3,816	25.6
88							
1st	13,679	3,644	26.6	6,344	46.4	3,691	27.0
2nd	17,277	4,597	26.6	7,979	46.2	4,701	27.2
3rd	17,952	5,890	32.8	7,385	41.1	4,677	26.1
4th	18,724	7,239	38.7	7,223	38.6	4,262	22.8
89							
1st	14,819	5,236	35.3	6,285	42.4	3,298	22.3
2nd	15,873	5,525	34.8	6,274	39.5	4,074	25.7

hanges in Cases eviewed by Hearing fficers After the troduction of andatory On-the-ecord Hearings

Data obtained from 47 Medicare carriers indicate that the majority of cases reviewed by carrier hearing officers before and after the introduction of mandatory on-the-record hearings involved physician claims. However, the percentage of physician and beneficiary claims reviewed decreased after the introduction of the mandatory hearings, while the percentage of claims involving nonphysicians showed the only increase (from 10.4 to 16.2 percent). (See fig. I.6. and table I.4.)



gure I.6: Hearing Officer Reviews, by aimant Group (Jan. 1987-Mar. 1989)



Note: Reviews by carrier hearing officers include "on-the-record," "telephone," and "in-person" carrier fair hearings

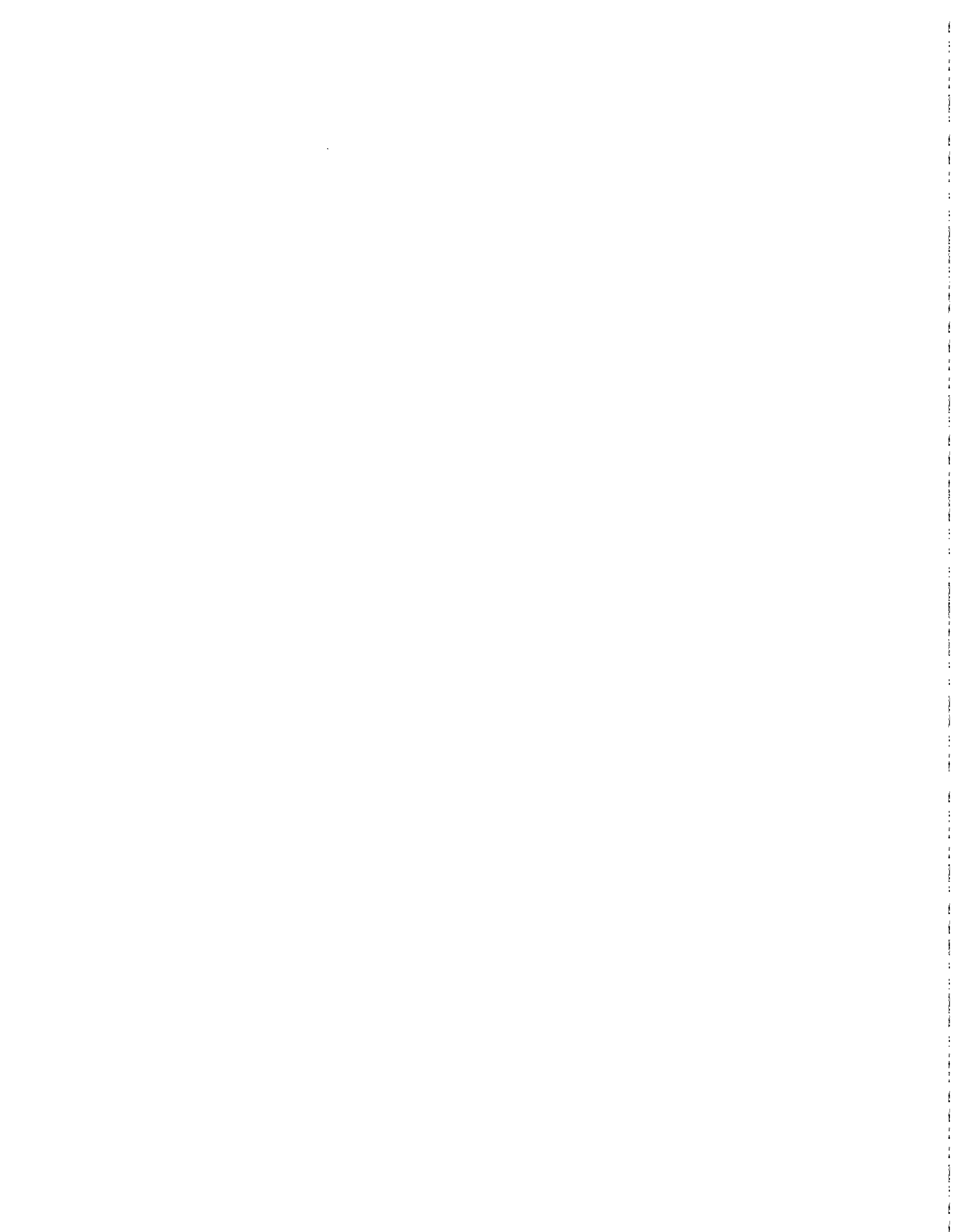
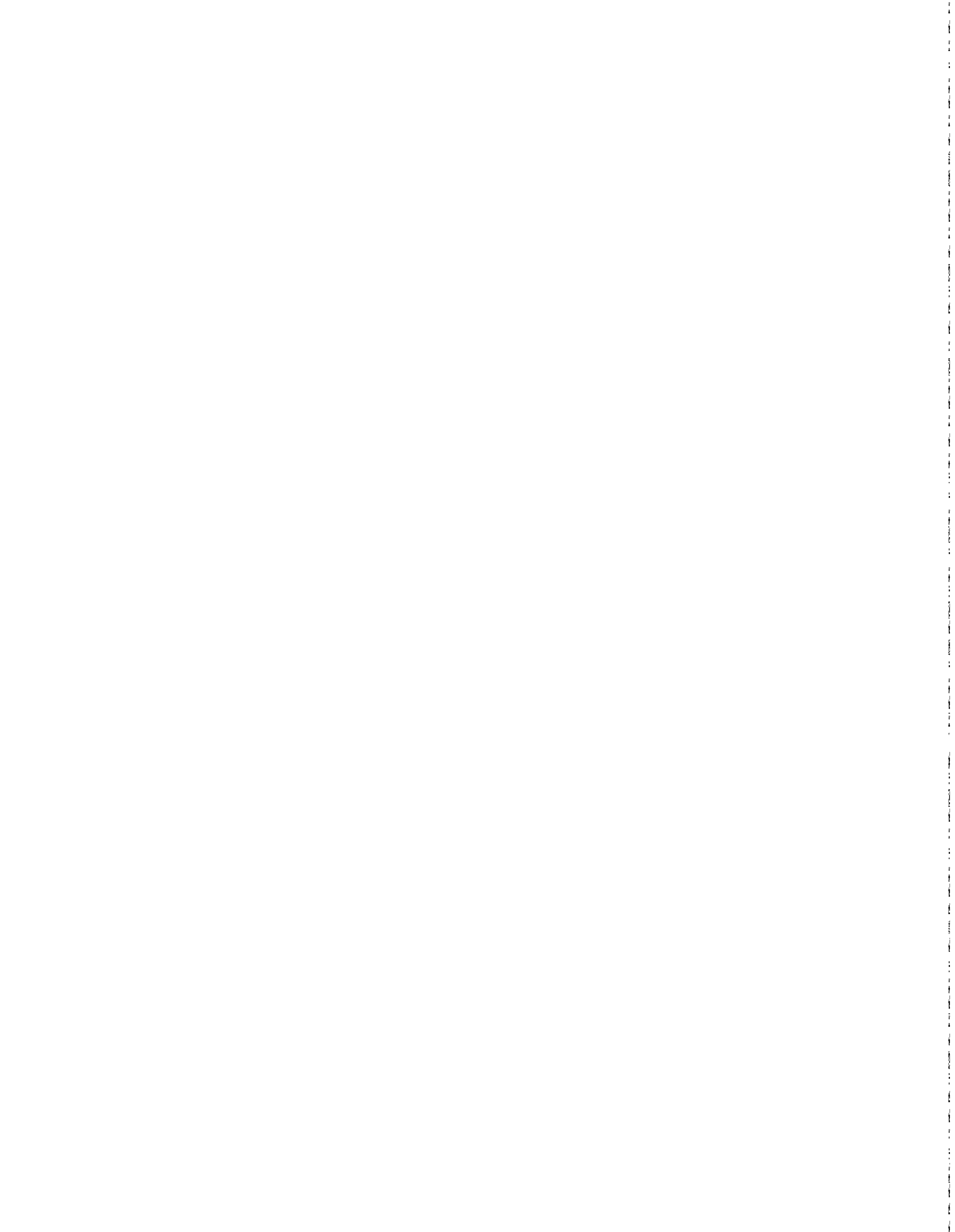


Table I.4: Hearing Officer Reviews, by Claimant Group (Jan 1987-Mar. 1989)

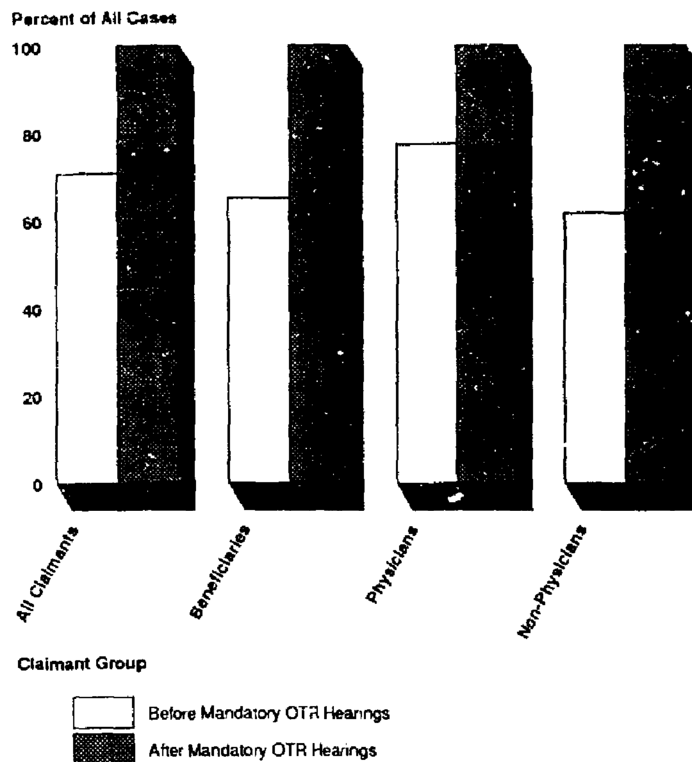
	Cases reviewed			
	Before		After	
Claimant group	Number	Percent	Number	Percent
Beneficiaries	10,000	40.0	7,600	36.2
Physicians	12,400	49.6	10,000	47.6
Nonphysicians	2,600	10.4	3,400	16.2
All claimants	**25,000**	**100.0**	**21,000**	**100.0**

Note: These data reflect the number of cases, rounded to the nearest hundred, that were reviewed by hearing officers at the carriers participating in our study. The "before" analysis includes cases reviewed from the introduction of the ALJ appeals option on January 1, 1987, to the time each carrier introduced the mandatory on-the-record hearings (sometime during the period April to June 1988). The "after" analysis includes cases reviewed by each carrier from the time each carrier introduced the mandatory on-the-record hearings to March 1989, the most current data available at the time we collected data from the carriers.

Before the introduction of the mandatory on-the-record hearings, 70.8 percent of all cases had an on-the-record hearing at the carrier level compared with 100 percent when these hearings were made mandatory. While a greater percentage of cases for all claimant groups had an on-the-record hearing after they were made mandatory, cases involving nonphysicians had the greatest increase. (See fig. I.7 and table I.5.)



igure I.7: On-the-Record Hearings, by laimant Group (Jan 1987-Mar 1989)

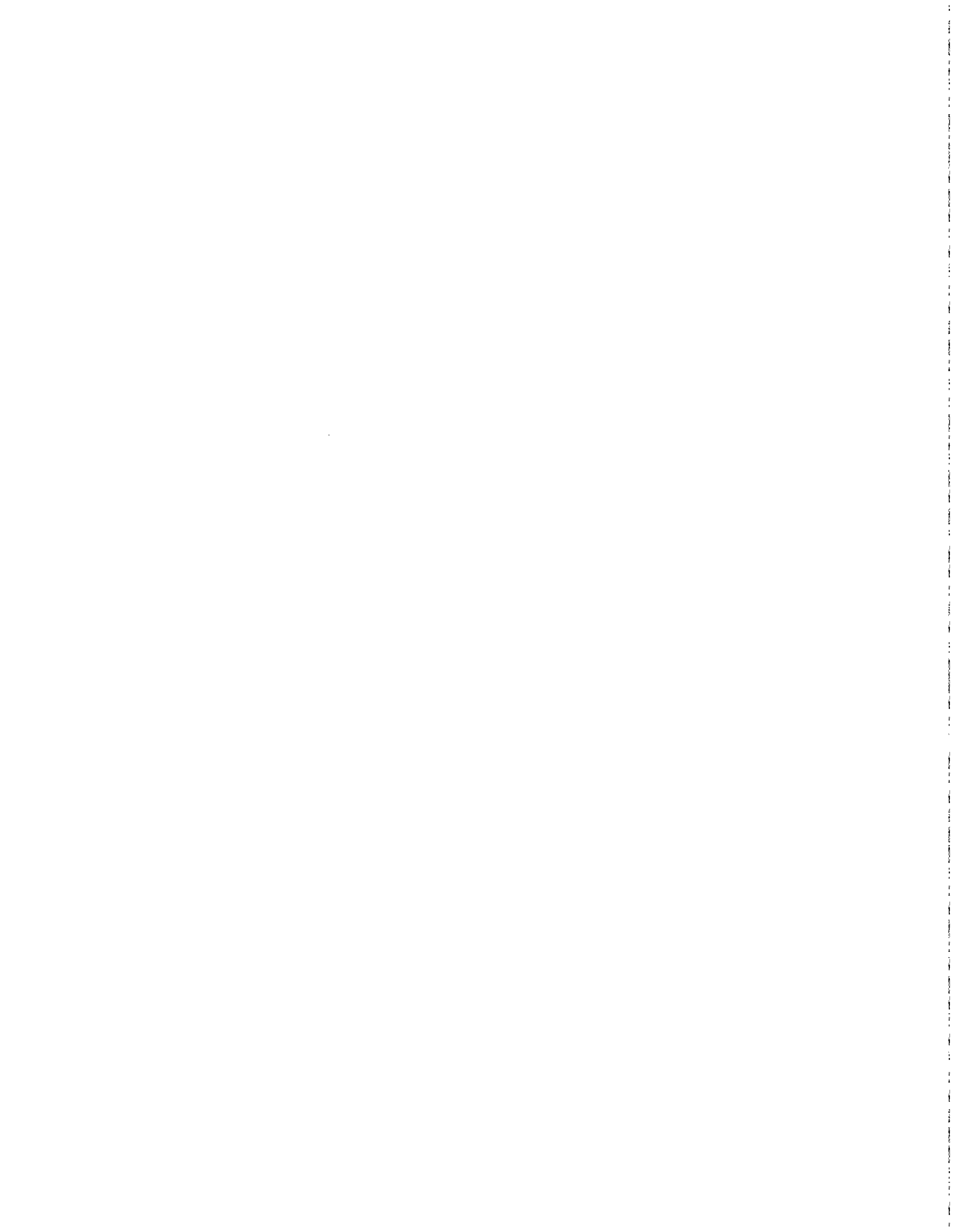


Note An on-the-record carrier fair hearing is an evaluation of written case documentation by a carrier hearing officer

able I.5: On-the-Record Hearings, by laimant Group (Jan 1987-Mar 1989)

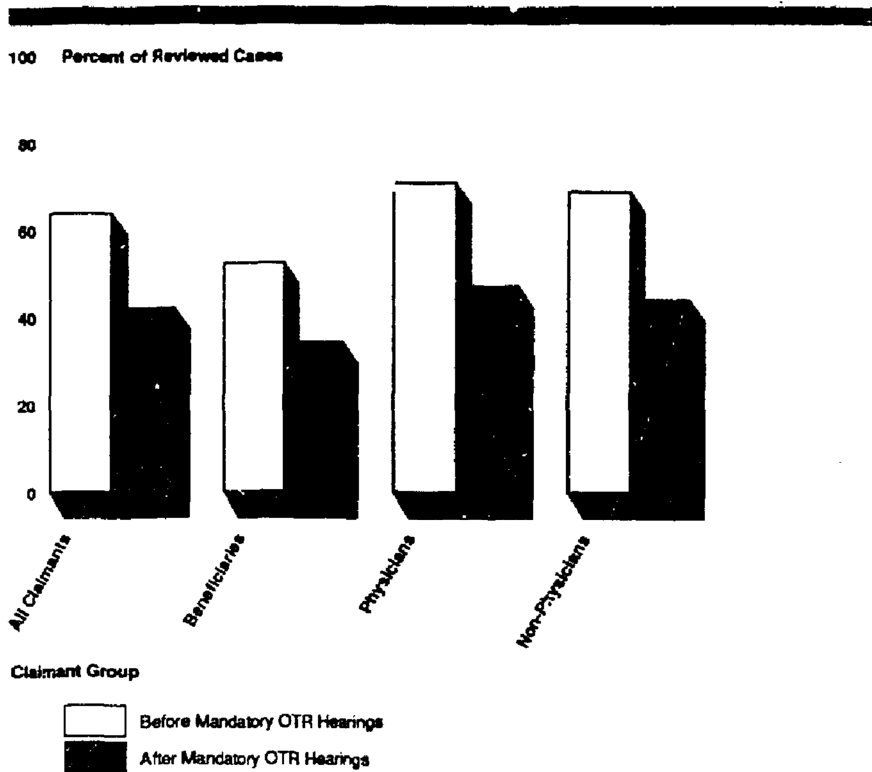
	Before			After		
Claimant group	Total cases	On-the-record hearings	Percent	Total cases	On-the-record hearings	Percent
Beneficiaries	10,000	6,500	65.0	7,600	7,600	100.0
Physicians	12,400	9,600	77.4	10,000	10,000	100.0
Nonphysicians	2,600	1,600	61.5	3,400	3,400	100.0
All claimants	**25,000**	**17,700**	**70.8**	**21,000**	**21,000**	**100.0**

The percentage of on-the-record hearings that resulted in payments to claimants was greater for all three claimant groups before these hearings were made mandatory. Physicians had the highest percentage of favorable decisions (70.8 percent). After the introduction of mandatory



on-the-record hearings, physicians still had the highest percentage of favorable decisions (47.0 percent) while all claimants had a favorable rate of 41.9 percent. (See fig. I.8 and table I.6.)

Figure I.8: On-the-Record Hearing Decisions Favoring Claimants, by Claimant Group (Jan. 1987-Mar. 1989)

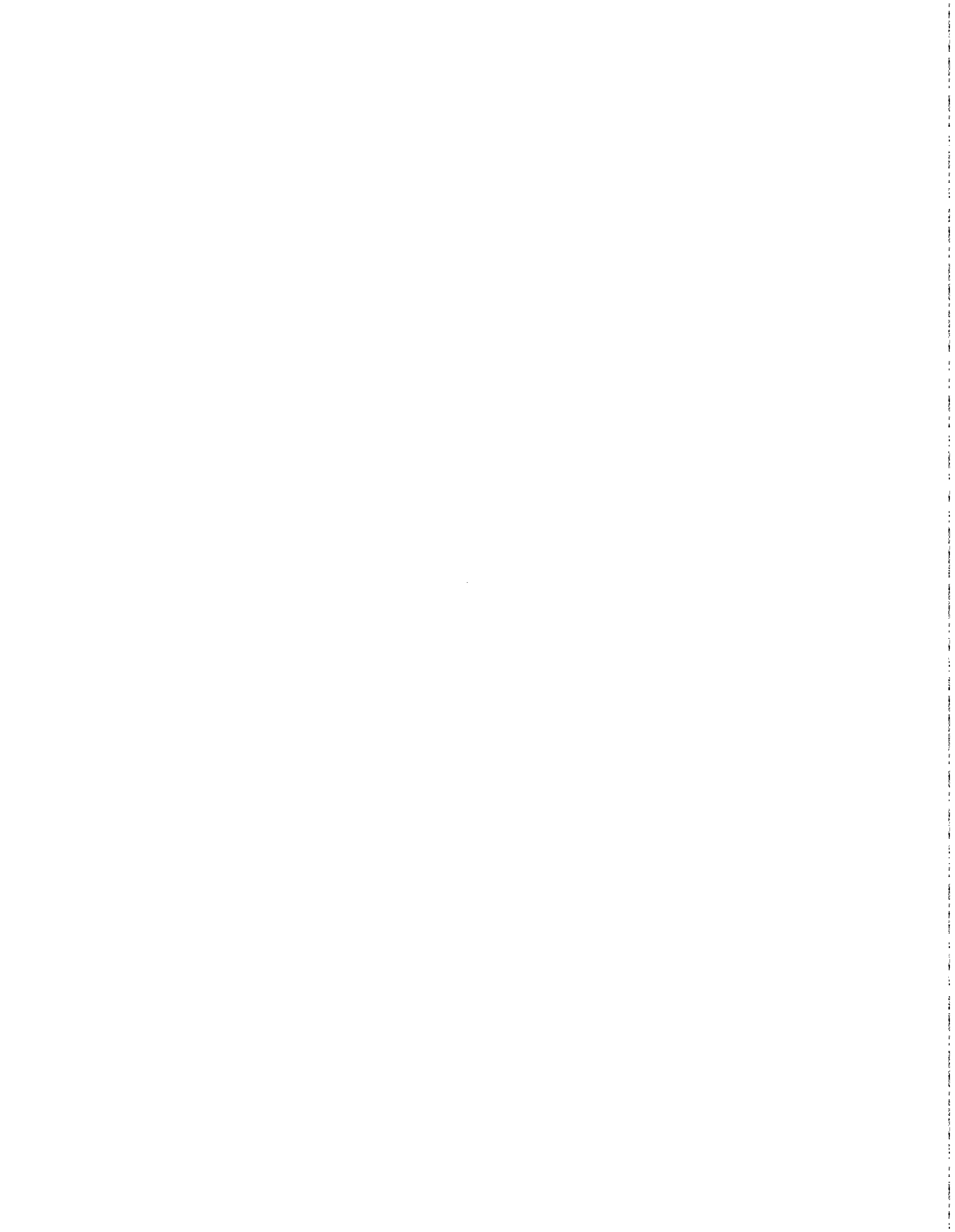


Note An "on-the-record" carrier fair hearing is an evaluation of written case documentation by a carrier hearing officer

Table I.6: On-the-Record Hearing Decisions Favoring Claimants, by Claimant Group (Jan 1987-Mar. 1989)

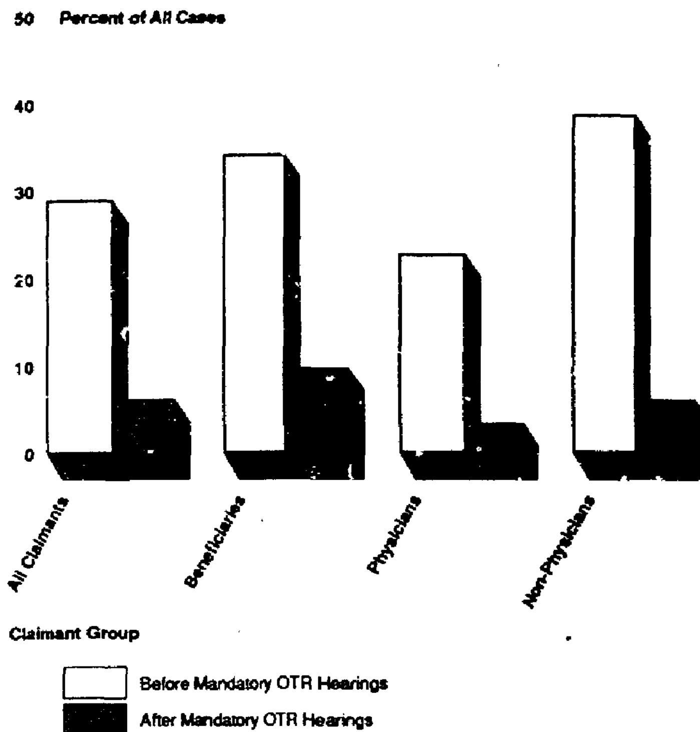
	Before			After		
Claimant group	**Cases reviewed**	**Favorable decisions**	**Percent**	**Cases reviewed**	**Favorable decisions**	**Percent**
Beneficiaries	6,500	3,400	52.3	7,600	2,600	34.2
Physicians	9,600	6,800	70.8	10,000	4,700	47.0
Nonphysicians	1,600	1,100	68.8	3,400	1,500	44.1
All claimants	**17,700**	**11,300**	**63.8**	**21,000**	**8,800**	**41.9**

Note For this analysis a favorable decision is defined as one that reverses, in whole or in part, the carrier's prior decision and results in a payment to the claimant



The percentage of cases that had a telephone or in-person hearing ranged from 22.6 percent for physicians to 38.5 percent for nonphysicians before on-the-record hearings were made mandatory. By comparison, after these hearings were made mandatory, the percentage of cases having a telephone or in-person hearing was significantly lower for all three claimant groups—3.2 percent for physicians, 5.9 percent for nonphysicians, and 9.6 percent for beneficiaries. (See fig. I.9 and table I.7.)

Figure I.9: Telephone and In-Person Hearings, by Claimant Group
(Jan. 1987-Mar. 1989)



Note: "Telephone" and "In-person" carrier fair hearings are conducted by a carrier hearing officer and provide claimants with an opportunity to give oral testimony.

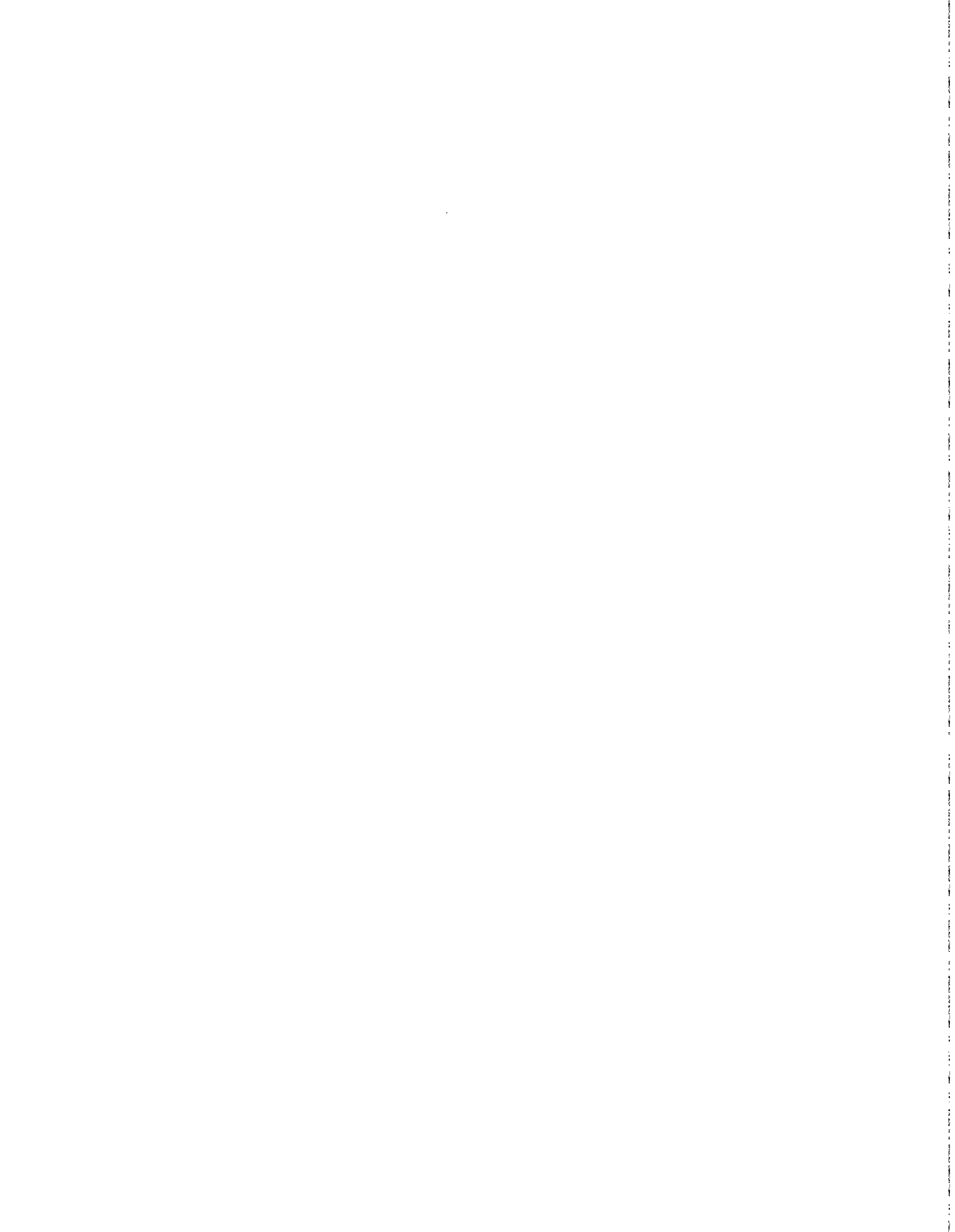
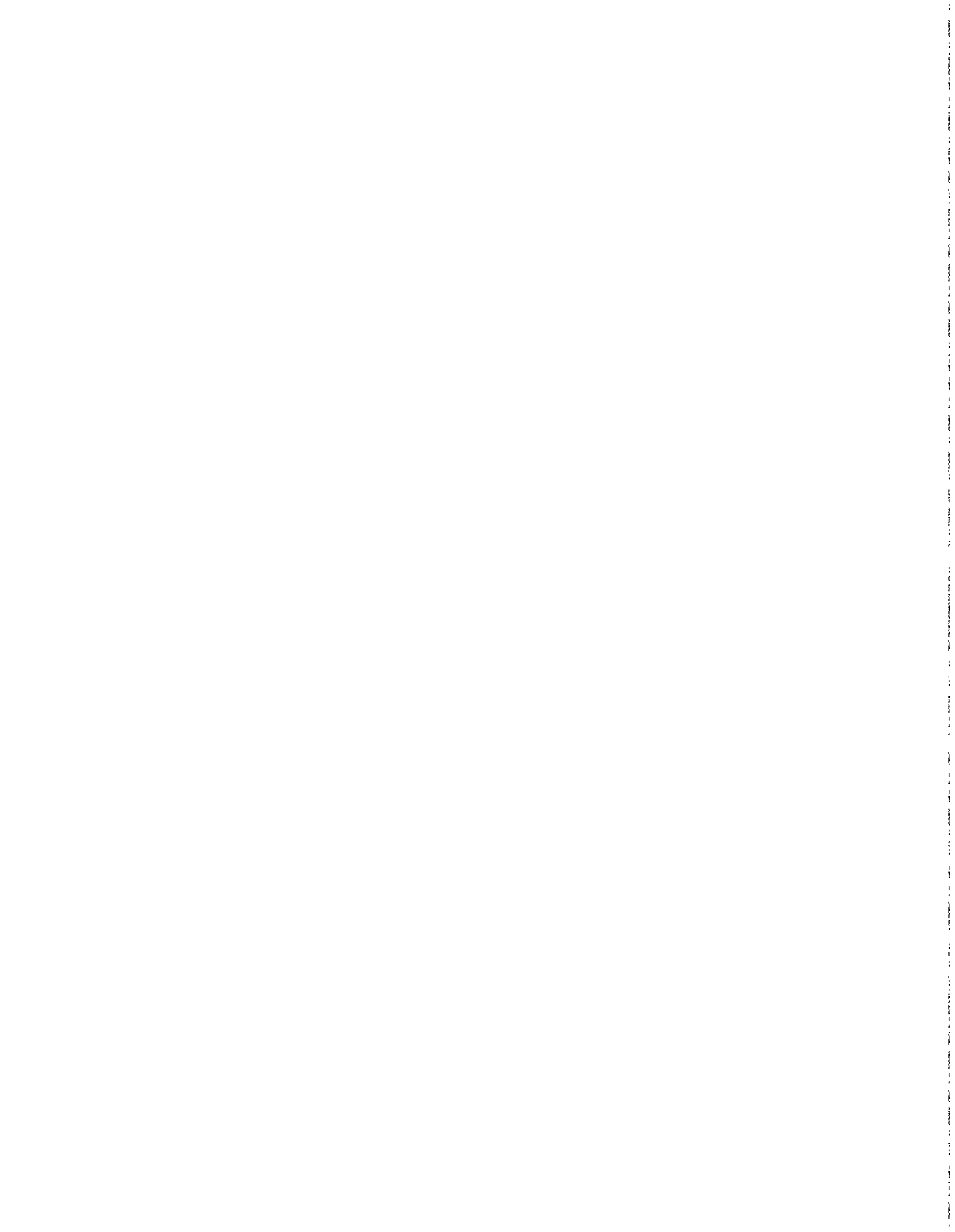


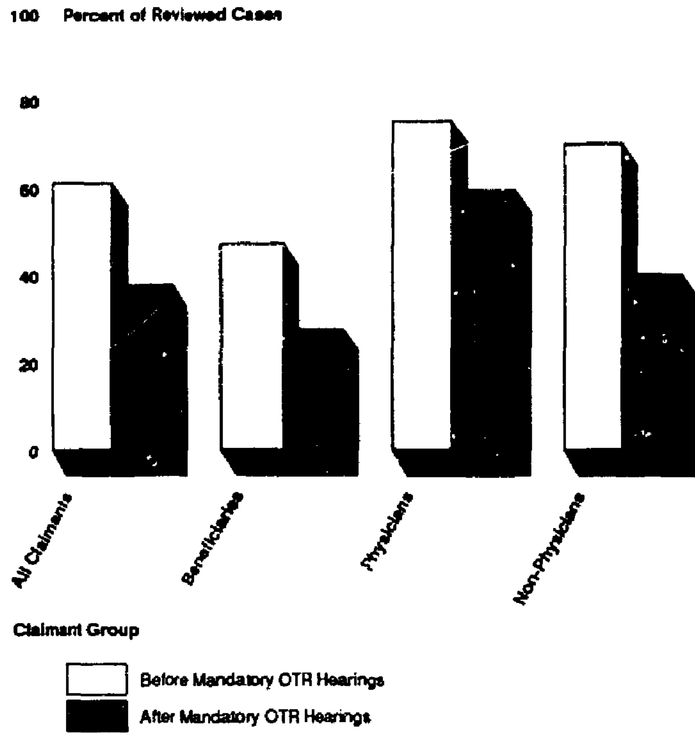
Table I.7: Telephone and In-Person Hearings, by Claimant Group
(Jan. 1987-Mar. 1989)

Claimant group	Before: Total cases	Before: Telephone and in-person hearings	Before: Percent	After: Total cases	After: Telephone and in-person hearings	After: Percent
Beneficiaries	10,000	3,400	34.0	7,600	730	9.6
Physicians	12,400	2,800	22.6	10,000	320	3.2
Nonphysicians	2,600	1,000	38.5	3,400	200	5.9
All claimants	**25,000**	**7,200**	**28.8**	**21,000**	**1,250**	**6.0**

The percentage of telephone and in-person hearing decisions resulting in payments to claimants decreased from 61.1 to 37.6 percent after on-the-record hearings were made mandatory. The greatest change involved cases filed by nonphysicians. Favorable decisions for this group decreased from 70 to 40 percent. (See fig. I.10 and table I.8.)



gure I.10: Telephone and In-Person
earing Decisions Favoring Claimants,
/ Claimant Group (Jan. 1987-Mar. 1989)



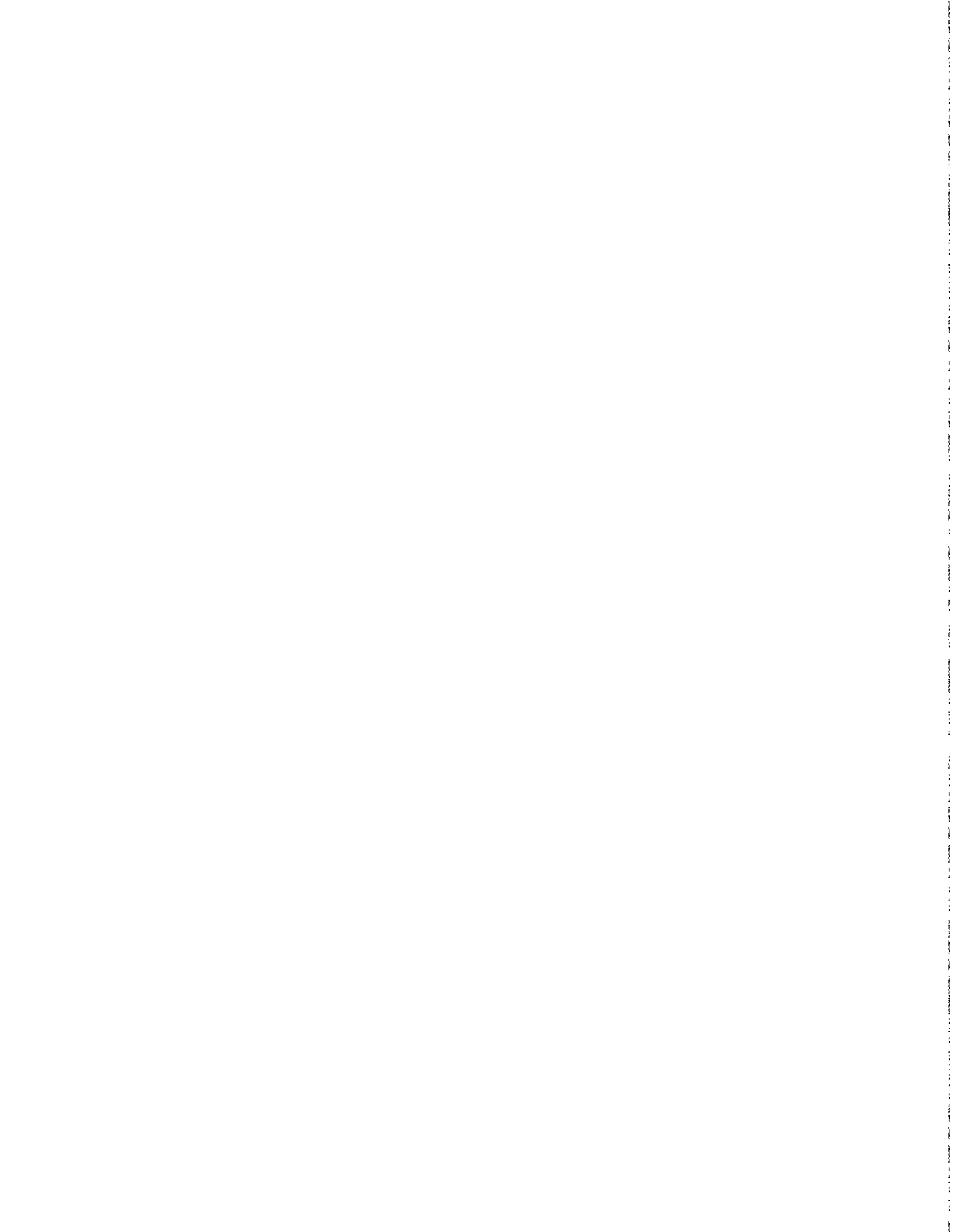
Note. "Telephone" and "In-person" carrier fair hearings are conducted by a carrier hearing officer and provide claimants with an opportunity to give oral testimony

ble I.8: Telephone and In-Person
aring Decisions Favoring Claimants,
Claimant Group (Jan. 1987-Mar. 1989)

	Before			After		
Claimant group	Cases reviewed	Favorable decisions	Percent	Cases reviewed	Favorable decisions	Percent
Beneficiaries	3,400	1,600	47.1	730	200	27.4
Physicians	2,800	2,100	75.0	320	190	59.4
Nonphysicians	1,000	700	70.0	200	80	40.0
All claimants	**7,200**	**4,400**	**61.1**	**1,250**	**470**	**37.6**

Note For this analysis a favorable decision is defined as one that reverses, in whole or in part, the carrier s prior decision and results in a payment to the claimant

A higher percentage of cases was appealed to ALJs by all three claimant groups after on-the-record hearings were made mandatory, with optional telephone and in-person hearings at the carrier. The greatest change was in beneficiary cases; about 16 percent were appealed to an



ALJ after on-the-record hearings were made mandatory, compared with 11 percent before. For all claimants, the percentage of cases appealed to ALJs increased from 10.8 to 12.9 percent. (See fig. I.11 and table I.9.)

Figure I.11: Appeals to an ALJ, by Claimant Group (Jan. 1987-Mar. 1989)

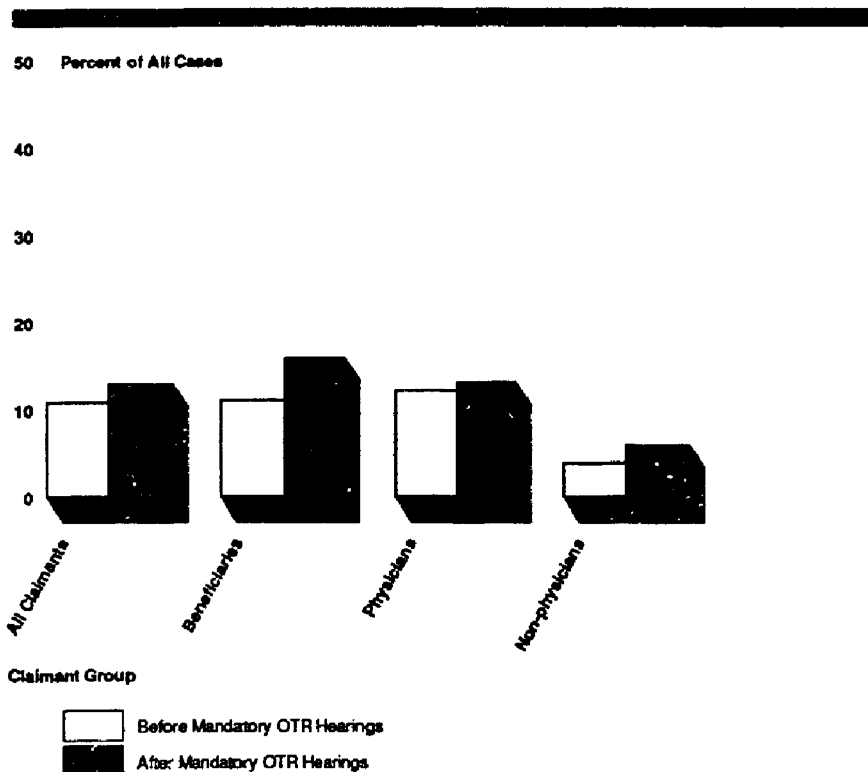
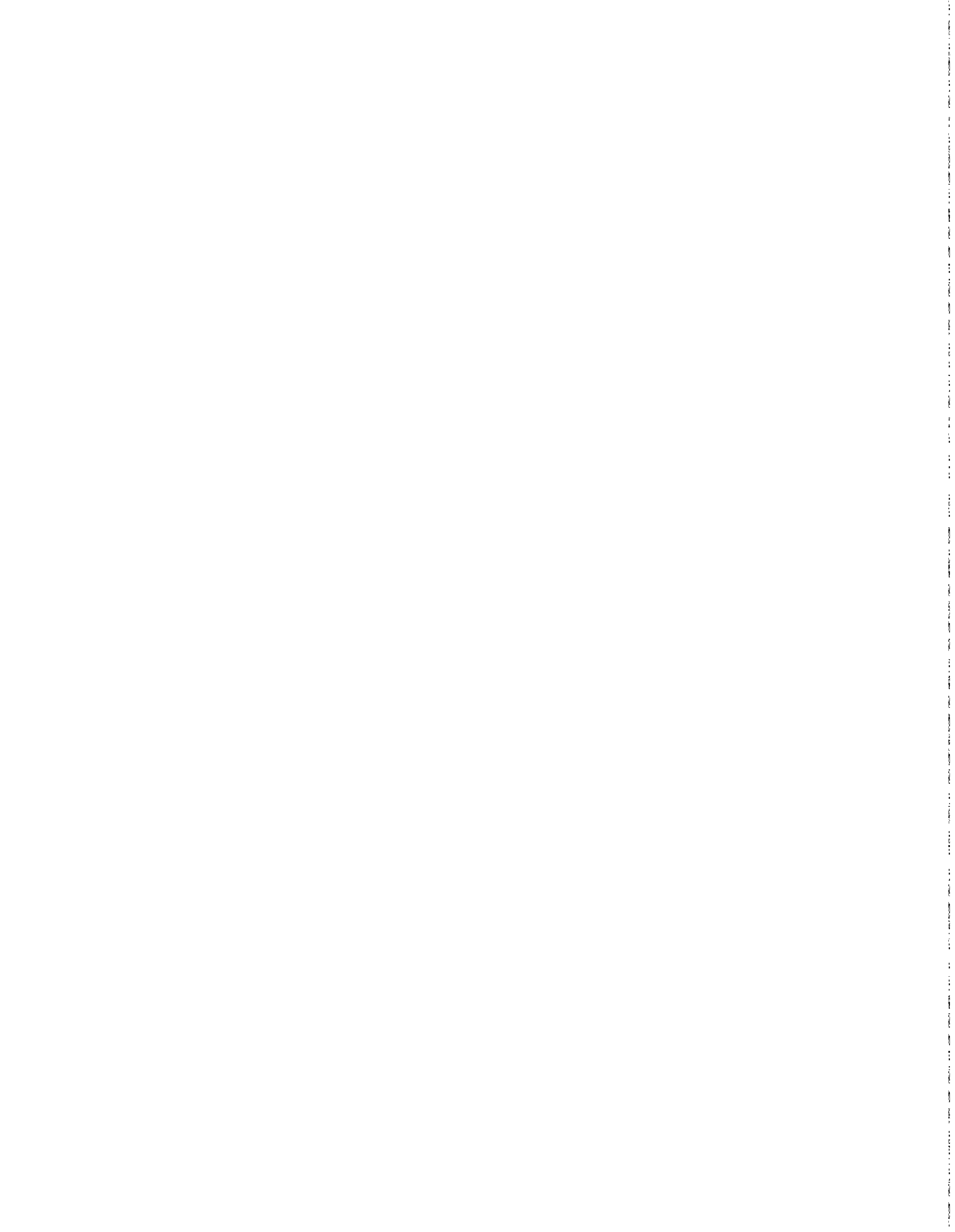


Table I.9: Number of Appeals to ALJ, by Claimant Group (Jan. 1987-Mar. 1989)

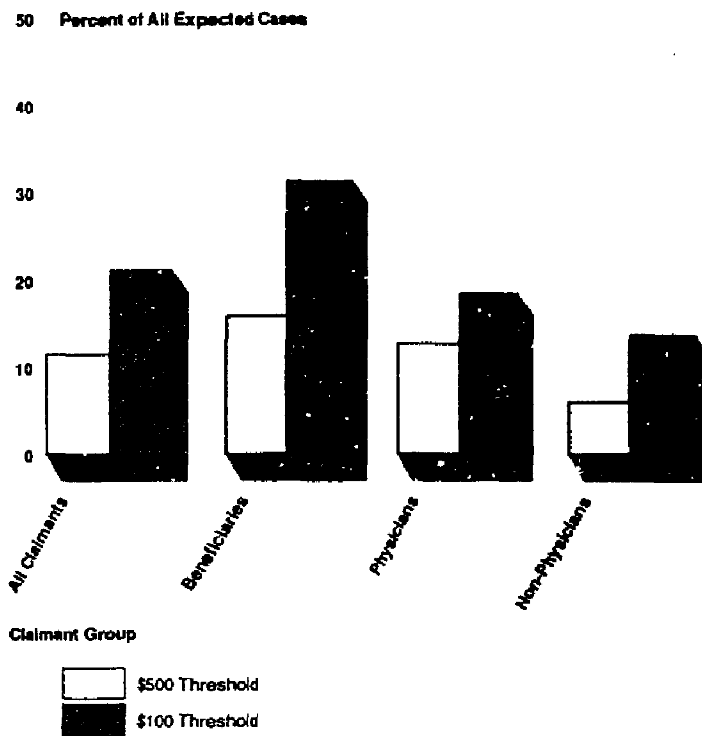
	Before			After		
Claimant group	**Total cases**	**Appeal to an ALJ**	**Percent**	**Total cases**	**Appeal to an ALJ**	**Percent**
Beneficiaries	10,000	1,100	11.0	7,600	1,200	15.8
Physicians	12,400	1,500	12.1	10,000	1,300	13.0
Nonphysicians	2,600	100	3.8	3,400	200	5.9
All claimants	**25,000**	**2,700**	**10.8**	**21,000**	**2,700**	**12.9**



Expected Appeals to an ALJ if the Threshold Was Lowered

The expected percentage of cases appealed to ALJs would be much greater if the Part B ALJ threshold was lowered from $500 to $100 (the threshold used for access to ALJs under Part A). At the $500 threshold, we estimate that 11.5 percent of cases would be appealed to ALJs, while at the $100 threshold, about 21.1 percent of cases would be appealed. (See fig. I.12 and table I.10. Also see figs. IV.1-IV.6.)

Figure I.12: Expected Appeals to an ALJ at Different Thresholds, by Claimant Group



Note: Currently, to appeal to the ALJ under Medicare Part B the disputed amount must be $500 or more. In contrast, to appeal to the ALJ under Medicare Part A (hospital-related services), the disputed amount must be $100 or more.

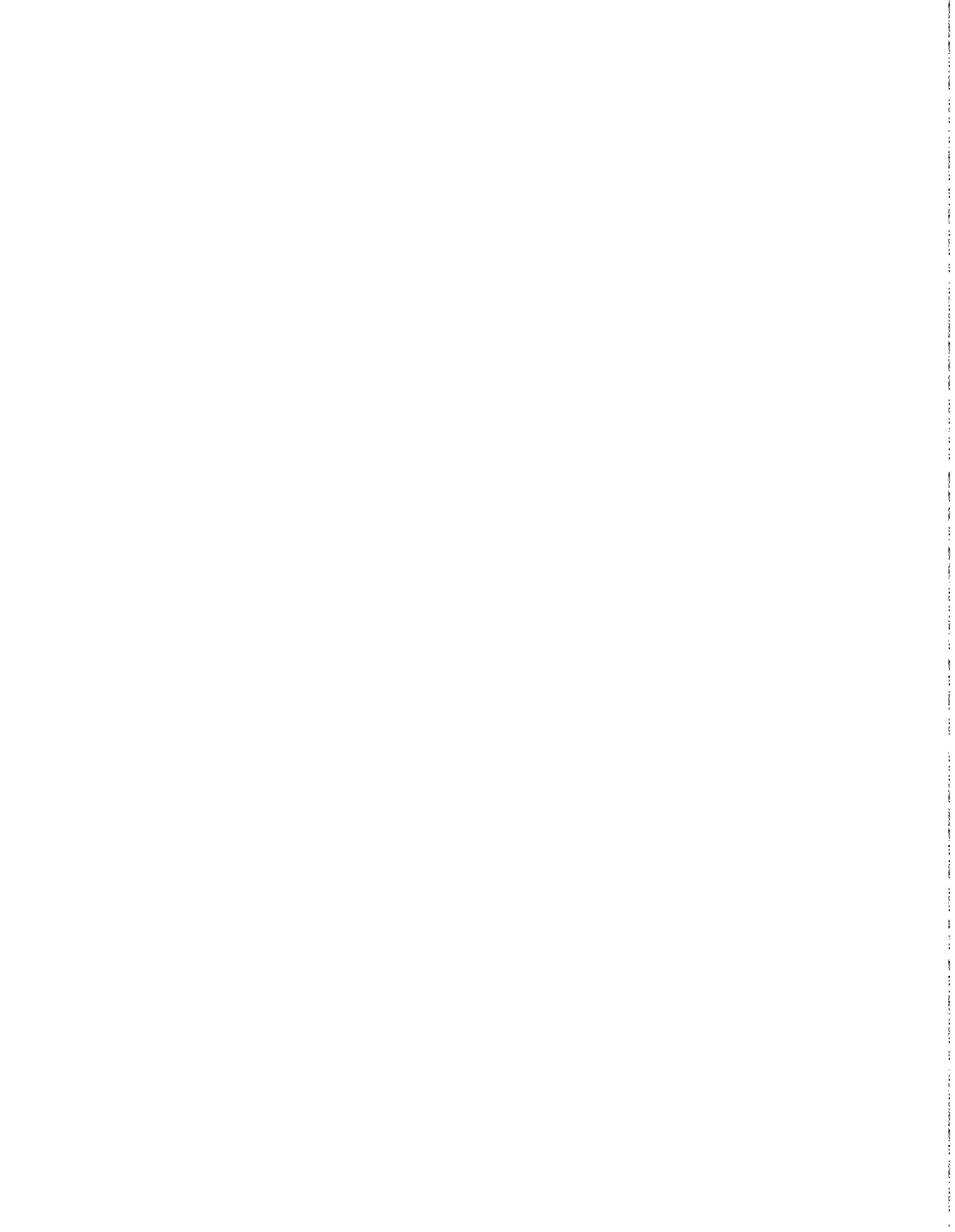


Table I.10: Expected Appeals to an ALJ at Different Thresholds, by Claimant Group

Claimant group	At $500 threshold: Total cases	Expected ALJ appeals	Percent	At $100 threshold: Total cases	Expected ALJ appeals	Percent
Beneficiaries	10,000	1,579	15 8	10,000	3,123	31 2
Physicians	10,000	1,269	12.7	10,000	1,840	18 4
Nonphysicians	10,000	604	6 0	10,000	1,368	13.7
All claimants	**30,000**	**3,452**	**11.5**	**30,000**	**6,331**	**21.1**

Note For this analysis, we assumed that the pattern of decisions and appeals for 10,000 cases for each claimant group at a $100 threshold would be the same as it was for the actual cases we reviewed that were subject to the $500 threshold

Congressional Intent Regarding Use of Carrier Fair Hearings for Claims Appealed to ALJs

Although the Congress originally intended to eliminate carrier fair hearings for claims involving disputed amounts of more than $500, and allow them to proceed directly to an ALJ, subsequent events make it difficult to determine whether that continues to be the congressional intent.

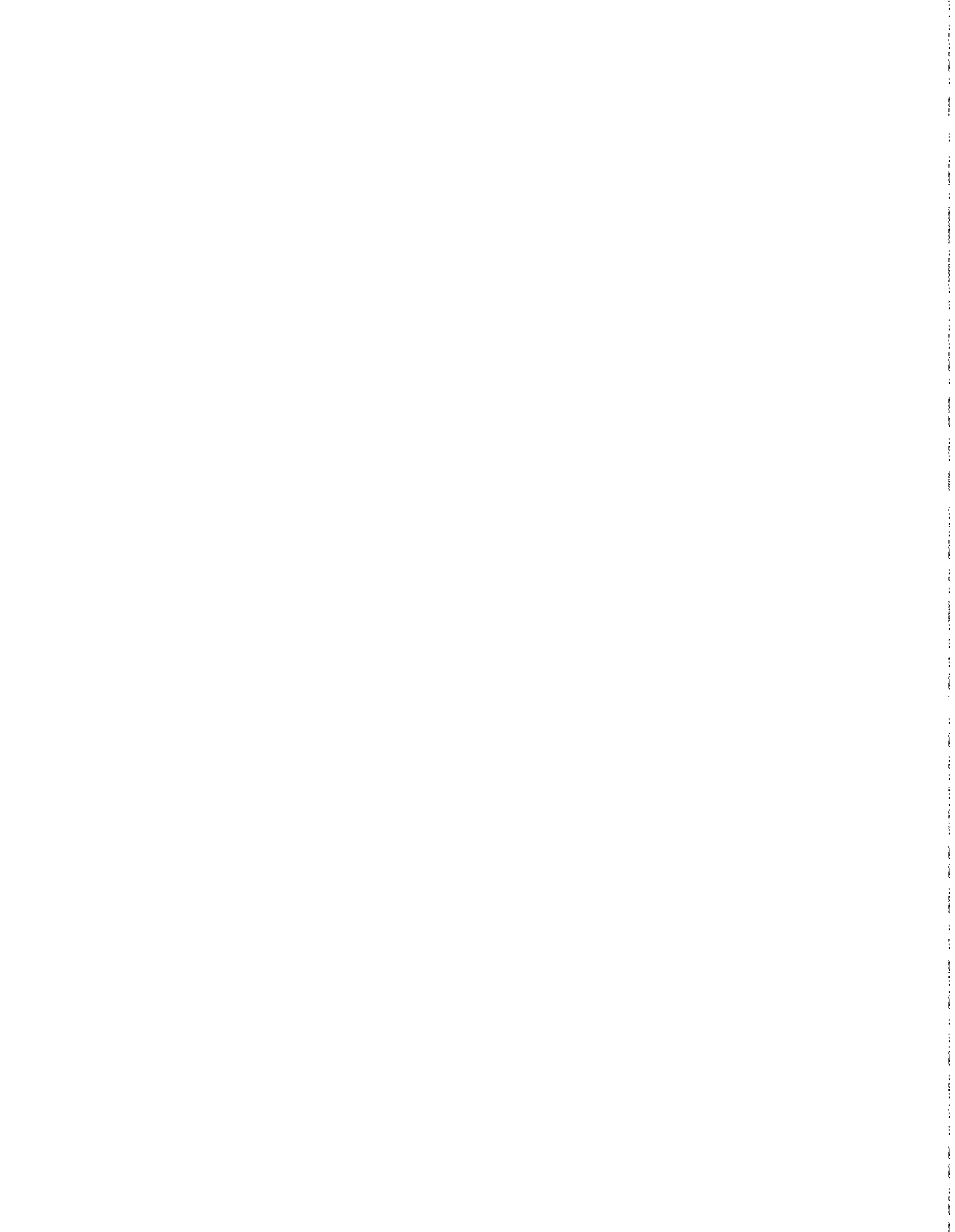
The Omnibus Budget Reconciliation Act of 1986 amended the Social Security Act to give Part B claimants the right to ALJ hearings for disputes where the amount in controversy exceeded $500. After the amendment was enacted, HCFA issued instructions requiring claimants with amounts in controversy of more than $500 to have a carrier fair hearing before proceeding to the ALJ.[6] A federal district court found that the Congress had intended the 1986 amendment to foreclose the use of carrier fair hearings for these claims.[7]

In 1987, the Congress amended that part of the statute which prescribes that carriers must provide a fair hearing for Part B claims between $100 and $500. This was a technical amendment, making no substantive change in the law. However, it was made at a time when the Congress knew of HCFA's interpretation of the carrier fair-hearing requirement and was aware of the litigation. Subsequently, the district court, which had heard the original suit, concluded on rehearing that the 1987 amendment, in effect, ratified the position of HCFA and that the instructions were valid.[8] The decision was based on the fact that the Congress, knowing of the dispute, had refrained from changing the law. The U.S.

[6]Medicare Manual Instructions, para. 1201 5B.

[7]Isaacs v. Bowen, 683 F. Supp. 930, 934 (S D N Y 1988).

[8]Medicare Manual Instructions, at 935.

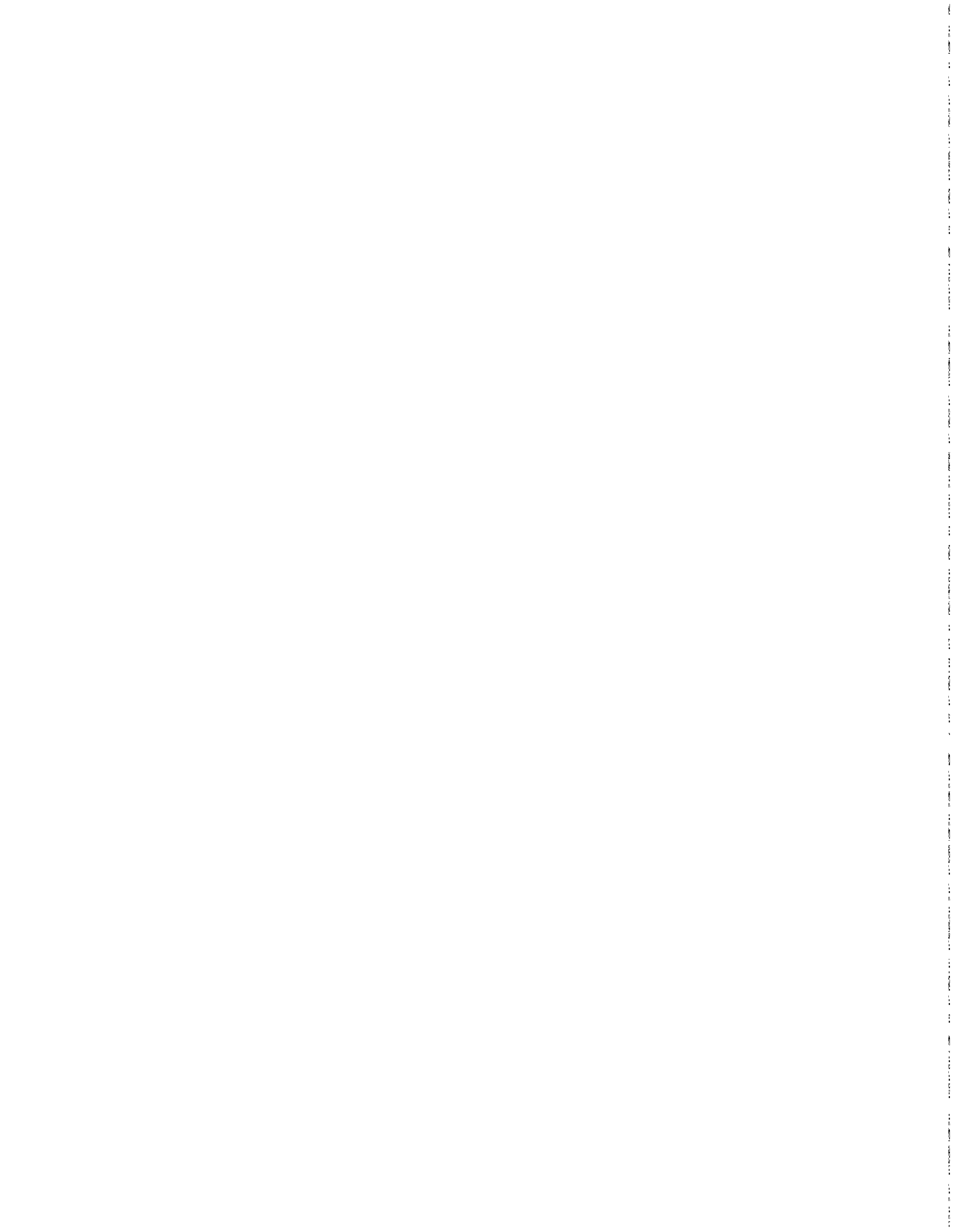


Court of Appeals for the Second Circuit, hearing an appeal of the district court decision in 1989, upheld this district court decision.[9]

The Court of Appeals found that the Congress had an opportunity to eliminate the carrier fair-hearing requirement in 1987, when it amended selected aspects of the provision, but did not clearly do so. The court believed that the 1987 act gave an "affirmative, legislative indication" of the Congress' willingness to leave the fair-hearing requirement in place, at least until we completed our study. The court found "a visible expression of congressional approval of the agency's position."

The legislative history and the language of the law provide support for the conclusion that the courts ultimately reached—that the Department of Health and Human Services, and thereby HCFA, may require claimants to have a carrier fair hearing before going to an ALJ—but they do not permit a definitive conclusion about congressional intent. However, even if legislative intent to preclude carrier fair hearings for claims over $500 was clear in 1986, as the courts thought, the Congress' action in 1987 and the Court of Appeals' opinion in 1989 make it difficult to conclude that this remains the legislative intent.

[9] Isaacs v. Bowen, 865 F. 2d 468 (2d Cir. 1989).



Appendix II

Case Sampling Methodology

To determine the changes after the introduction of mandatory on-the-record hearings in case volume and outcomes at the carrier level for each claimant group, we obtained individual case data from 47 of the 51 Medicare carriers for the period January 1987 to March 1989.[1] During this period, the ALJ appeals option was in place and the on-the-record hearings were made mandatory.

We asked carriers to separate cases considered when on-the-record hearings were mandatory from those considered before the carrier implemented HCFA's on-the-record hearing requirement. The carriers entered case data on two forms that we pretested at carriers in New York, Massachusetts, and Maryland. (See appendix III for the data collection forms used to obtain individual case data.)

Of the 47 participating carriers, 6 indicated that they were unable to provide data on all cases for the 2-year period because a large number of cases were involved, they did not have an automated filing and retrieval system, or both. However, these six carriers provided data for a sample of cases randomly selected in accordance with our instructions.

We constructed a final data set consisting of the universe of cases for 41 carriers and a sample of cases for 6. In total, data were collected on about 18,000 individual cases. We weighted the sampled cases from the 6 carriers using the weights shown in table II.1.

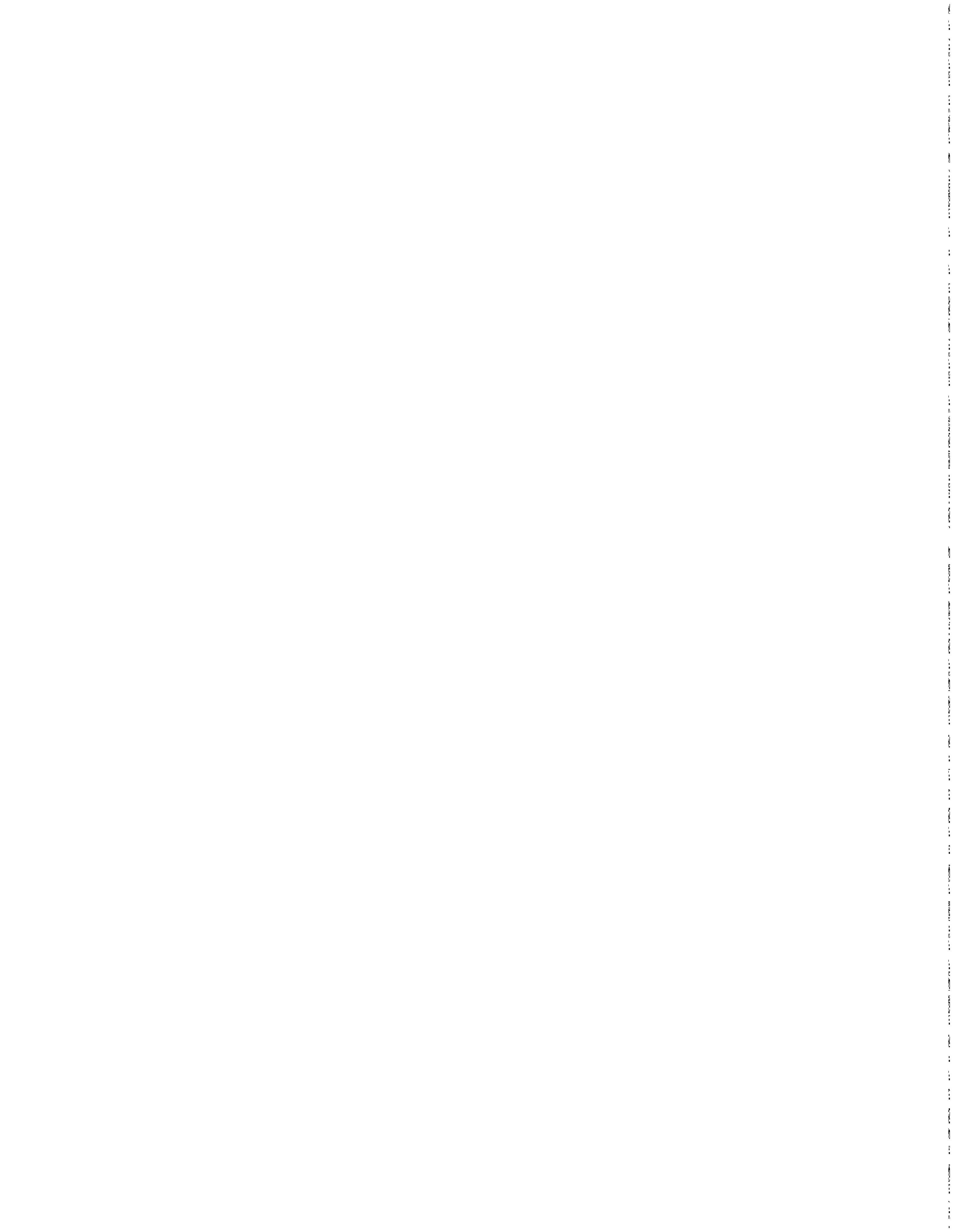
Table II.1: Weights for Sampled Cases in Six Carriers

	Sampled case weights	
Carrier	**1987**	**1988**
A	100 0	87 0
B	48 9	48.9
C	30.3	59.0
D	a	24 2
E	41.7	43 6
F	49 1	49.1

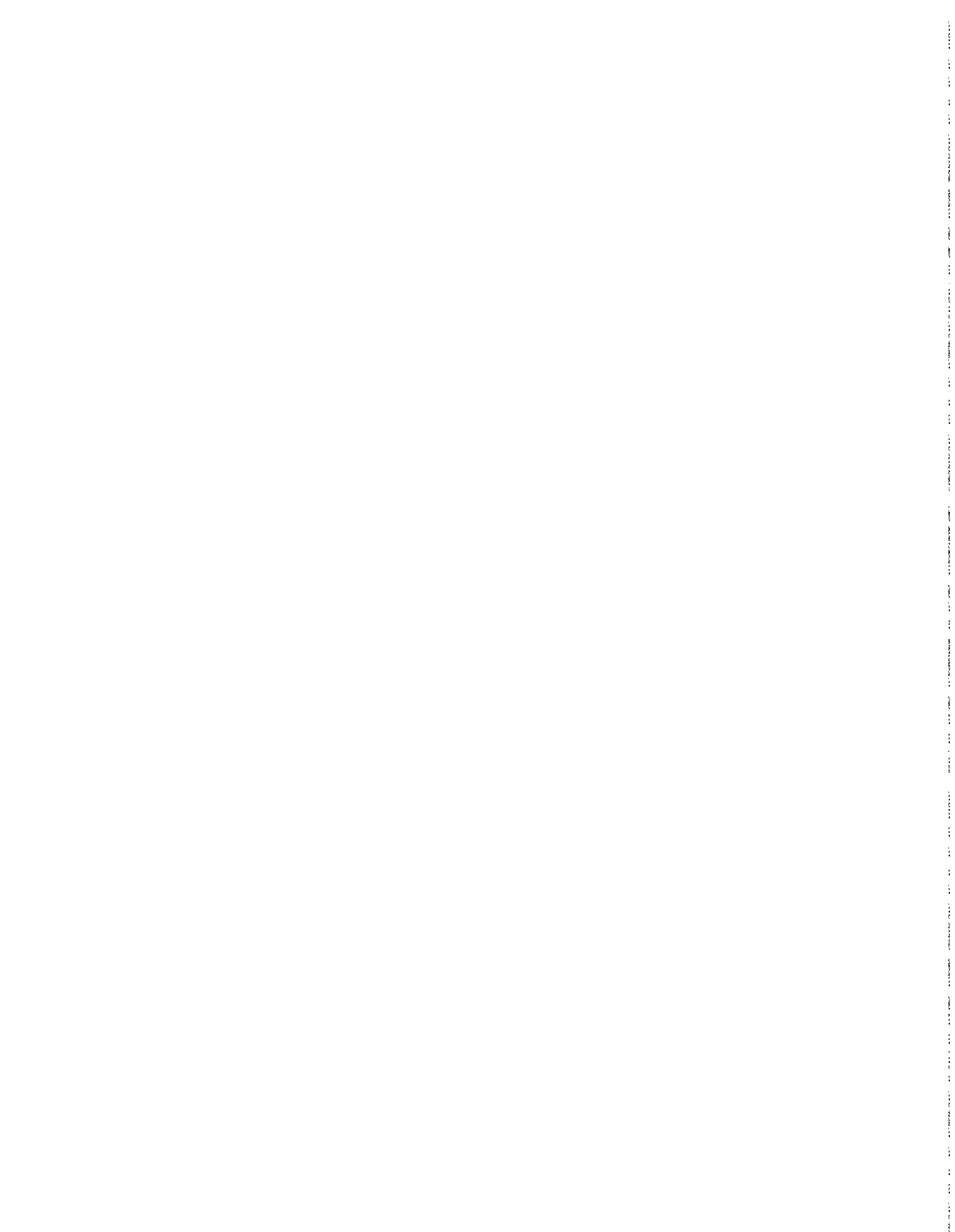
[a]Data for 1987 were not available

The estimates of case outcomes obtained through this analysis are subject to error because of the sampled cases. At the 95-percent confidence

[1] We did not obtain data from three carriers representing Prudential of America because they discontinued participating in the Medicare Part B program in late 1988. We also did not obtain data from one Aetna carrier because of its limited Part B appeals activity.



level, the error range does not exceed plus or minus 4 percent in any of our estimates.



Survey Form Sent to Medicare Part B Carriers

SURVEY OF MEDICARE
PART B HEARING OFFICE CASES
WITH A DATE OF SERVICE ON OR AFTER
JANUARY 01, 1987

INTRODUCTION

This survey is being conducted by the U.S. General Accounting Office (GAO) for the U.S. Congress. The results will be used to help determine the effects of changes in the Medicare Part B hearing appeal process. Your help is needed in order to complete this project successfully. You may wish to consult with the person(s) who track and administer your case load statistics when addressing these data requests.

Before you begin, please check for accuracy purposes, your NAME, TITLE, and ADDRESS on the attached letter introducing our survey and make any corrections in the space provided below:

NAME : ______________________________

TITLE : ______________________________

ADDRESS : ______________________________

CITY : ______________________________

Also, if applicable, please list any other pertinent Carrier officials extensively involved in managing Medicare Part B fair hearing (CFH) appeals:

NAME : ______________________________

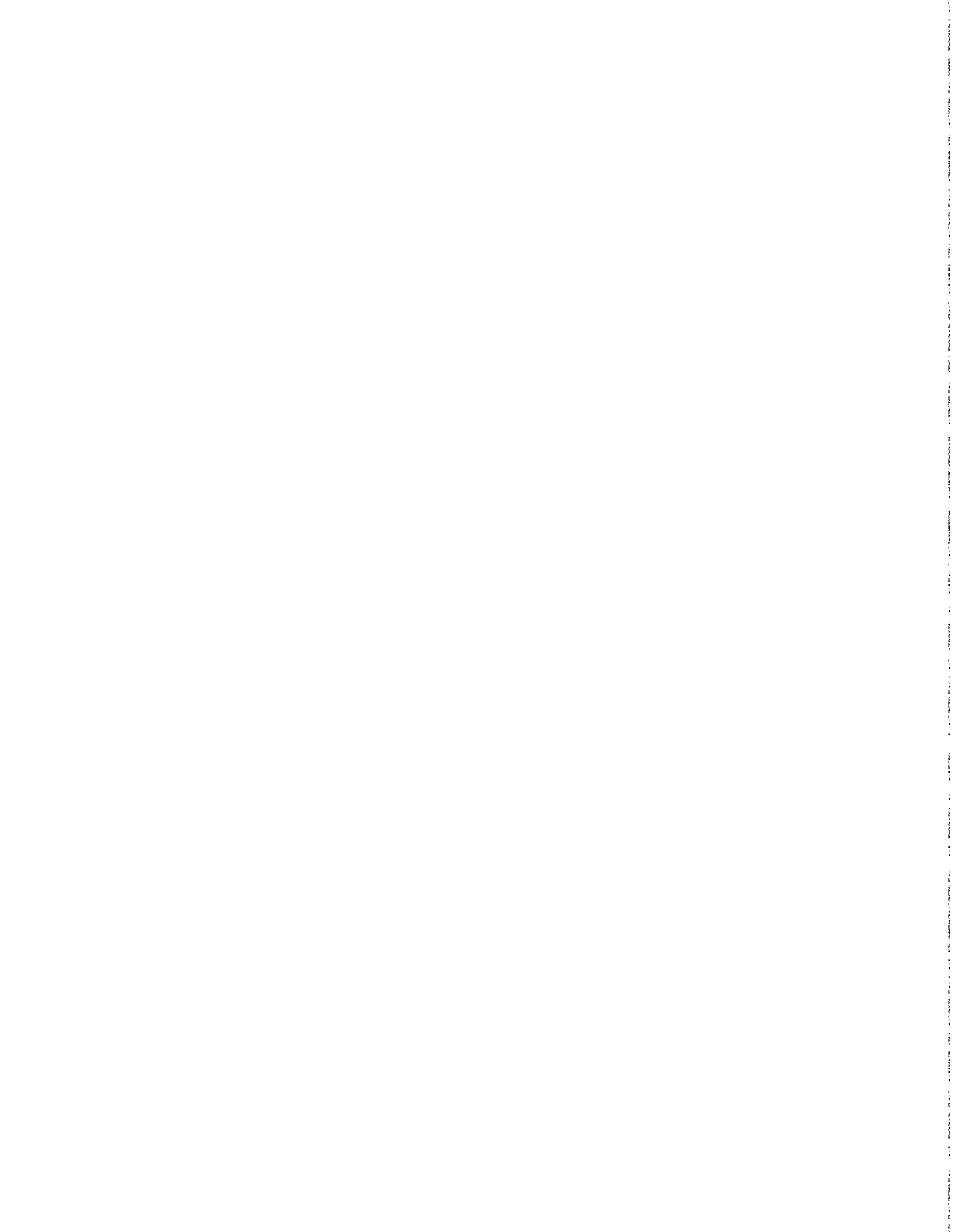
TITLE : ______________________________

Please provide a telephone number(s) where you and, if applicable, the other involved manager can be reached, if we have any questions about your responses.

PHONE : ______________________________

PHONE : ______________________________

PLEASE RETURN THIS SHEET WITH THE SURVEY FORMS. THANK YOU



INSTRUCTIONS

Enclosed are two data collection forms i.e., schedules -- each requesting Medicare Part B claimant and Carrier fair hearing information.

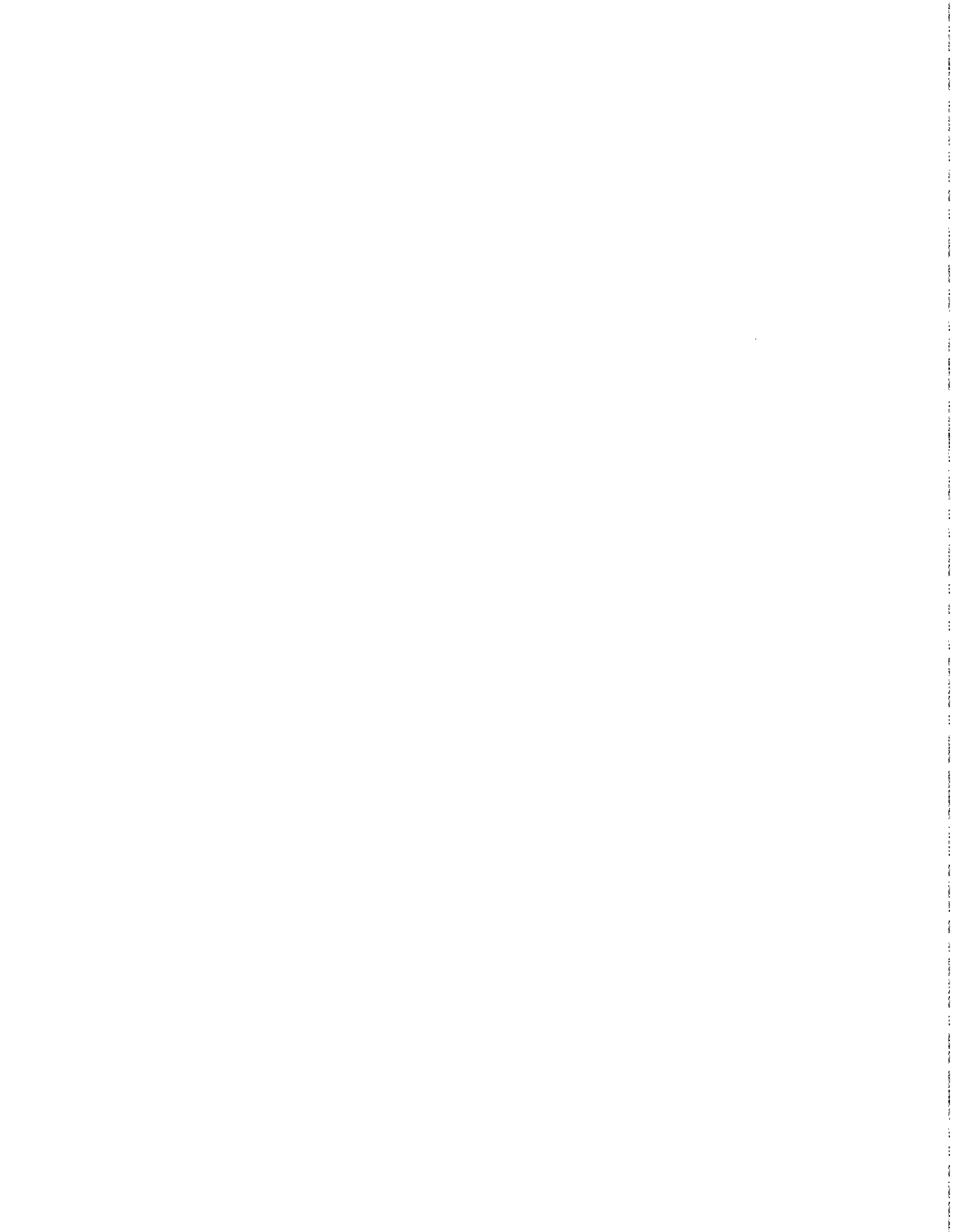
The first form: Form A, relates only to those Medicare Part B cases with a 'date of service' (incurred by the claimant) on or after January 01, 1987; but, not beyond the processing date used by Carriers in implementing the Health Care Financing Administration's (HCFA) Part B Interim Guidelines - Hearings and Appeals. The aforementioned guidelines suggested an effective date of no later than May 01, 1988, and instituted a general requirement (with minor exceptions) for conducting a mandatory on-the-record hearing, whether or not an in-person or telephone hearing is requested. In the space provided below, please indicate Carrier implementing date for instituting HCFA's interim guidelines: ________(month) _______(day) _______(year).

The second form: Form B, pertains to only these Medicare Part B cases with a 'date of service' on or after January 01, 1987, and those considered by the Carriers under HCFA's implementing interim guidelines which require mandatory on-the-record reviews, whether or not an in-person or telephone hearing is requested.

For the specific information requested under each column in the two schedules, refer to detailed instructions provided below. Once you have completed the survey forms/schedules, place them in the pre-addressed envelope and mail them as soon as possible, but no later than March 27, 1989. Also, if you have any questions or problems with the survey, call Joe Faley or Claude Hayeck collect at (202) 523-8666.

PLEASE RETURN THIS SHEET WITH THE SURVEY FORMS

THANK YOU FOR YOUR COOPERATION!



SPECIFIC INFORMATION

Refer to designated column title headings. Please note that information below identified by an asterisk (*) only applies to Form B for recording mandatory on-the-record reviews.

Case Reference Number:

Identify by either an in-house control number (preferable identifier) or a number in descending order for those cases listed. Also, depending upon the Carrier, the term "case" is sometimes used interchangeably with the term "claim", use either for your listing purposes, but for whatever definitional reference number terminology used, please identify as such and be consistent in its usage

Type of Claimant:

Identify by a check mark the type of claimant requesting a hearing, i.e., beneficiary and provider with the latter further classified as either physician or non-physician (including durable equipment suppliers, laboratories, etc.)

Number of Claims In Each Case:

Identify the number of claims combined by the claimant to reach the required $100 dollar threshold. Also, refer to "COL #1" discussion on case versus claim terminology.

Original Dollar Amount In Controversy:

Identify the original dollar amount in dispute at the time of the hearing request.

* **Mandatory On-The-Record Review Decision:**

Identify the on-the-record-review decision as "totally favorable" only if the amount in controversy is totally upheld or decided in the whole amount for the claimant. Likewise, identify any total reversal as "totally unfavorable." For all other claimant rulings involving partial amounts upheld in the favor of the claimant, identify as a "partial" decision. Also, when you pre-determined that a formal hearing was necessary, identify these cases as "exempted" from an on-the record review.

* **Dollar Amount In Controversy After The Mandatory On-The Record Review:**

Identify the remaining dollar amount in controversy after the on-the-record decision

* **Claimant Continued With Formal CFH Appeal?:**

Identify by a yes or no answer

Type of CFH:

Identify what type of formal hearing the claimant requested. In the situations where mandatory on-the-record reviews were already held, the telephone and in-person formal settings are the only options available to the claimant.

CFH Decision:

Identify the Carrier fair hearing decision as "totally favorable" if the remaining dollar amount in controversy is totally upheld in the favor of the claimant, otherwise, identify any total reversal as "totally unfavorable" and any partial decision as "partial."

Date of CFH Decision

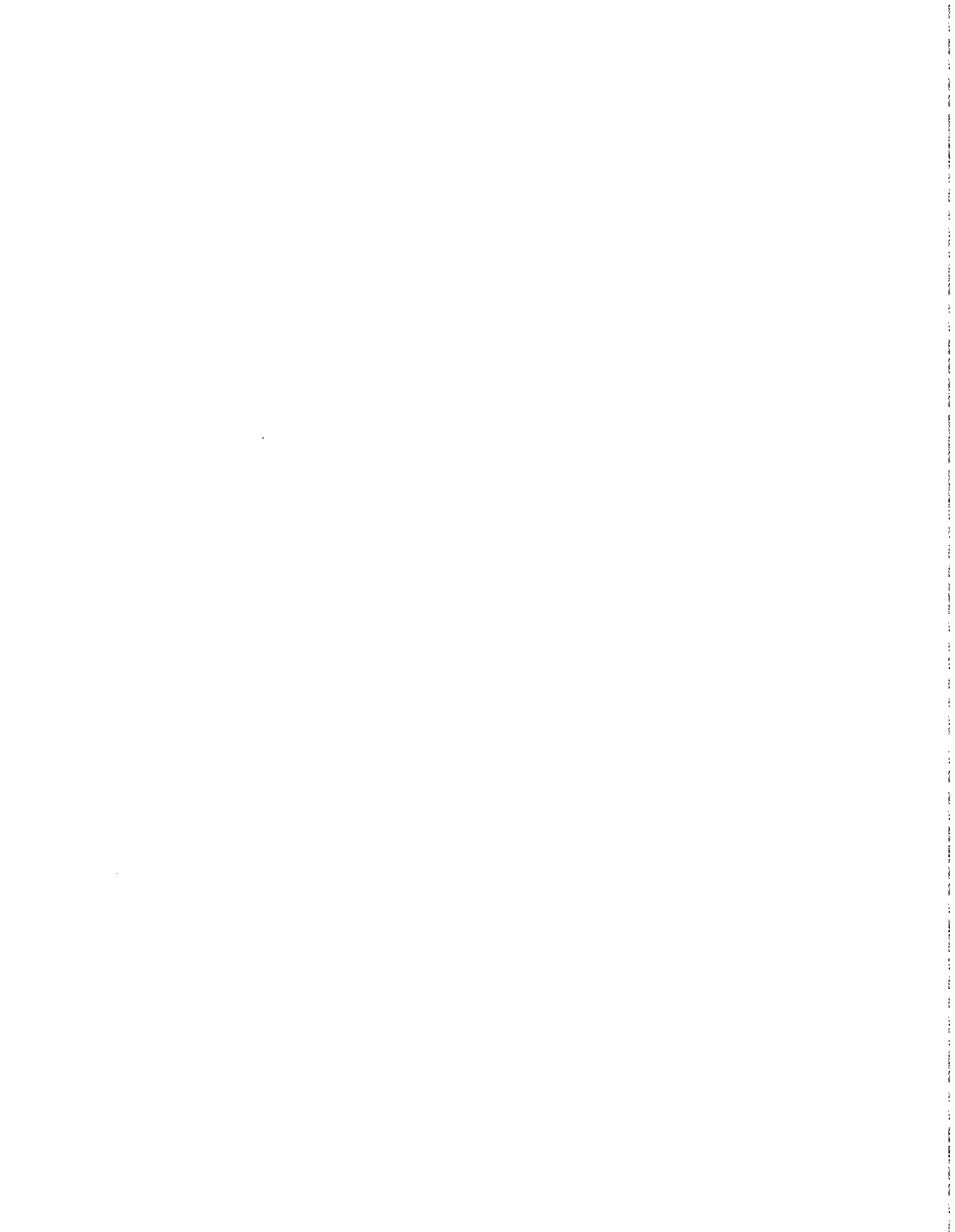
Identify by day, month, and year.

Dollar Amount In Controversy After CFH Decision:

Identify the remaining dollar amount in controversy after the Carrier fair hearing decision.

Appealed To ALJ?:

Identify by a check mark whether, to your knowledge, claimant requested a hearing by an Administrative Law Judge (ALJ).



FORM A

Page 1 of 1

Case #	Type of Claimant (Check Only One)	Provider		Number of Claims in Case	Original Dollar Amount in Controversy	Type of CFH (Check One)			CFH Decision (Check One)			Date of CFH Decision	Dollar Amount in Controversy After CFH Decision	Appealed to ALJ? (Check One)	
	Beneficiary	Physician	Non-Physician			On-The-Record	Telephone	In-Person	Totally Favorable	Partial	Totally Unfavorable			Yes	No

FORM B

Page 1 of 2

Case #	Type of Claimaint (Check Only One)	Provider		Number of Claims in Case	Original Dollar Amount in Controversy	Mandatory On-The-Record Review Decision (Check Only One)				Dollar Amount in Controversy After Mandatory On-The-Record Decision	Continued With CFH Appeal? (Check One)	
	Beneficiary	Physician	Non-Physician			Totally Favorable	Partial	Totally Unfavorable	Exempted		Yes	No

FORM B (Continued)

Page 2 of 2

Case #	Type of CFH (Check One)		CFH Decision (Check One)			Dollar Amount in Controversy After CFH Decision	Date of CFH Decision	Appealed TO ALJ? (Check One)	
	Telephone	In-Person	Totally Favorable	Partial	Totally Unfavorable			Yes	No

Estimates of the Potential Effect of Lowering the Threshold for Access to an ALJ

Using the data obtained from the carriers, we applied actual conditional probabilities to a hypothetical set of 10,000 cases for each claimant group to assess the potential effect of lowering the ALJ threshold to $100.[1] That means that at each of the 47 Medicare carriers participating in our study, we looked at the actual cases and what happened to them at each point in the appeals process. We then assumed for this analysis that 10,000 cases coming into the appeals process in the future for each claimant group will act in the same way as the actual cases we reviewed; that is, under the same appeals process rules, future cases will have the same patterns of "win," "continue," and "lose" as did the actual cases we reviewed. In these analyses,

- "win" denotes a decision that results in a payment to a claimant,
- "continue" denotes a case in which the claim is totally or partially upheld in the carrier's favor and the disputed amount is equal to or greater than the monetary threshold for appeal to an ALJ, and
- "lose" denotes a case in which the claim is totally or partially upheld in the carrier's favor but the dollar amount remaining in controversy is less than the monetary threshold for appeal to an ALJ.

The results of the conditional probability analyses are shown below for each claimant group for a $500 threshold (figs. IV.1-IV.3) and a $100 threshold (figs. IV.4-IV.6).

[1] Conditional probabilities represent the likelihood that an individual claimant possesses a particular trait or set of traits related to different decisions in the carrier hearing process. For example, a discrete probability would show the likelihood of being a physician (type of claimant) who selected a telephone carrier fair hearing (type of hearing), lost the decision, and decided to appeal that decision to an ALJ. The probability in this example is conditional because it includes or is conditional on all earlier probabilities. That is, the probabilities of being a physician, having a telephone hearing, losing the hearing, and deciding to appeal are multiplied together to obtain the final conditional probability

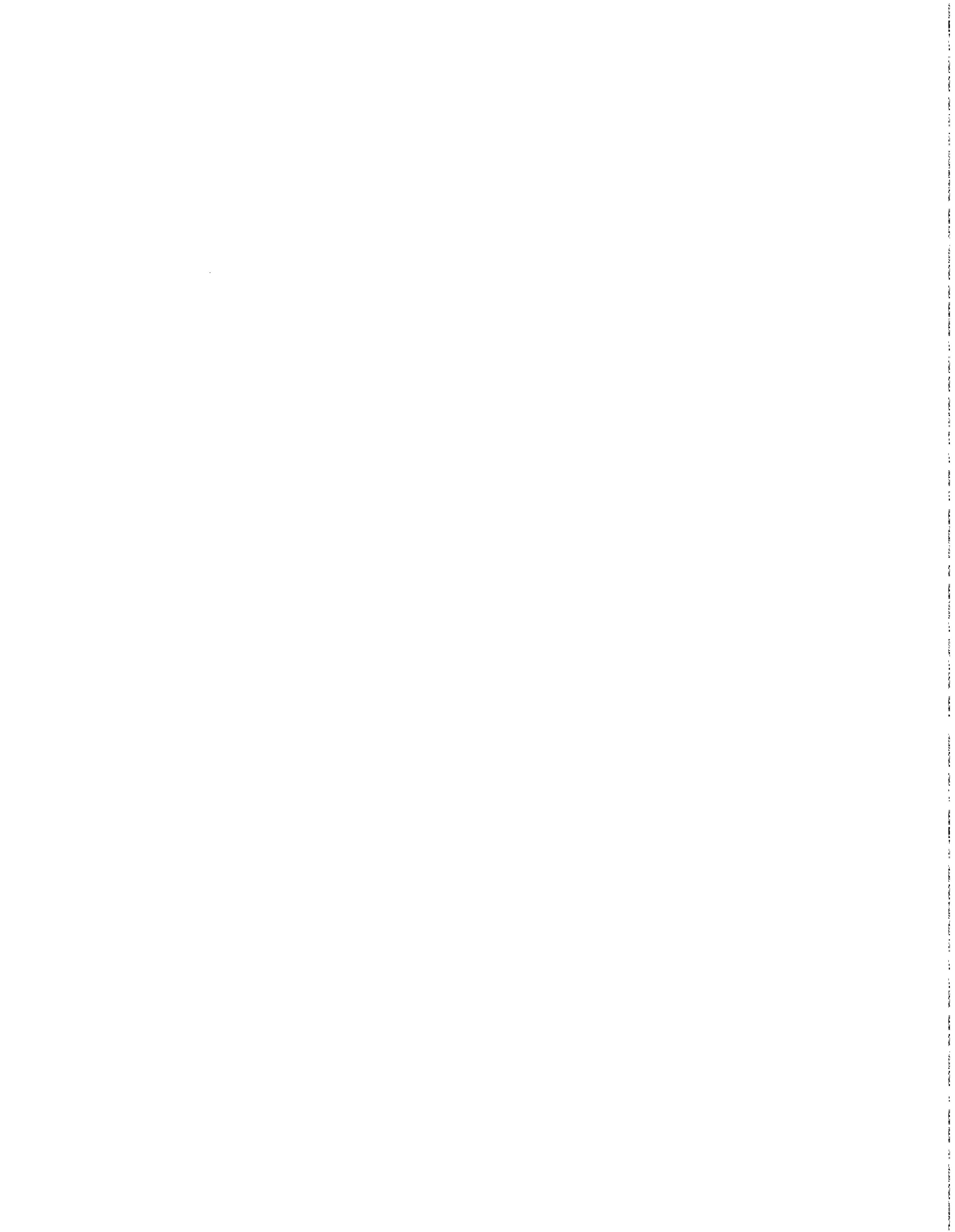
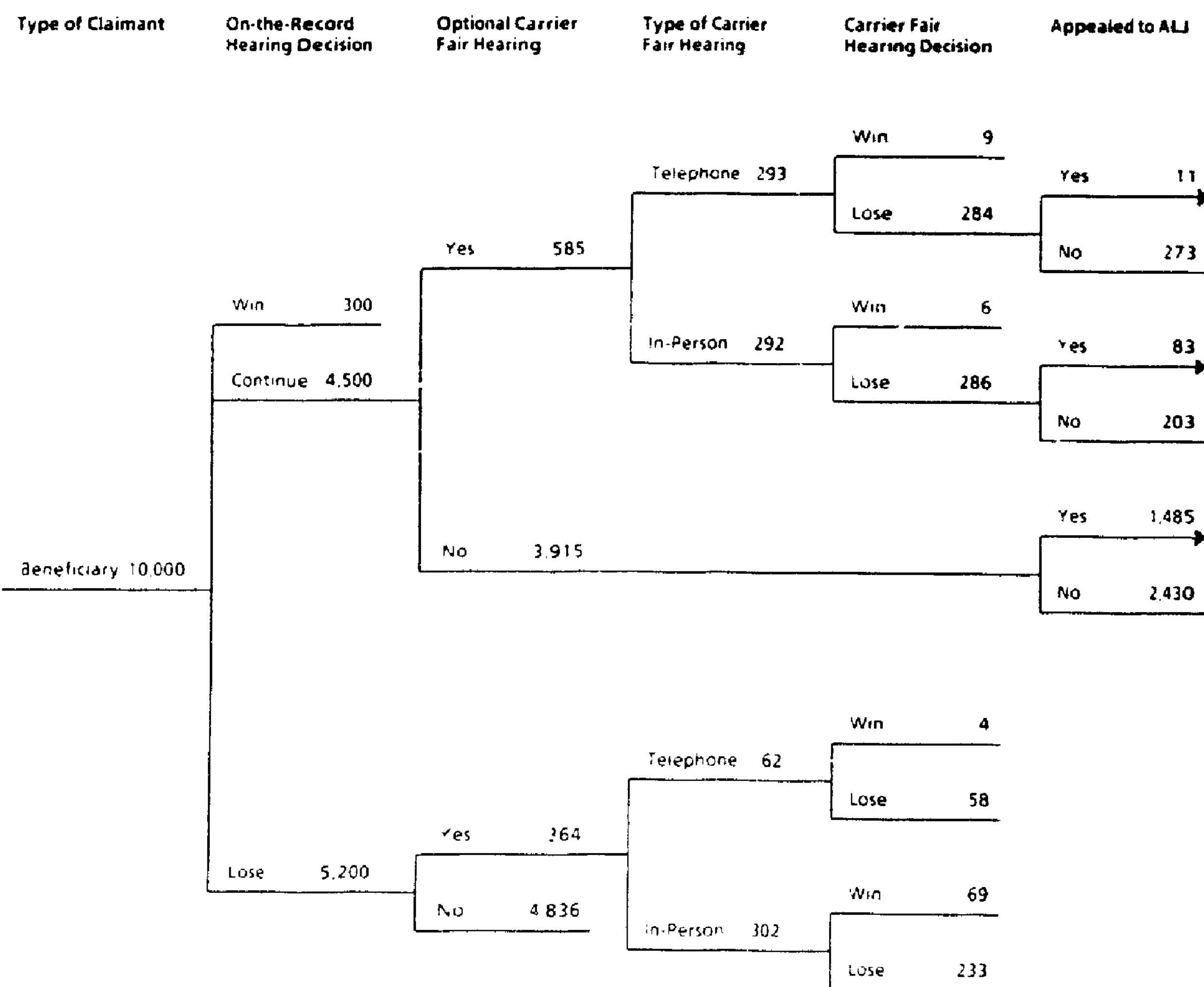


Figure IV.1: Expected Outcomes for Beneficiaries at a $500 ALJ Threshold



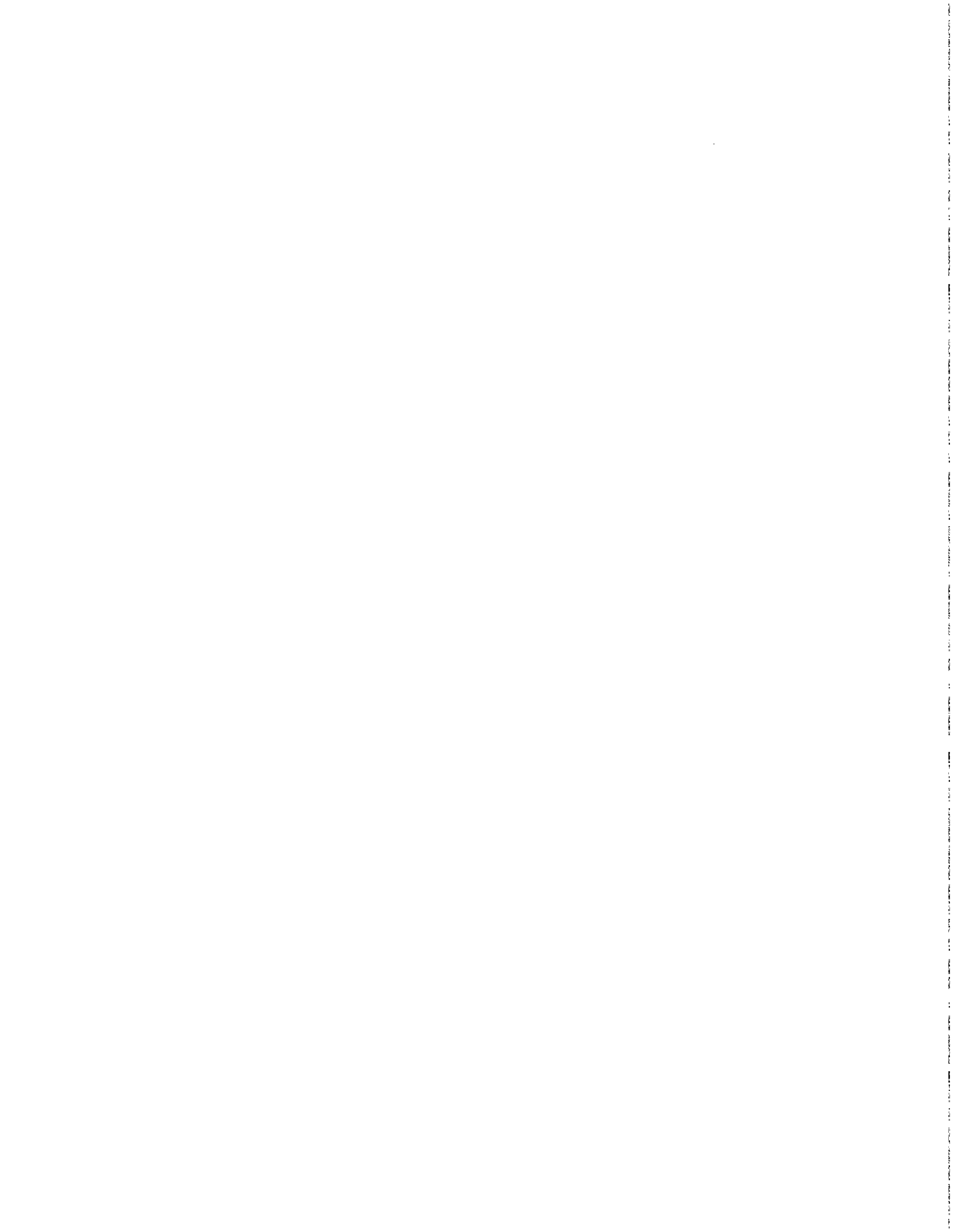
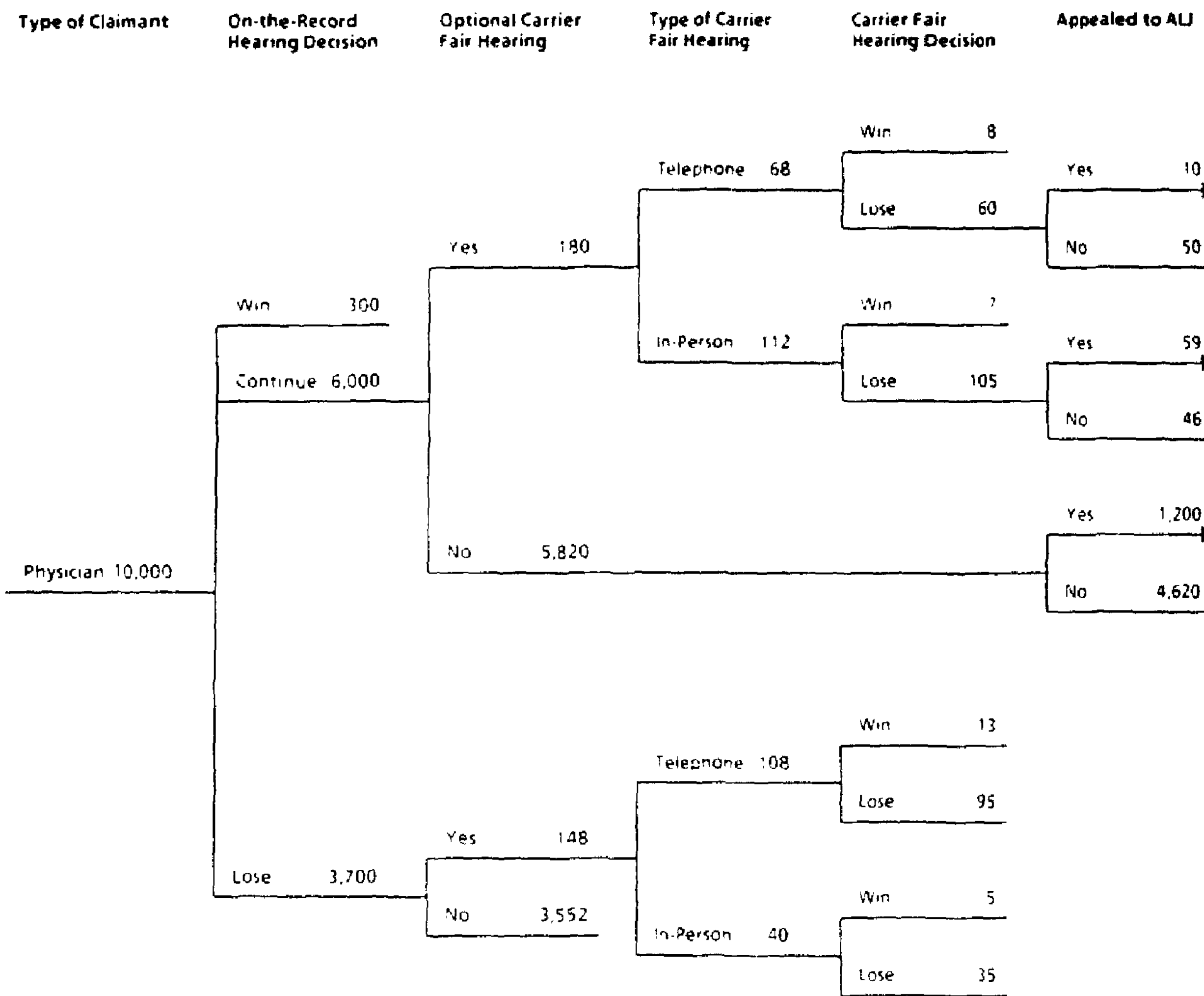


Figure IV.2: Expected Outcomes for Physicians at a $500 ALJ Threshold

Expected Outcomes per 10,000 Claimants



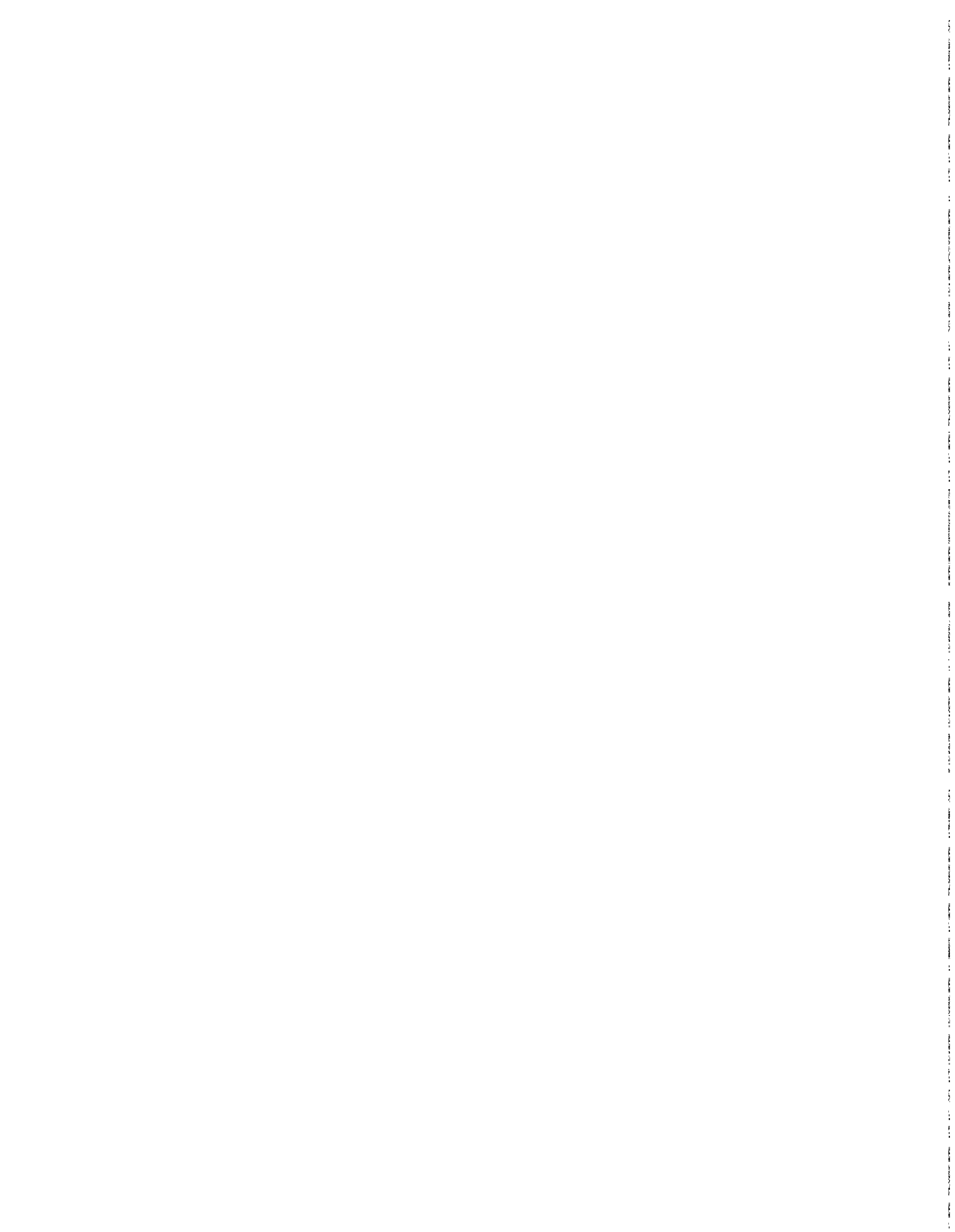


Figure IV.3: Expected Outcomes for Nonphysicians at a $500 ALJ Threshold

Expected Outcomes per 10,000 Claimants

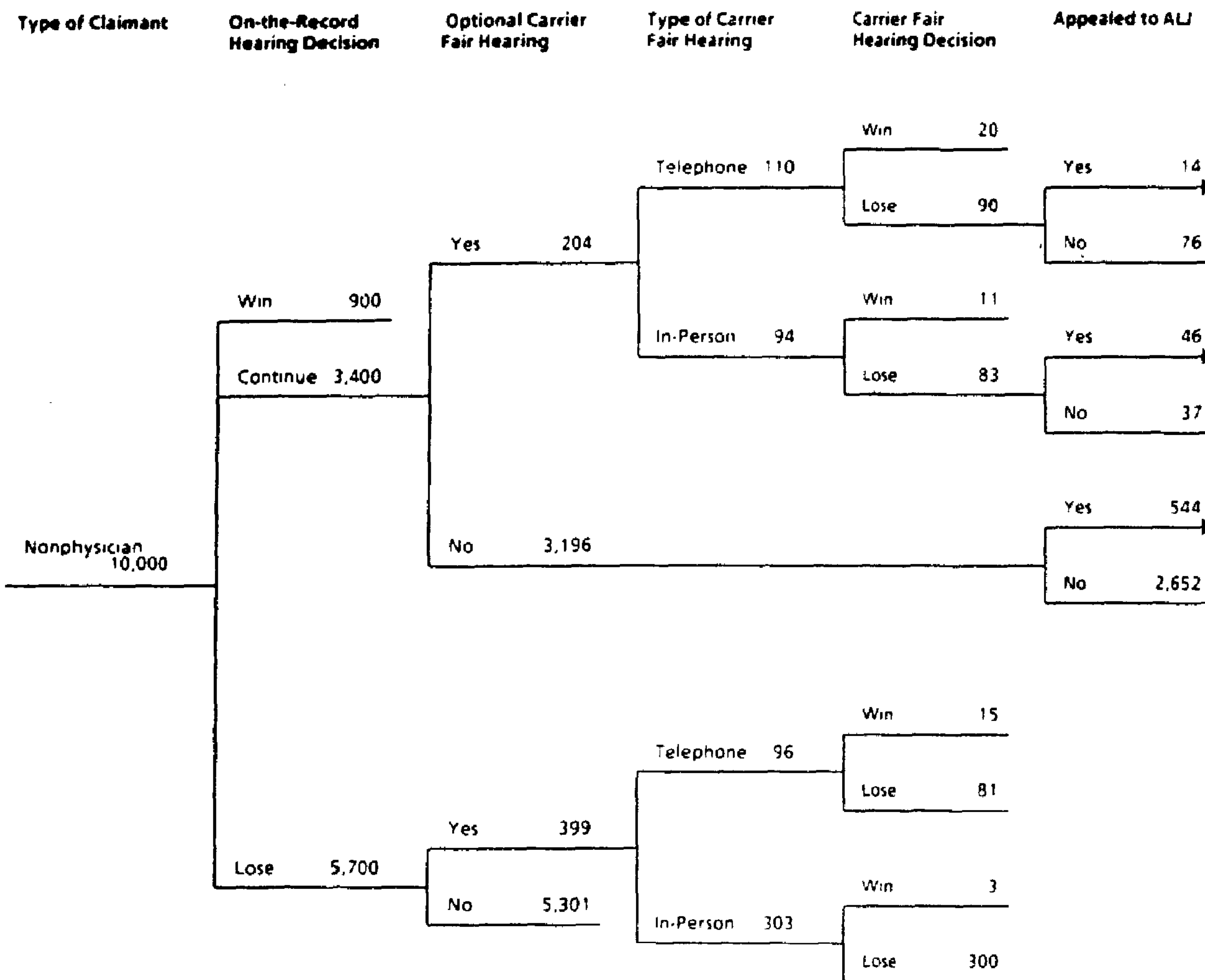


Figure IV.4: Expected Outcomes for Beneficiaries at a $100 ALJ Threshold

Expected Outcomes per 10,000 Claimants

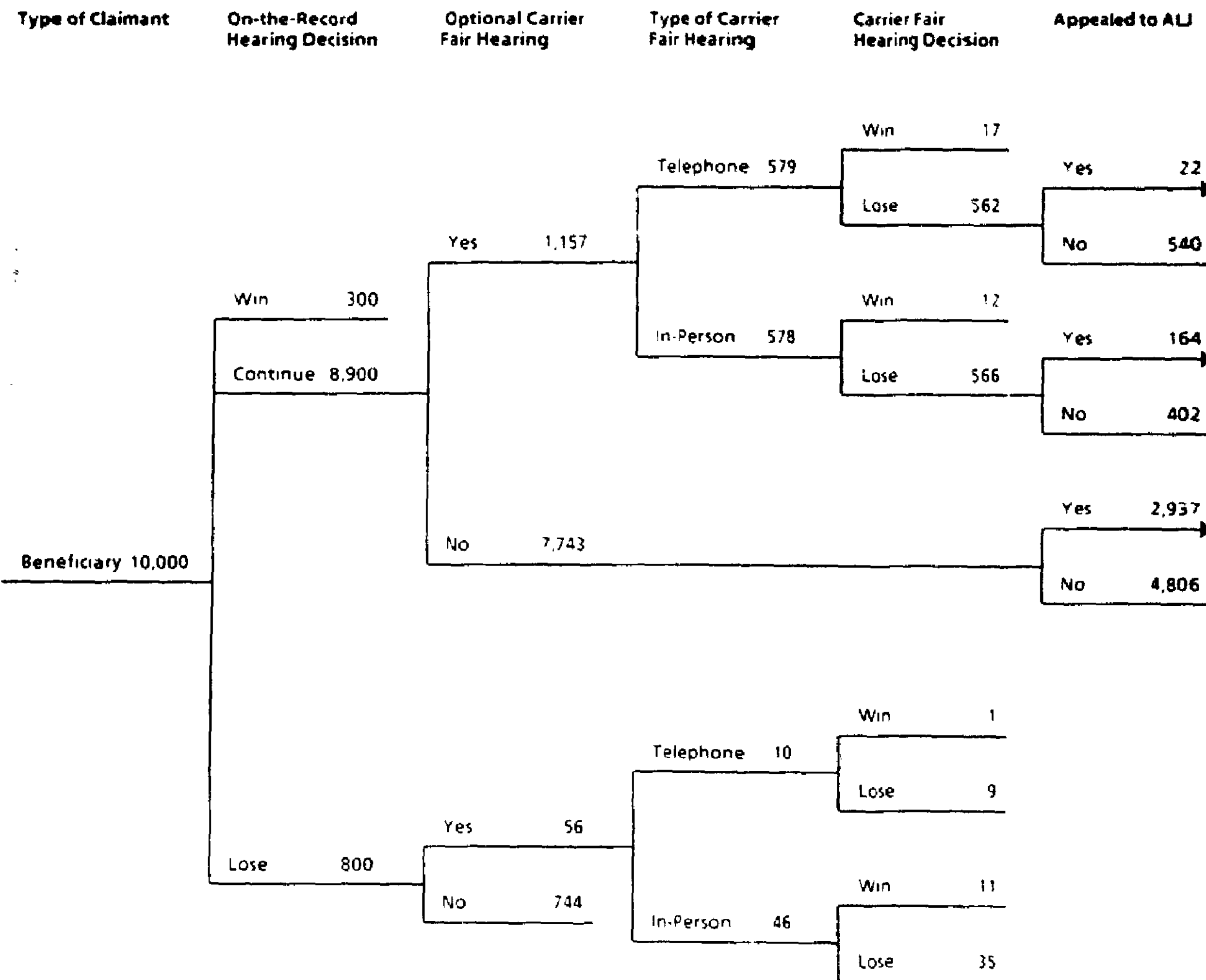


Figure IV.5: Expected Outcomes for Physicians at a $100 ALJ Threshold

Expected Outcomes per 10,000 Claimants

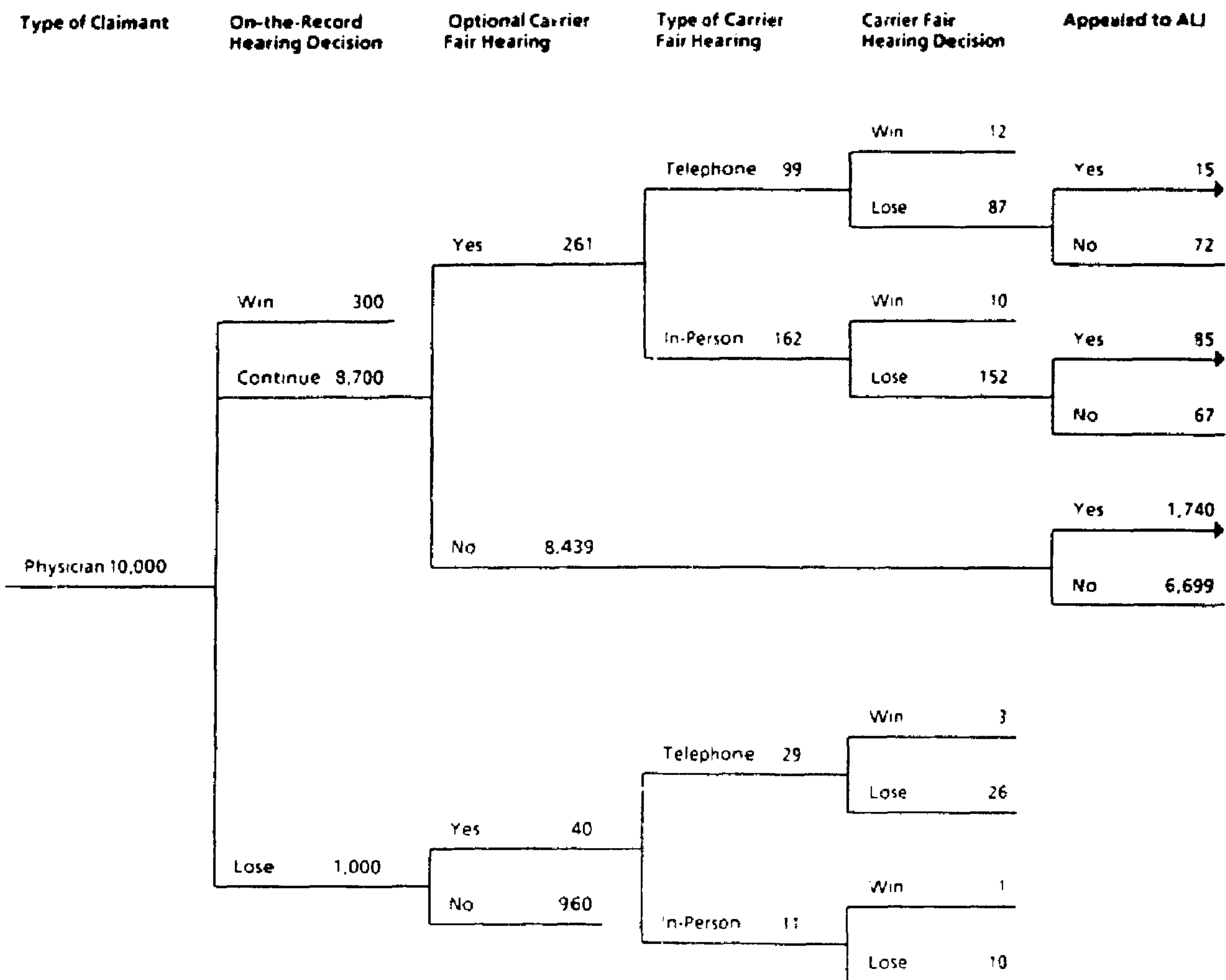
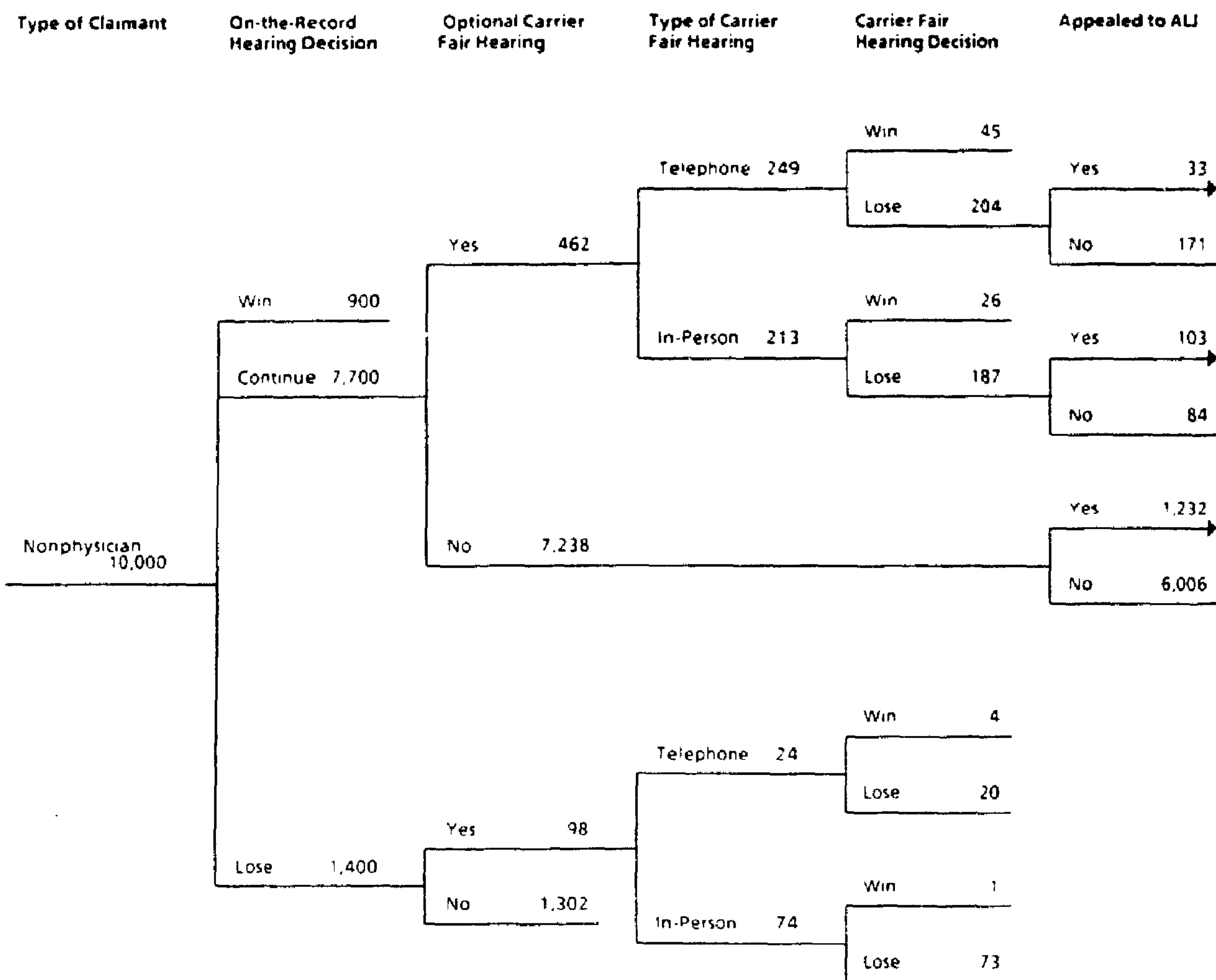


Figure IV.6: Expected Outcomes for Nonphysicians at a $100 ALJ Threshold

Expected Outcomes per 10,000 Claimants



Appendix V

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