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MEDICARE FEE-FOR-SERVICE

Opportunities Remain to Improve Appeals Process

GAO Highlights

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

Why GAO Did This Study

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

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

What GAO Recommends

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

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

What GAO Found

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

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

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