

Fact Sheet

Part C Reconsideration Appeals Data - 2018

Part C Appeals Process

An appeal is the process by which an individual enrolled in a Medicare Health Plan (enrollee) may challenge a plan's organization determination. Appeals begin with a request by an enrollee (or his or her representative) for reconsideration by the plan. If the plan's reconsideration decision continues to uphold its original denial, in whole or in part, the plan must forward the reconsideration to the Part C Independent Review Entity (also called the Part C Qualified Independent Contractor or "Part C QIC"). An enrollee who is dissatisfied with the Independent Review Entity's decision may appeal to an Administrative Law Judge. If the enrollee continues to be dissatisfied with the decision, additional appeal levels include the Medicare Appeals Council and federal judicial review.

The following data summarizes and highlights some of the key data on Part C reconsiderations from January 1, 2018 – December 31, 2018.

Reconsideration Volume

The Part C QIC received 84,383 reconsideration requests during calendar year 2018. This represents a rate of 3.95 reconsiderations for each 1,000 Medicare beneficiaries enrolled¹. It also represents a 27.9% increase in the aggregate number of appeals received in 2017, and an increase of 18.6% in the rate of appeals per 1,000 beneficiaries.

Standard pre-service cases represented 18.4% of all appeals received and resulted in a rate of 0.73 reconsiderations for each 1,000 beneficiaries enrolled.

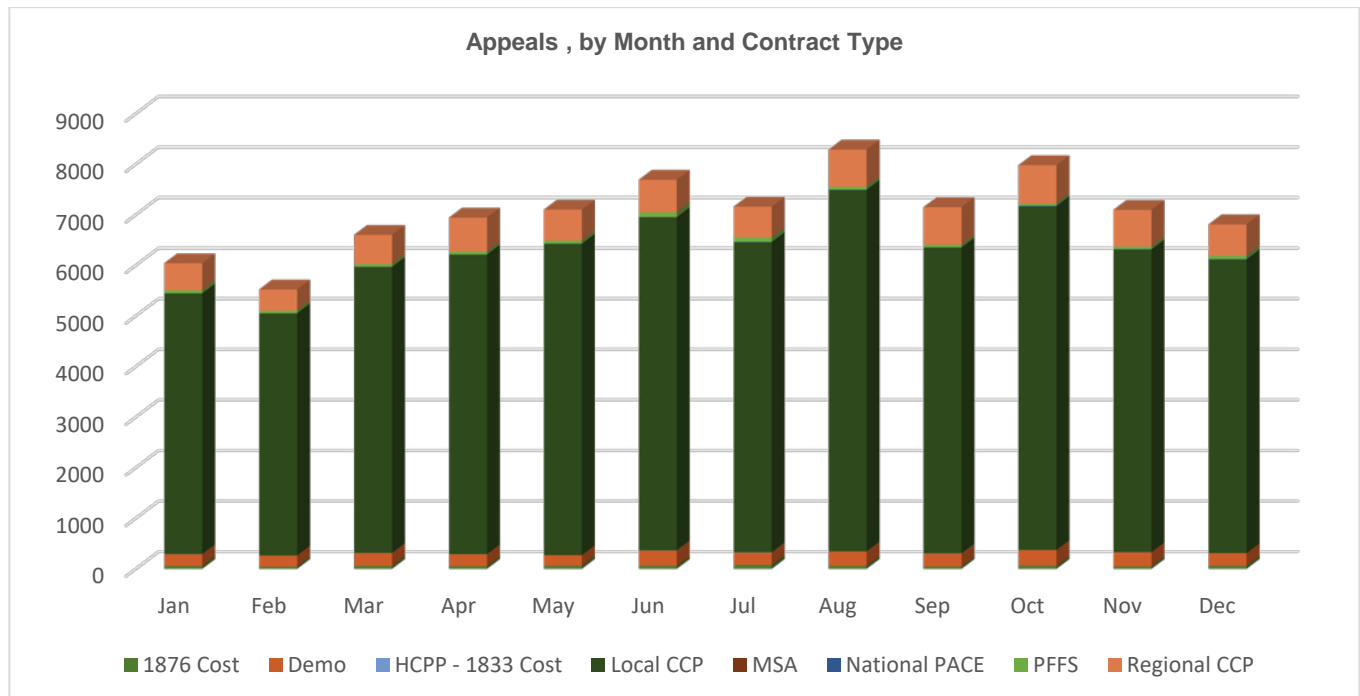
Standard retrospective cases represented 65.9% of all appeals received and resulted in a rate of 2.60 reconsiderations for each 1,000 beneficiaries enrolled.

Expedited cases represented 15.8% of all appeals received and resulted in a rate of 0.62 expedited cases for each 1,000 beneficiaries enrolled.

¹ Annual volume, divided by mid-year enrollment (times 1,000) is used to calculate the annual rate of appeals per 1,000 enrollees.

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Number of appeals received by the Part C QIC by Month and Contract Type



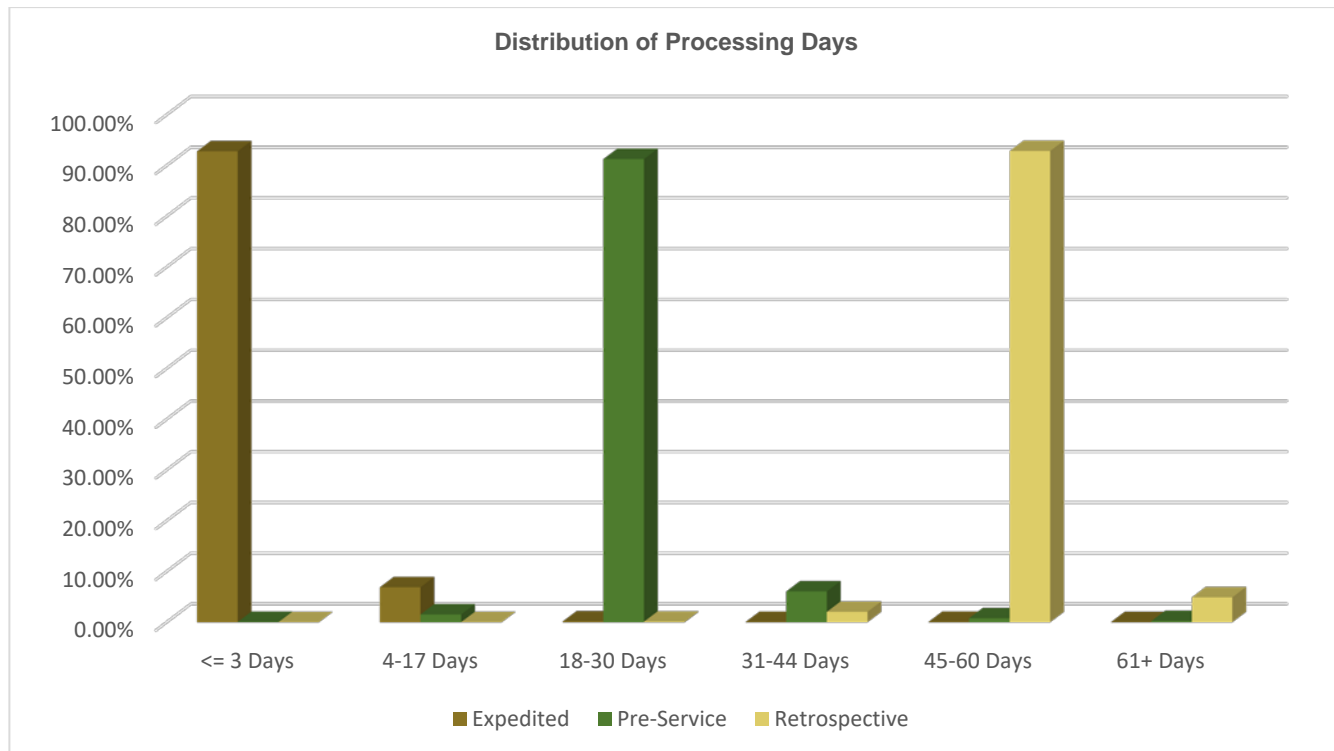
Month	1876 Cost	Demo	HCPP - 1833 Cost	Local CCP	MSA	National PACE	PFFS	Regional CCP	Grand Total
Jan	57	230	4	5,153	1		61	535	6,041
Feb	45	219	1	4,784	1	2	52	418	5,522
Mar	59	253	2	5,648	4	6	57	572	6,601
Apr	54	232	3	5,919	3	4	54	674	6,943
May	60	211		6,147	5	8	54	616	7,101
Jun	60	297	7	6,580	6	6	89	646	7,691
Jul	75	247	4	6,130		6	83	616	7,161
Aug	58	285	2	7,140	2	10	56	735	8,288
Sep	47	252	6	6,044		7	49	745	7,150
Oct	60	312	2	6,787	2	13	49	754	7,979
Nov	50	278	1	5,980	3	8	50	727	7,097
Dec	60	250		5,798	4	11	67	619	6,809
Grand Total	685	3,066	32	72,110	31	81	721	7,657	84,383

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Types of Appeals and Rates of Overturn of Plan Denials Part C 2018 Appeals

Appeal Type	Cases	Substantive Cases	% of Cases	Overtures	% Overturned	% of All Overtures
Chiropractic	7	6	85.7 %	0	0.0 %	0.0 %
DME	10,836	10,089	93.1 %	269	2.6 %	5.8 %
Dental	5,580	5,214	93.4 %	196	3.7 %	4.2 %
Diagnostic Imaging	3,516	2,955	84.0 %	508	17.1 %	11.0 %
Drugs	3,920	3,569	91.0 %	211	5.9 %	4.5 %
Emergency	1,398	1,202	85.9 %	67	5.5 %	1.4 %
Home Health	1,649	1,360	82.4 %	62	4.5 %	1.3 %
Hospital Inpatient	7,911	6,319	79.8 %	646	10.2 %	14.0 %
Laboratory	9,432	7,685	81.4 %	696	9.0 %	15.1 %
Medical Supplies	38	32	84.2 %	1	3.1 %	0.0 %
Non-MD Practitioner	5,227	4,573	87.4 %	295	6.4 %	6.4 %
Other	3,230	2,188	67.7 %	63	2.8 %	1.3 %
Out of Area	57	51	89.4 %	1	1.9 %	0.0 %
Physician Services	22,131	17,856	80.6 %	1,115	6.2 %	24.2 %
Prosthetics/Orthotics	78	69	88.4 %	3	4.3 %	0.0 %
Skilled Nursing Facility	4,206	3,884	92.3 %	334	8.5 %	7.2 %
Transportation	3,637	3,132	86.1 %	66	2.1 %	1.4 %
Vision Care	1,530	1,387	90.6 %	65	4.6 %	1.4 %
Totals:	84,383	71,571	84.8 %	4,598	6.4 %	100.0 %

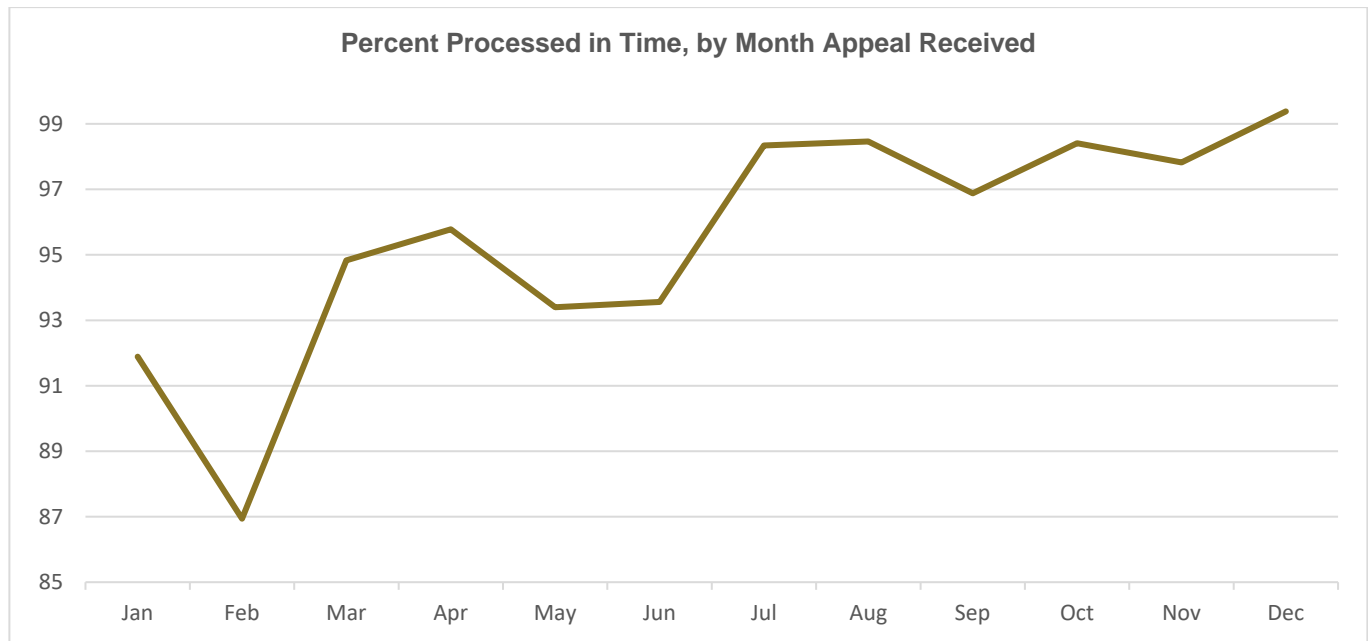
Timeliness of Reconsideration Cases, Calendar Year 2018



Days	Expedited	Pre-Service	Retrospective	Grand Total
<= 3 Days	92.81%	0.06%	0.01%	14.64%
4-17 Days	6.90%	1.54%	0.02%	1.39%
18-30 Days	0.16%	91.28%	0.12%	16.86%
31-44 Days	0.05%	6.08%	2.06%	2.48%
45-60 Days	0.06%	0.80%	92.87%	61.34%
61+ Days	0.02%	0.24%	4.92%	3.29%
Grand Total	100.00%	100.00%	100.00%	100.00%

Variable time standards apply to the completion of appeals of different appeal priorities. Expedited appeals are to be completed in 3 days, unless an extension is warranted to complete information required of the decision. An extension can be for up to 14 additional days. Standard pre-service appeals are to be completed in 30 days; again, an extension of up to 14 days may be taken if warranted. Standard retrospective (claim) denials are to be completed within 60 days.

Processing of Part C Reconsiderations During 2018



Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
91.9%	86.9%	94.8%	95.8%	93.4%	93.6%	98.3%	98.5%	96.9%	98.4%	97.8%	99.4%