Fact Sheet
Original Medicare (Fee-For-Service) Appeals Data - 2017

Appeal Rights under Original Medicare

Individuals enrolled in Original Medicare may file an appeal if they believe Medicare should have paid for, or did not pay enough for, an item or service that they received. An individual's appeal rights are on the back of the Medicare Summary Notice (MSN) mailed to Medicare beneficiaries after they receive services. The MSN explains why a bill was not paid and how to file an appeal. The providers and suppliers of services that file claims on behalf of Medicare beneficiaries may also file appeals.

Background on Medicare Contractors

The Centers for Medicare & Medicaid Services (CMS) contracts with private insurance companies to perform many functions on behalf of the Medicare program, including processing claims for Medicare payment and carrying out the first level of the Medicare claims appeals process. CMS relies on a network of Medicare Administrative Contractors (MACs) to process Medicare claims and to serve as the primary operational contact between the Medicare Fee-For-Service program and health care providers enrolled in the program.

Please click on the following link for more information about MACs:
http://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/MedicareAdministrativeContractors.html

Original Medicare Appeals Process

Once a Medicare contractor makes an initial decision about whether a service is covered by Medicare and how much to pay for the claim, Medicare beneficiaries, providers, and suppliers have the right to appeal these decisions. By law, Medicare offers five levels in the Part A and Part B appeals process. The levels, listed in order, are:

- **Redetermination** by a MAC
  - An individual, provider, or supplier must file an appeal within 120 days of the initial decision on a claim.
  - The MAC must issue its decision within 60 days.
- **Reconsideration** by a Qualified Independent Contractor (QIC)
  - An individual, provider, or supplier must file an appeal within 180 days of the redetermination.
  - The QIC must issue its decision within 60 days.

- **Hearing** by an Administrative Law Judge (ALJ)
  - An individual, provider, or supplier must file an appeal within 60 days of the QIC's reconsideration, provided that the case involves at least $160 in dispute for ALJ hearing requests filed on or after January 1, 2017.
  - The ALJ must issue a decision within 90 days.
- **Review** by the Medicare Appeals Council within the Departmental Appeals Board
  - An individual, provider, or supplier must file an appeal within 60 days of the ALJ's decision.
  - The Medicare Appeals Council must issue a decision within 90 days.
- **Judicial Review** in U.S. District Court
  - An individual has 60 days to file for judicial review, provided that at least $1,560 remains in dispute for appeals to Federal District Court filed on or after January 1, 2017.

Please click on the following link for more information on each level in the appeals process: https://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/index.html.

Redeterminations

Category	Part A	Part B	DME
Total Claims Processed at Initial Determination	221 million	947 million	63 million
Claims Denied at Initial Determination	16 million	89 million	9 million
Claim Denial Rate at Initial Determination	7%	9%	15%
Denied Claims Appealed to MAC	361,000	2.7 million	
Appeal Rate of Denied Claims	2%	3%	
Timeliness of Appeals Processing at MAC Level	99%	99%	99%

Please click on the following link for more information on redeterminations. http://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/RedeterminationbyaMedicareContractor.html

*While these include claims for Medicare Parts A & B of A, for ease of reference, we refer to appeals of these types of claims as "Part A."

Note: Claims identified by specialty contractors (e.g., Recovery Auditors, Zone Program Integrity Contractors, etc.) with overpayment determinations are not included in the claims denial count.

2017 Redetermination Categories

Redetermination Categories – Part A

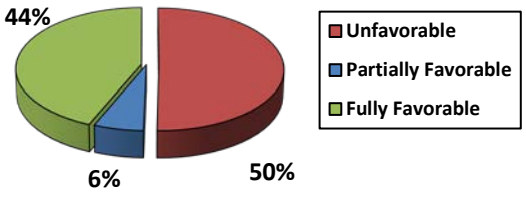
Appeal Category	Decided Claims	Percent
Other (Hospice, etc.)	96,292	27%
Lab	84,617	23%
Outpatient	80,717	22%
Home Health	69,453	19%
Inpatient	14,476	4%
Skilled Nursing Facility (SNF)	13,918	4%
Ambulance	2,034	1%
TOTAL	361,507	100%

Redetermination Categories – Part B

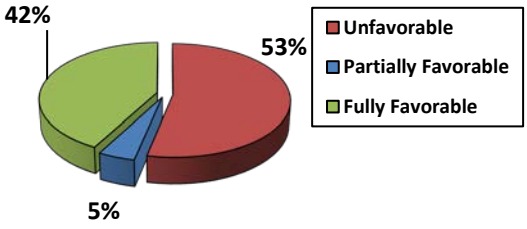
Appeal Category	Decided Claims	Percent
Physician	1,401,383	51%
Durable Medical Equipment (DME)	916,551	33%
Other (Preventative Services, Vision, etc.)	157,842	6%
Lab	152,485	6%
Ambulance	121,064	4%
Total	2,749,325	100%

Redetermination Dispositions for 2017

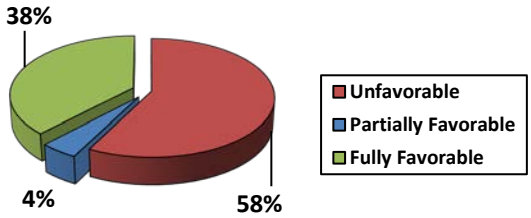
Part A Redeterminations



Part B Redeterminations



DME Redeterminations



Note: A "favorable" decision means that the appeal was successful and the claim in dispute was paid. An "unfavorable" decision means that an appellants' appeal was denied. Calculation of the reversal rates above excludes cases that were dismissed.

Reconsiderations

Category	Part A	Part B	DME
Number of Qualified Independent Contractors (QICs)	2	2	1
Claims Processed at QIC Level	808,018		
Timeliness of Appeals Processing at QIC Level	95%	100%	100%

Please click on the following link for more information on reconsiderations.
http://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/ReconsiderationbyaQualifiedIndependentContractor.html

Top 10 Part A Reconsideration Categories for 2017

Appeal Category	Decided Claims	% of Total
MSP	55,032	33%
Home Health	29,009	18%
Skilled Nursing Facility	15,487	9%
Outpatient Therapies / CORF	10,758	7%
Outpatient Hospital / ASC	7,007	4%
Drugs	6,745	4%
Hospice	6,436	4%
Imaging/Radiology	5,561	3%
Acute Inpatient Rehab.	5,437	3%
AC Dismissal	4,469	3%

Top 10 Part B Reconsideration Categories for 2017

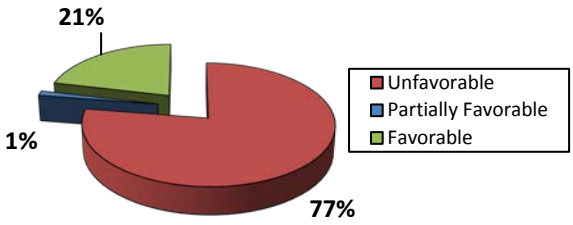
Appeal Category	Decided Claims	% of Total
Other	37,306	13%
Pathology/Laboratory	34,460	12%
Office E/M Services	33,946	12%
Ground Transportation	28,373	10%
Imaging/Radiology	28,282	10%
Integum/Muscular-skeletal Surgery	16,443	6%
Respiratory/Cardiovascular Surgery	13,110	5%
Hospital E/M Services	12,642	4%
AC Dismissal	12,370	4%
Nervous System Surgery	10,907	4%

Top 10 DME Reconsideration Categories for 2017

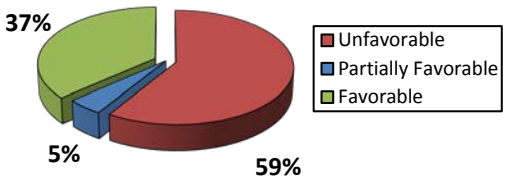
Appeal Category	Decided Claims	% of Total
Oxygen	130,098	37%
Positive Airway Pressure Device	45,863	13%
Glucose Monitors	27,265	8%
AC Dismissal	22,977	7%
Nebulizers & Drugs	22,726	7%
Surgical Dressings	16,798	5%
Orthoses	12,798	4%
Manual Wheelchairs	11,429	3%
Ostomy & Urological	11,374	3%
Hospital Bed & Support Surfaces	10,937	3%

Reconsideration Dispositions for 2017

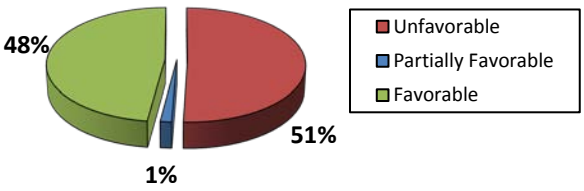
Part A Reconsiderations



Part B Reconsiderations



DME Reconsiderations

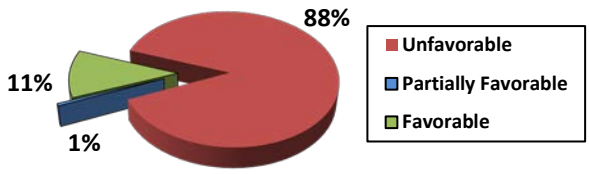


Note: A "favorable" decision means that the appeal was successful and the claim in dispute was paid. An "unfavorable" decision means that an appellants' appeal was denied. Calculation of the rates above excludes cases that were dismissed. Also, in some cases the totaling of the decisions' percent (%) may not add up to exactly 100% because the values (in %) are rounded and entered as calculated.

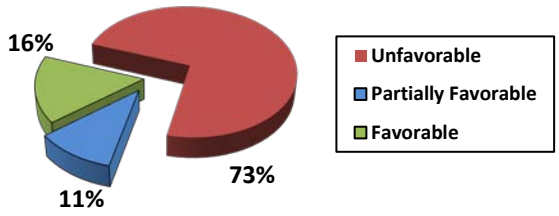
Specialty Contractor Reconsideration Dispositions 2017

As part of the overall reconsideration workload, the results of several other Medicare payment audit activities impact the volume of claims in the appeals process. The Recovery Auditors that pursue Medicare overpayments for items or services that were incorrectly paid, and the Zone Program Integrity Contractors (ZPICs) that pursue overpayments related to alleged fraudulent activity are two sub-groups of activities that are specially tracked within the total number of reconsiderations. For more information on these programs, please visit the Recovery Auditor Program website at:
https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/
and the Medicare Program Integrity Manual for the ZPICs at:
http://www.cms.gov/manuals/downloads/pim83c04.pdf.

Recovery Auditors Reconsiderations



ZPIC Reconsiderations



Note: A "favorable" decision means that the appeal was successful and the claim in dispute was paid. An "unfavorable" decision means that an appellants' appeal was denied. Calculation of the rates above excludes cases that were dismissed. There were 10,267 Recovery Auditor appeals (in claims) and 45,216 ZPIC appeals (in claims) processed in 2017.