Fact Sheet
Original Medicare (Fee-For-Service) Appeals Data - 2018

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, 2018.
  - 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 $1,600 remains in dispute for appeals to Federal District Court filed on or after January 1, 2018.

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	223 million	953 million	66 million
Claims Denied at Initial Determination	16 million	91 million	10 million
Claim Denial Rate at Initial Determination	7%	10%	15%
Denied Claims Appealed to MAC	365,000	2.4 million	
Appeal Rate of Denied Claims	2%	2%	
Timeliness of Appeals Processing at MAC Level	100%	98%	100%

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.

2018 Redetermination Categories

Redetermination Categories – Part A

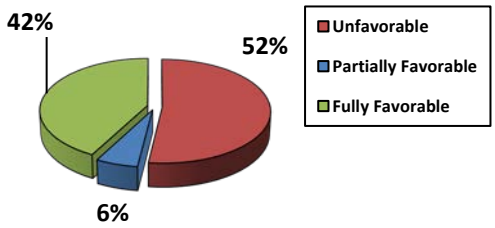
Appeal Category	Decided Claims	Percent
Other (Hospice, etc.)	166,047	46%
Lab	87,866	24%
Outpatient	50,379	14%
Home Health	36,285	10%
Skilled Nursing Facility (SNF)	12,356	3%
Inpatient	10,075	3%
Ambulance	1,778	<1%
TOTAL	364,786	100%

Redetermination Categories – Part B

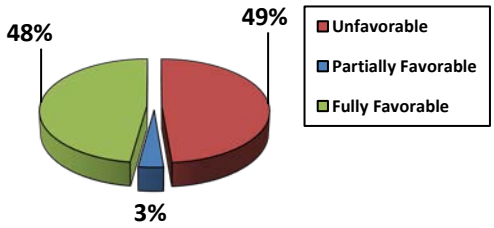
Appeal Category	Decided Claims	Percent
Physician	1,526,924	63%
Durable Medical Equipment (DME)	568,901	24%
Lab	120,584	5%
Ambulance	97,432	4%
Other (Preventative Services, Vision, etc.)	97,278	4%
Total	2,411,119	100%

Redetermination Dispositions for 2018

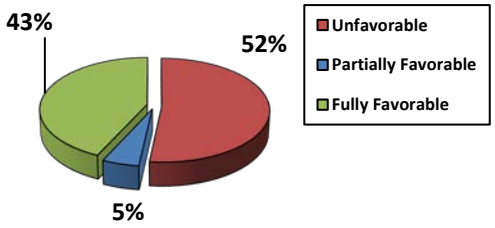
Part A Redeterminations



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	672,000		
Timeliness of Appeals Processing at QIC Level	100%	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 2018

Appeal Category	Decided Claims	% of Total
MSP	66,191	34%
Home Health	29,328	15%
AC Dismissal	28,533	15%
Skilled Nursing Facility	16,143	8%
Hospice	9,396	5%
ESRD Facility	7,645	4%
Drugs	4,937	3%
Acute Inpatient Rehab.	4,882	3%
Outpatient Hospital / ASC	4,143	2%
Outpatient Therapies / CORF	3,892	2%

Top 10 Part B Reconsideration Categories for 2018

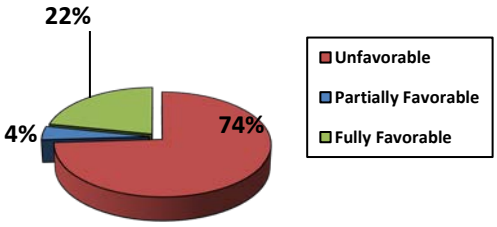
Appeal Category	Decided Claims	% of Total
Other	79,447	29%
Office E/M Services	24,988	9%
Pathology/Laboratory	22,662	8%
Ground Transportation	18,875	7%
Hospital E/M Services	13,891	5%
Integum/Musc-skeletal Sur	13,466	5%
Facility E/M: SNF/Asst/Home	13,445	5%
Imaging/Radiology	10,928	4%
AC Dismissal	10,747	4%
Outpatient Therapies / CORF	10,065	4%

Top 10 DME Reconsideration Categories for 2018

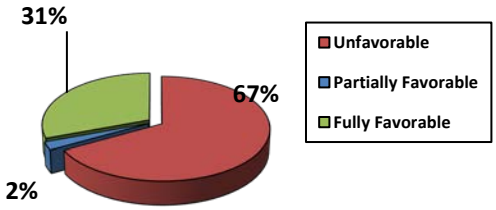
Appeal Category	Decided Claims	% of Total
Oxygen	71,673	35%
Pos. Airway Pressure Device	38,759	19%
Glucose Monitors	11,393	6%
Orthoses	9,946	5%
Miscellaneous DMEPOS	8,787	4%
Manual Wheelchairs	8,330	4%
Ostomy & Urological	7,878	4%
Nebulizers & Drugs	7,830	4%
Neg. Pressure Wound Therapy	6,033	3%
Surgical Dressings	4,860	2%

Reconsideration Dispositions for 2018

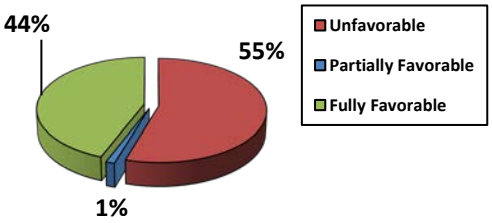
Part A Reconsiderations



Part B Reconsiderations



DME Reconsiderations

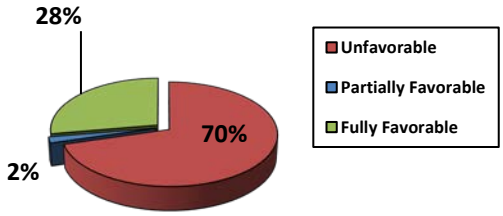


Note: A “favorable” decision means that the appeal was successful and the claim in dispute was paid. An “unfavorable” decision means that an appellants’ appeal was denied. Calculation of the rates above excludes cases that were dismissed.

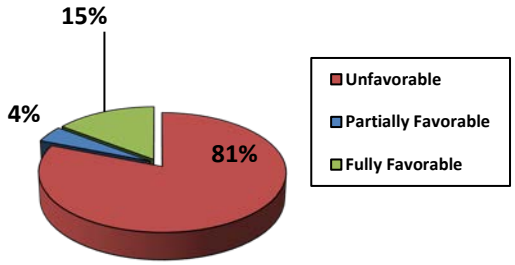
Specialty Contractor Reconsideration Dispositions 2018

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 Unified Program Integrity Contractors (UPICs) 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 UPICs
at: http://www.cms.gov/manuals/downloads/pim83c04.pdf.

Recovery Auditors Reconsiderations



UPIC 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 2,024 Recovery Auditor appeals (in claims) and 64,677 UPIC appeals (in claims) processed in 2018.