Original Medicare (Fee-For-Service) Appeals Data – 2021

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 and suppliers 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 determination 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 determinations. 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 calendar days of receipt of the initial determination on a claim.
  - The MAC generally issues its decision within 60 calendar days of the date it receives the request for redetermination.
- **Reconsideration** by a Qualified Independent Contractor (QIC)
  - An individual, provider, or supplier must file an appeal within 180 calendar days of receipt of the redetermination.
  - The QIC generally issues its decision within 60 calendar days of the date it receives the request for reconsideration.

- **Hearing** by an Administrative Law Judge (ALJ) or review by an attorney adjudicator
  - An individual, provider, or supplier must file an appeal within 60 calendar days after receipt of the QIC's reconsideration. The amount remaining in controversy in the case must be at least $180 for ALJ hearing requests filed on or after January 1, 2021.
  - The ALJ (or attorney adjudicator, as applicable) generally issues a decision within 90 calendar days of receipt of the request for hearing. If the ALJ or attorney adjudicator does not issue a decision, dismissal, or remand within the applicable adjudication timeframe, the appellant may request to escalate the appeal to the Medicare Appeals Council.
- **Review** by the Medicare Appeals Council within the Departmental Appeals Board
  - An individual, provider, or supplier must file an appeal within 60 calendar days after receipt of the ALJ's or attorney adjudicator's decision.
  - The Medicare Appeals Council generally issues a decision within 90 calendar days of receipt of the request for review. If the Medicare Appeals Council does not issue a decision, dismissal, or remand within the applicable adjudication timeframe, the appellant may request to escalate the appeal to Federal district court.
- **Judicial Review** in U.S. District Court
  - An individual must file for judicial review within 60 calendar days after receipt of the Medicare Appeals Council's decision. The amount remaining in controversy in the case must be at least $1,760 to file an appeal in Federal District Court on or after January 1, 2021.

*In limited situations, a provider or supplier can also file a request for judicial review.

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.

Redetermination

Category	Part A*	Part B	DME
Total Claims Processed at Initial Determination	222 million	929 million	56 million
Claims Denied at Initial Determination	27 million	80 million	7 million
Claim Denial Rate at Initial Determination	12%	9%	13%
Denied Claims Appealed to MAC	369,000	1.8 million	
Appeal Rate of Denied Claims	1%	2%	
Timeliness of Appeals Processing at MAC Level	100%	100%	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 and 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 Audit Contractors (RACs), Unified Program Integrity Contractors (UPICs), etc.) with overpayment determinations are not included in the claims denial count.

2021 Redetermination Categories

Redetermination Categories – Part A

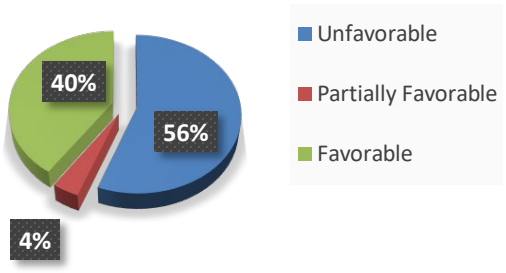
Appeal Category	Decided Claims	Percent
Drugs	92,453	25%
Hospital Evaluation and Management (E/M) Services	78,677	21%
Imaging / Radiology	28,150	8%
Pathology / Laboratory	27,353	7%
Hospice	22,388	6%
Outpatient Hospital / Ambulatory Surgical Center (ASC)	21,610	6%
Home Health	21,337	6%
Other Surgery	20,949	6%
Acute Inpatient Hospital	11,097	3%
Outpatient Therapies / Comprehensive Outpatient Rehabilitation Facility (CORF)	8,075	2%
Other categories	36,549	10%
Total	**368,638**	**100%**

Redetermination Categories – Part B

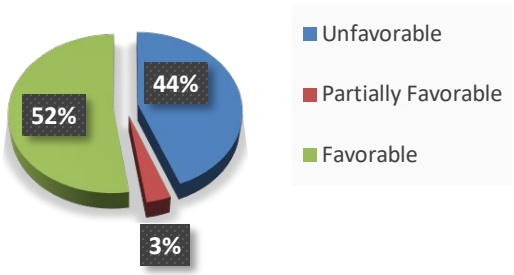
Appeal Category	Decided Claims	Percent
Physician	1,198,505	67%
Durable Medical Equipment (DME)	343,254	19%
Lab	89,536	5%
Ambulance	80,836	5%
Other (Preventative Services, Vision, etc.)	73,408	4%
Total	**1,785,539**	**100%**

Redetermination Dispositions for 2021

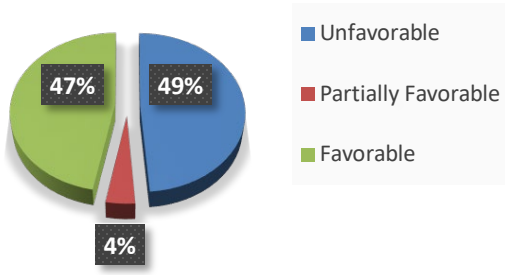
Part A Redeterminations



Part B Redeterminations



DME Redeterminations



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

Reconsideration

Category	Part A	Part B	DME
Number of QICs	2	2	1
Claims Processed at QIC Level	466,000		
Timeliness of Appeals Processing at QIC Level	100%	99%	99%

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 2021

Appeal Category	Decided Claims	% of Total
Medicare Secondary Payer (MSP)	131,352	50%
Administrative Contractor (AC) Dismissal	68,707	26%
Hospice	15,727	6%
Skilled Nursing Facility	11,122	4%
Home Health	10,629	4%
Drugs	5,415	2%
Outpatient Hospital / ASC	4,871	2%
Imaging / Radiology	2,569	1%
Other Surgery	1,987	1%
Acute Inpatient Hospital	1,935	1%

Top 10 Part B Reconsideration Categories for 2021

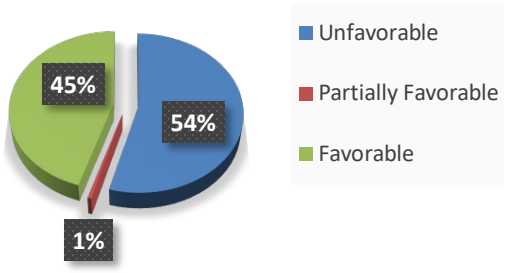
Appeal Category	Decided Claims	% of Total
Pathology / Laboratory	22,293	18%
Home Health	16,469	13%
Other	14,159	11%
Ground Transportation	11,430	9%
Office E/M Services	8,208	7%
Imaging / Radiology	8,157	6%
Integumentary / Musculoskeletal Surgery	6,802	5%
Administrative Contractor (AC) Dismissal	5,444	4%
Outpatient Therapies / CORF	4,565	4%
Drugs	4,555	4%

Top 10 DME Reconsideration Categories for 2021

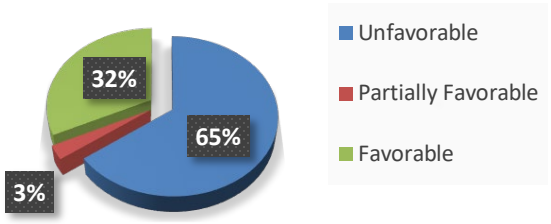
Appeal Category	Decided Claims	% of Total
Orthoses	13,008	17%
Miscellaneous DME	12,538	17%
Positive Airway Pressure Device	8,398	11%
Surgical Dressings	7,159	10%
Negative Pressure Wound Therapy	7,007	9%
Oxygen	4,531	6%
Glucose Monitors	3,529	5%
Pneumatic Compressor	3,372	4%
Ostomy & Urological	2,484	3%
Respiratory - Miscellaneous	2,288	3%

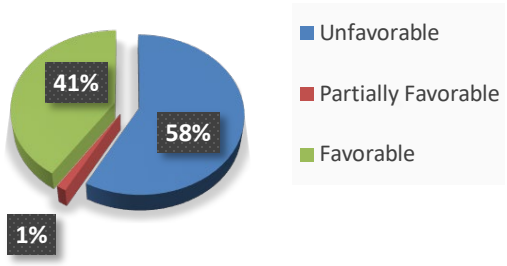
Reconsideration Dispositions for 2021

Part A Reconsiderations



Part B Reconsiderations





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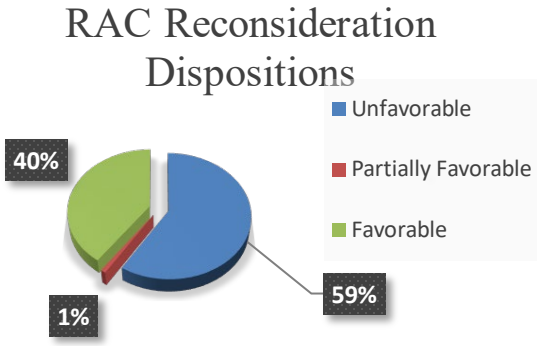
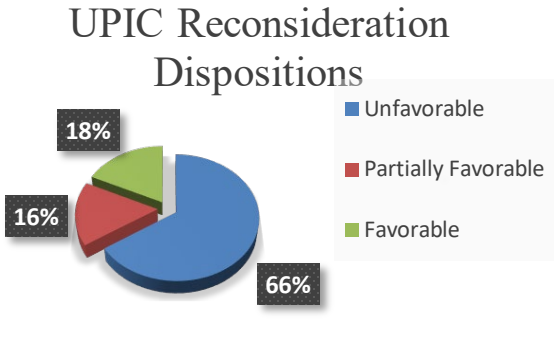
Specialty Contractor Reconsideration Dispositions for 2021

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 Audit Contractors (RACs) 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 Audit 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
at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c04pdf.pdf.





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