Original Medicare (Fee-For-Service) Appeals Data – 2023

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 in calendar year 2023.
  - 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 $1,850 to file an appeal in Federal District Court in calendar year 2023.

*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.

Redetermination

Category	Part A*	Part B	DME
Total Claims Processed at Initial Determination	190 million	893 million	55 million
Claims Denied at Initial Determination	15 million	87 million	7 million
Claim Denial Rate at Initial Determination	8%	10%	13%
Denied Claims Appealed to MAC	319,000	2.05 million	
Appeal Rate of Denied Claims	2%	2%	
Timeliness of Appeals Processing at MAC Level	100%	99%	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.

2023 Redetermination Categories

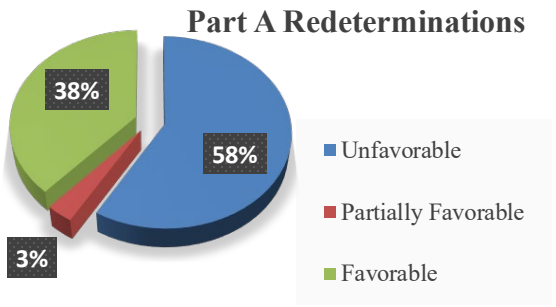
Redetermination Categories – Part A

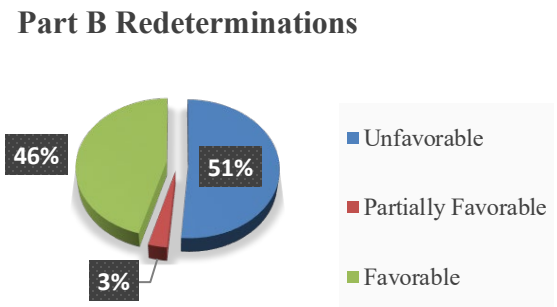
Appeal Category	Decided Claims	Percent
Drugs	59,631	19%
Pathology / Laboratory	43,000	13%
Hospice	36,887	12%
Other Surgery	29,279	9%
Imaging / Radiology	27,829	9%
Home Health	23,423	7%
Outpatient Hospital / Ambulatory Surgical Center (ASC)	20,131	6%
Outpatient Therapies / Comprehensive Outpatient Rehabilitation Facility (CORF)	17,952	6%
Acute Inpatient Hospital	11,462	4%
Skilled Nursing Facility	7,194	2%
Other categories	42,447	13%
Total	**319,235**	**100%**

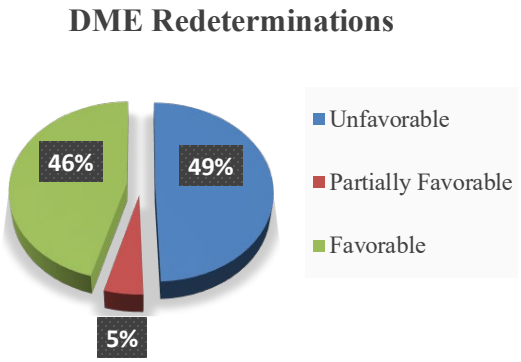
Redetermination Categories – Part B

Appeal Category	Decided Claims	Percent
Physician	1,383,380	68%
Durable Medical Equipment (DME)	370,960	18%
Lab	133,694	7%
Ambulance	81,075	4%
Other (Preventative Services, Vision, etc.)	78,356	4%
Total	**2,047,465**	**100%**

Redetermination Dispositions for 2023







Disposition percentages may not add up to 100% due to rounding.

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

Reconsideration

Category	Part A	Part B	DME
Number of QICs	2	2	1
Reconsiderations Processed*	416,000		
Timeliness of Appeals Processing at QIC Level	100%	100%	100%

*Reconsiderations processed count is in claims appealed to the QICs.

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 2023

Appeal Category	Decided Claims	% of Total
Medicare Secondary Payer (MSP)	88,490	47%
Hospice	27,462	15%
Home Health	15,210	8%

Administrative Contractor (AC) Dismissal	12,718	7%
Skilled Nursing Facility	11,937	6%
Outpatient Hospital / ASC	7,357	4%
Drugs	5,918	3%
Outpatient Therapies / CORF	3,651	2%
Other Surgery	3,178	2%
Imaging / Radiology	2,748	1%

Top 10 Part B Reconsideration Categories for 2023

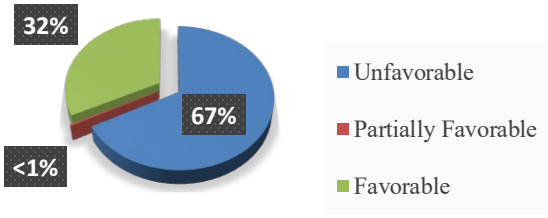
Appeal Category	Decided Claims	% of Total
Pathology / Laboratory	26,560	17%
Imaging / Radiology	18,645	12%
Integumentary / Musculoskeletal Surgery	15,989	10%
Ground Transportation	12,717	8%
Nervous System Surgery	12,004	8%
Other	11,025	7%
AC Dismissal	9,998	7%
Drugs	7,773	5%
Office Evaluation and Management (E/M) Services	6,406	4%
Outpatient Therapies / CORF	5,560	4%

Top 10 DME Reconsideration Categories for 2023

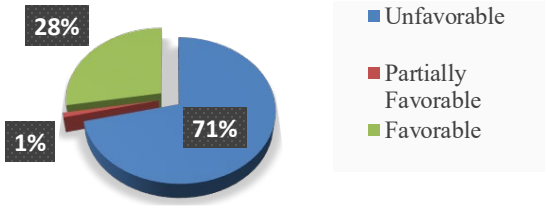
Appeal Category	Decided Claims	% of Total
Orthoses	12,375	18%
Miscellaneous Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)	6,557	10%
Surgical Dressings	6,509	9%
Ostomy & Urological	5,448	8%
Respiratory - Miscellaneous	4,882	7%
Power Mobility Devices	4,362	6%
Enteral / Parenteral Nutrition	4,235	6%
Glucose Monitors	4,194	6%
Pneumatic Compressor	4,055	6%
Negative Pressure Wound Therapy	3,180	5%

Reconsideration Dispositions for 2023

Part A Reconsiderations*

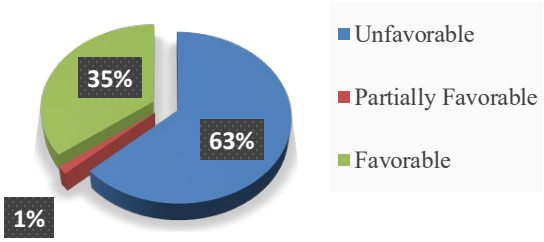


Part B Reconsiderations



*Part A reconsideration disposition percent of partially favorable decision is 0.33% but it is indicated as "<1%" in the chart to keep the rounding method consistent.

DME Reconsiderations



Disposition percentages may not add up to 100% due to rounding.

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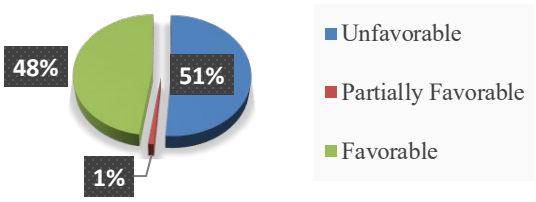
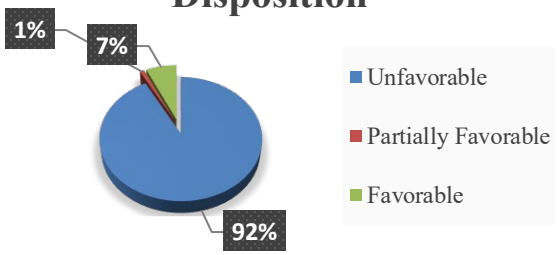
Specialty Contractor Reconsideration Dispositions for 2023

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 improper payments for items or services 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.

RAC Reconsideration Disposition



UPIC Reconsideration Disposition



Note: A “favorable” decision means that the appeal was successful and the issues on the claim in dispute were paid in full. A “partially favorable” decision means that the appellant’s appeal was partially denied and the issues on the claim in dispute were paid in part. An “unfavorable” decision means that an appellant’s appeal was denied. Calculation of the rates above excludes cases that were dismissed. There were 13 005 RAC appeals (in claims) and 25 584 UPIC appeals (in claims) processed in 2023.