Original Medicare (Fee-For-Service) Appeals Data - 2019

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 calendar days of receipt of the initial decision on a claim.
  - The MAC must issue 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 must issue its decision within 60 calendardays of the date it receives the request for reconsideration.

- **Hearing** by an Administrative Law Judge (ALJ)
  - 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 $160 for ALJ hearing requests filed on or after January 1, 2019.
  - The ALJ (or attorney adjudicator, as applicable) should issue a decision within 90 calendar days of receipt of the request for hearing or the appellant may 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 decision.
  - The Medicare Appeals Council should issue a decision within 90 calendar days of receipt of the request for review or the appellant may file for judicial review.
- **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 $1,630 to file an appeal in Federal District Court on or after January 1, 2019.

*In limited situations, a provider or supplier can also 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.

Redeterminations

Category	Part A*	Part B	DME
Total Claims Processed at Initial Determination	222 million	959 million	64 million
Claims Denied at Initial Determination	16 million	90 million	8 million
Claim Denial Rate at Initial Determination	7%	9%	13%
Denied Claims Appealed to MAC	443,000	2.3 million	
Appeal Rate of Denied Claims	3%	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.

2019 Redetermination Categories

Redetermination Categories – Part A

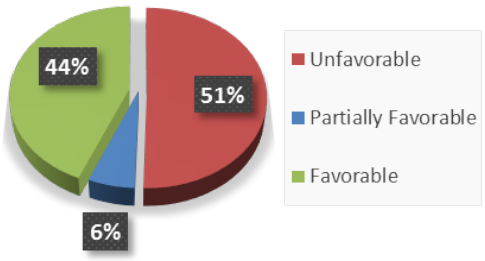
Appeal Category	Decided Claims	Percent
Drugs	210,551	48%
Pathology / Laboratory	58,793	13%
Home Health	29,114	7%
Outpatient Hospital / Ambulatory Surgical Center (ASC)	28,275	6%
Imaging / Radiology	27,641	6%
Other Surgery	14,290	3%
Outpatient Therapies / Comprehensive Outpatient Rehabilitation Facility (CORF)	12,453	3%
Hospital Evaluation and Management Services	11,432	3%
Acute Inpatient Hospital	9,498	2%
Skilled Nursing Facility	7,823	2%
Other categories	32,957	7%
Total	**442,827**	**100%**

Redetermination Categories – Part B

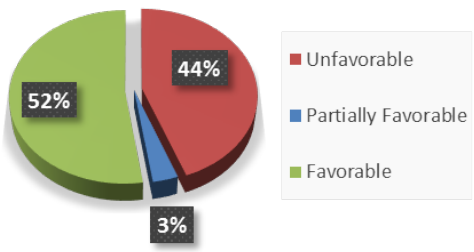
Appeal Category	Decided Claims	Percent
Physician	1,530,077	68%
Durable Medical Equipment (DME)	428,284	19%
Lab	126,870	6%
Ambulance	96,223	4%
Other (Preventative Services, Vision, etc.)	81,161	4%
Total	**2,262,615**	**100%**

Redetermination Dispositions for 2019

Part A Redeterminations

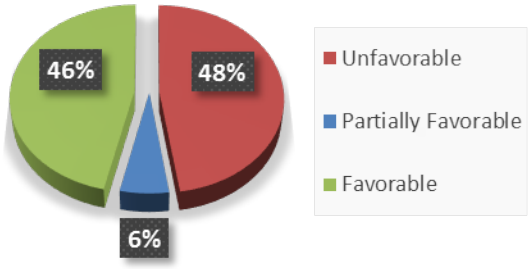


Part B Redeterminations



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

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.

Reconsiderations

Category	Part A	Part B	DME
Number of QICs	2	2	1*
Claims Processed at QIC Level	528,000		
Timeliness of Appeals Processing at QIC Level	100%	100%	99%

*In September 2019, the DME QIC transitioned from C2C to Maximus.

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 2019

Appeal Category	Decided Claims	% of Total
Administrative Contractor (AC) Dismissal	92,293	40%
Medicare Secondary Payer (MSP)	71,175	31%
Home Health	18,722	8%
Skilled Nursing Facility	15,010	7%
Hospice	5,557	2%
Drugs	5,370	2%
Outpatient Therapies / CORF	3,763	2%
Outpatient Hospital / ASC	3,476	2%
Imaging / Radiology	3,318	1%
Pathology / Laboratory	2,488	1%

Top 10 Part B Reconsideration Categories for 2019

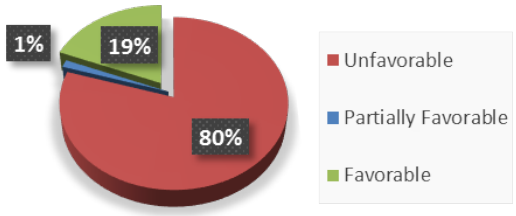
Appeal Category	Decided Claims	% of Total
Office Evaluation and Management Services	29,232	16%
Pathology / Laboratory	22,623	12%
Other	22,117	12%
Ground Transportation	17,277	10%
Integumentary / Musculoskeletal Surgery	11,368	6%
AC Dismissal	9,658	5%
Eligibility	8,882	5%
Imaging / Radiology	8,398	5%
Hospital Evaluation and Management Services	7,065	4%
Outpatient Therapies / CORF	7,038	4%

Top 10 DME Reconsideration Categories for 2019

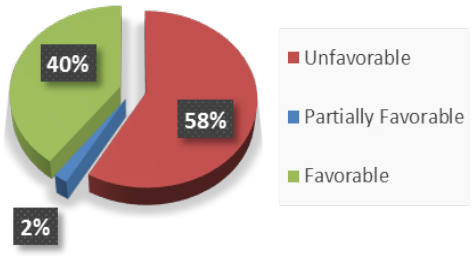
Appeal Category	Decided Claims	% of Total
Oxygen	42,026	37%
Glucose Monitors	11,000	10%
Positive Airway Pressure Device	10,548	9%
Orthoses	9,290	8%
Miscellaneous Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)	7,151	6%
Surgical Dressings	4,739	4%
Nebulizers and Drugs	3,859	3%
Negative Pressure Wound Therapy	3,287	3%
Ostomy and Urological	2,835	3%
Enteral / Parenteral Nutrition	2,806	2%

Reconsideration Dispositions for 2019

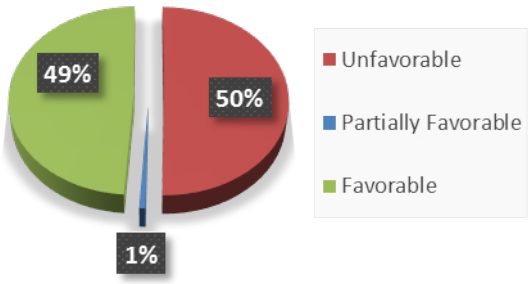
Part A Reconsiderations



Part B Reconsiderations



DME Reconsiderations



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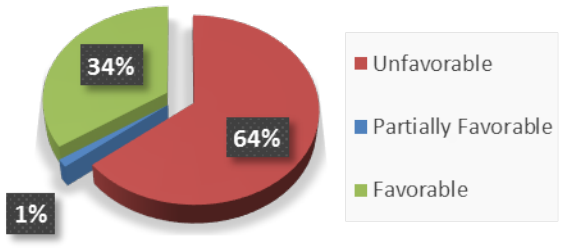
Specialty Contractor Reconsideration Dispositions 2019

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.

RAC Reconsiderations



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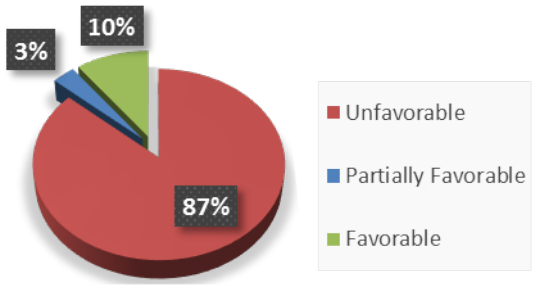
UPIC Reconsiderations



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