Original Medicare (Fee-For-Service) Appeals Data - 2020

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 $170 for ALJ hearing requests filed on or after January 1, 2020 and before 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 $1,670 to file an appeal in Federal District Court on or after January 1, 2020 and before 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	201 million	838 million	60 million
Claims Denied at Initial Determination	15 million	74 million	8 million
Claim Denial Rate at Initial Determination	8%	9%	13%
Denied Claims Appealed to MAC	392,000	2.1 million	
Appeal Rate of Denied Claims	3%	3%	
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.

2020 Redetermination Categories

Redetermination Categories – Part A

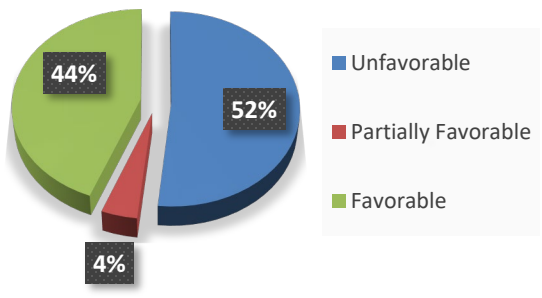
Appeal Category	Decided Claims	Percent
Drugs	126,754	32%
Hospital Evaluation and Management Services	89,475	23%
Pathology / Laboratory	31,494	8%
Outpatient Hospital / Ambulatory Surgical Center (ASC)	25,769	7%
Imaging / Radiology	25,081	6%
Home Health	16,903	4%
Other Surgeries	15,929	4%
Outpatient Therapies / Comprehensive Outpatient Rehabilitation Facility (CORF)	10,108	3%
Hospice	9,931	3%
Acute Inpatient Hospital	8,981	2%
Other categories	31,439	8%
Total	**391,864**	**100%**

Redetermination Categories – Part B

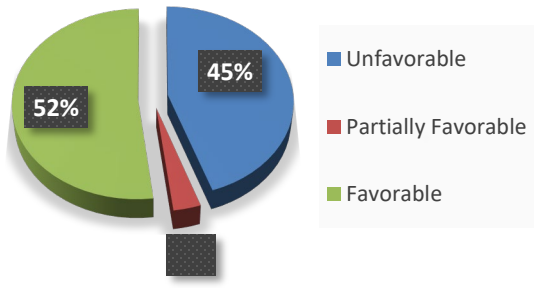
Appeal Category	Decided Claims	Percent
Physician	1,330,514	64%
Durable Medical Equipment (DME)	408,004	20%
Lab	178,732	9%
Ambulance	95,248	5%
Other (Preventative Services, Vision, etc.)	65,674	3%
Total	**2,078,172**	**100%**

Redetermination Dispositions for 2020

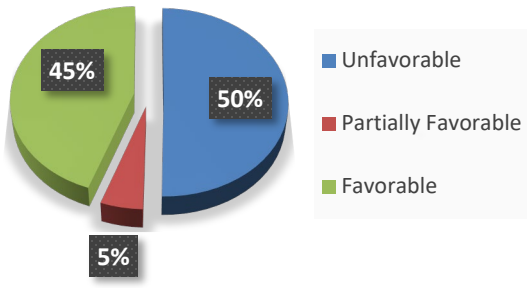
Part A Redeterminations



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	528,000		
Timeliness of Appeals Processing at QIC Level	100%	99%	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 2020

Appeal Category	Decided Claims	% of Total
Medicare Secondary Payer (MSP)	118,697	44%
Administrative Contractor (AC) Dismissal	91,952	34%
Home Health	15,080	6%
Skilled Nursing Facility	11,003	4%
Drugs	7,019	3%
Outpatient Hospital / ASC	5,279	2%
Hospice	4,545	2%
Imaging / Radiology	3,365	1%
Acute Inpatient Hospital	2,341	1%
Outpatient Therapies / CORF	2,060	1%

Top 10 Part B Reconsideration Categories for 2020

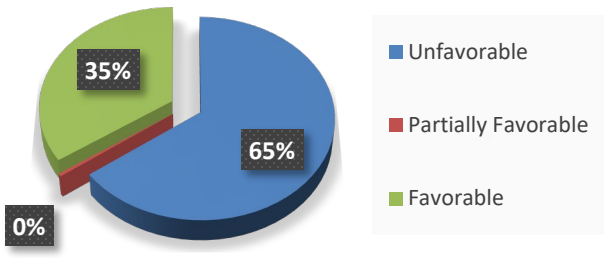
Appeal Category	Decided Claims	% of Total
Other	36,366	21%
Pathology / Laboratory	20,467	12%
Office Evaluation and Management Services	20,394	12%
Ground Transportation	17,361	10%
Integumentary / Musculoskeletal Surgery	10,543	6%
Imaging / Radiology	8,928	5%
AC Dismissal	7,167	4%
Gastrointestinal / Genitourinary Surgery	6,167	4%
Hospital Evaluation and Management Services	6,142	4%
Outpatient Therapies / CORF	6,083	4%

Top 10 DME Reconsideration Categories for 2020

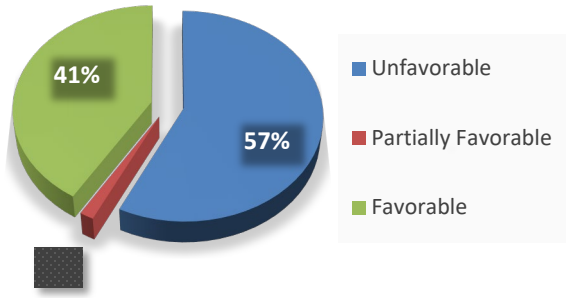
Appeal Category	Decided Claims	% of Total
Positive Airway Pressure Device	14,942	18%
Miscellaneous DME	14,508	18%
Orthoses	12,934	16%
Oxygen	11,820	14%
Surgical Dressings	5,505	7%
Glucose Monitors	3,767	5%
Negative Pressure Wound Therapy	3,566	4%
Enteral / Parenteral Nutrition	1,946	2%
Manual Wheelchairs	1,821	2%
Pneumatic Compressor	1,782	2%

Reconsideration Dispositions for 2020

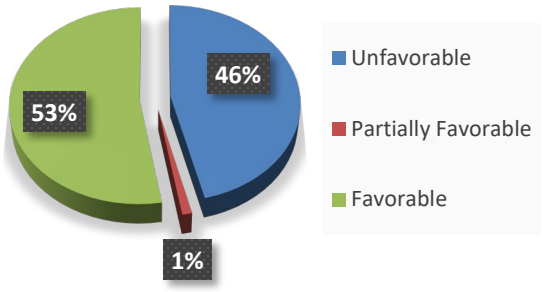
Part A Reconsiderations



Part B Reconsiderations



DME Reconsideration



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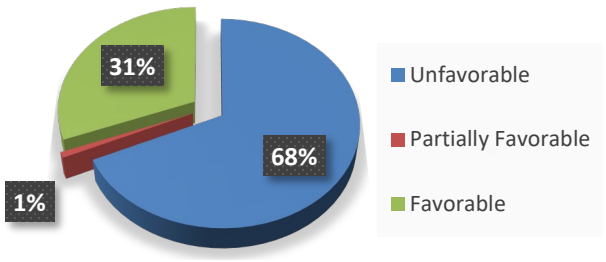
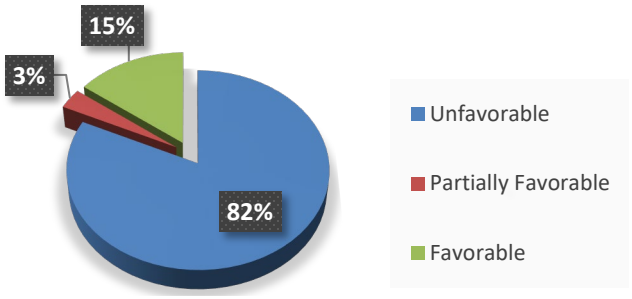
Specialty Contractor Reconsideration Dispositions 2020

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 Reconsideration Dispositions



UPIC Reconsideration Dispositions



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