Fact Sheet
Original Medicare (Fee-For-Service) Appeals Data - 2016

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 $150 in dispute for ALJ hearing requests filed on or after January 1, 2016.
  - 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 $1,500 remains in dispute for appeals to Federal District Court filed on or after January 1, 2016.

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?redirect=/orgMedFFSAppeals/.

Redeterminations

In 2016, MACs processed over 219 million Part A claims* for services furnished by hospitals, skilled nursing facilities, home health agencies, and other providers. Of these claims, approximately 16 million or 7% were denied (e.g., services not covered, services not medically necessary, etc.). MACs processed approximately 417,000 Part A redeterminations in 2016, meaning that about 3% of these denials resulted in requests for an appeal.

MACs processed over 952 million Part B claims, of which 91 million or 10% were denied. DME MACs processed over 66 million claims of which 10 million or 15% were denied. MACs and DME MACs processed over 3 million Part B and DME redeterminations in 2016, meaning that about 3% of these denials resulted in requests for an appeal. Generally, MACs are required to process redeterminations within 60 days of receiving requests for an appeal. In 2016, Part A, Part B, and DME MACs have demonstrated timeliness above 99% for all the four quarters of 2016.

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.

2016 Redetermination Categories

Redetermination Categories – Part A

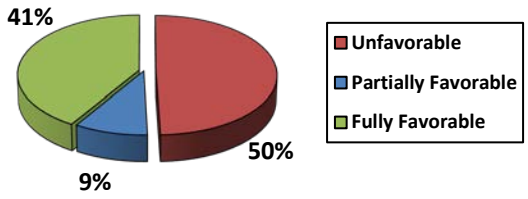
Appeal Category	Decided Claims	Percent
Outpatient	163,661	39%
Home Health	72,710	17%
Other (Hospice, etc.)	78,530	19%
Inpatient	31,180	7%
Skilled Nursing Facility (SNF)	14,194	3%
Lab	52,891	13%
Ambulance	3,994	1%
TOTAL	417,160	100%

Redetermination Categories – Part B

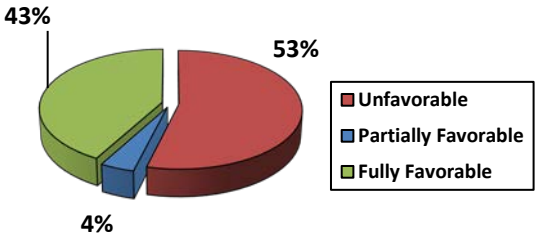
Appeal Category	Decided Claims	Percent
Physician	1,502,178	49%
Durable Medical Equipment (DME)	1,109,356	36%
Lab	143,746	5%
Ambulance	134,126	4%
Other (Preventative Services, Vision, etc.)	166,274	5%
TOTAL	3,055,680	100%

Redetermination Dispositions for 2016

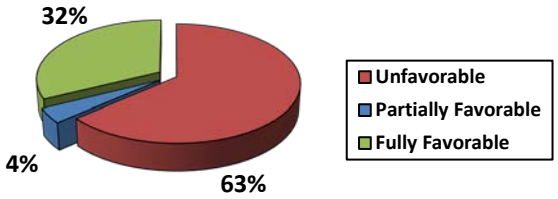
Part A Redeterminations



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

All reconsiderations are adjudicated by the Qualified Independent Contractors (QICs). In 2016, there were two Part A QICs, two Part B QICs, and one DME QIC. The QICs processed approximately 1,046,000 reconsiderations in 2016. Generally, QICs are required to process reconsiderations within 60 days of receiving requests for an appeal. In 2016, Part A QICs had timeliness above 90% and Part B and DME QICs had timeliness above 99% throughout the four quarters of 2016.

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 2016

Appeal Category	Decided Claims	% of Total
Home Health	40,871	27%
Outpatient Therapies / CORF	24,228	16%
Skilled Nursing Facility	14,626	10%
Acute Inpatient Hospital	14,448	9%
MSP	11,237	7%
Hospice	8,288	5%
Outpatient Hospital / ASC	7,907	5%
Drugs	5,017	3%
Acute Inpatient Rehab.	4,908	3%
AC Dismissal	3,449	2%

Top 10 Part B Reconsideration Categories for 2016

Appeal Category	Decided Claims	% of Total
Pathology/Laboratory	115,417	29%
Ground Transportation	44,547	11%
Other	44,185	11%
Office E/M Services	25,604	6%
Integum/Muscular-skeletal Surgery	22,771	6%
Imaging/Radiology	18,036	4%
Outpatient Therapies / CORF	18,031	4%
Hospital E/M Services	17,110	4%
Drugs	13,461	3%
AC Dismissal	11,846	3%

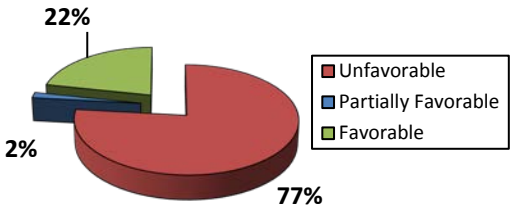
Top 10 DME Reconsideration Categories for 2016

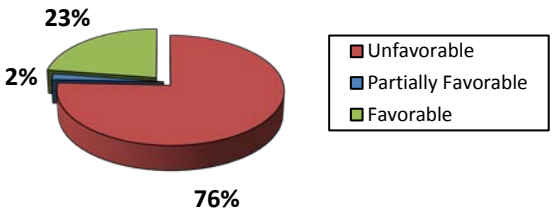
Appeal Category	Decided Claims	% of Total
Oxygen	186,514	38%
Positive Airway Pressure Device	60,859	12%
Surgical Dressings	46,995	10%
Glucose Monitors	33,875	7%
Hospital Bed & Support Surfaces	23,218	5%
Orthoses	18,664	4%
Nebulizers & Drugs	17,215	4%
Negative Pressure Wound Therapy	16,883	3%
Manual Wheelchairs	14,667	3%
Ostomy & Urological	13,319	3%

Reconsideration Dispositions for 2016

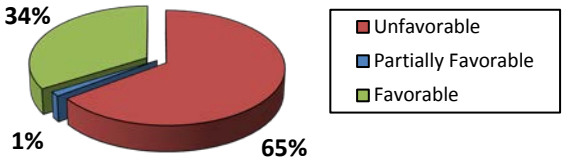
Part A Reconsiderations

Part B Reconsiderations





DME Reconsiderations

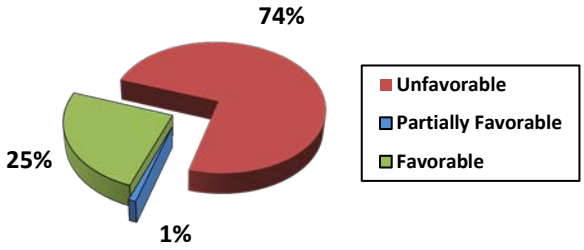


Note: A "favorable" decision means that the appeal was successful and the claim in dispute was paid. An "unfavorable" decision means that an appellants' appeal was denied. Calculation of the rates above excludes cases that were dismissed.

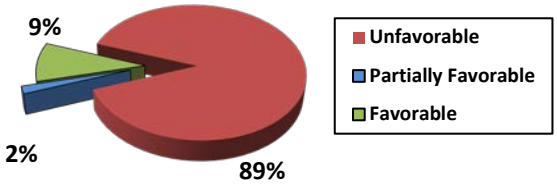
Specialty Contractor Reconsideration Dispositions 2016

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 Zone Program Integrity Contractors (ZPICs) 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: http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/?redirect=/rac/, and the Medicare Program Integrity Manual for the ZPICs at: http://www.cms.gov/manuals/downloads/pim83c04.pdf.

Recovery Auditors Reconsiderations



ZPIC 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 approximately 33,300 Recovery Auditor appeals (in claims) and 80,400 ZPIC appeals (in claims) processed in 2016.