Fact Sheet
Original Medicare (Fee-For-Service) Appeals Data - 2008

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. Historically, these companies have been known as fiscal intermediaries (FIs) for Part A services and carriers for Part B services; however, as directed by section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, both Part A and B work is being integrated under new entities called Medicare Administrative Contractors (MACs). For more information on MAC implementation, see: http://www.cms.hhs.gov/MedicareContractingReform/.

Original Medicare (Fee-For-Service) 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 the Medicare payment processor - FI, carrier, or MAC
  - An individual, provider, or supplier must file an appeal within 120 days of the initial decision on a claim.
  - The FI, carrier, or 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 $120 in dispute.
  - 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 $1,180 remains in dispute.

Please click on the following link for more information on each level in the appeals process: http://www.cms.hhs.gov/OrgMedFFSAppeals.

Redeterminations

In 2008, FIs and MACs processed over 190 million claims* for services furnished by hospitals, skilled nursing facilities, home health agencies, and other providers. Of these claims, approximately 15.4 million were denied (e.g., services not covered, services not medically necessary, etc.). FIs and MACs carried out approximately 265,000 Part A redeterminations in 2008, meaning that about 1.7 percent of these denials resulted in requests for an appeal.

Carriers and MACs processed over 925 million claims, of which 132 million were denied. DME MACs processed over 78 million claims, of which 12 million were denied. Carriers and MACs carried out approximately 2.6 million Part B redeterminations in 2008, meaning that about 1.8 percent of these denials resulted in requests for an appeal.

Please click on the following link for more information on redeterminations: http://www.cms.hhs.gov/OrgMedFFSAppeals/02_RedeterminationbyaMedicareContractor.asp#TopOfPage

*While these include claims for Medicare Part A & Part B institutional claims, for ease of reference, we refer to appeals of these types of claims as "Part A."

2008 Redetermination Categories

Redetermination Categories – Part A

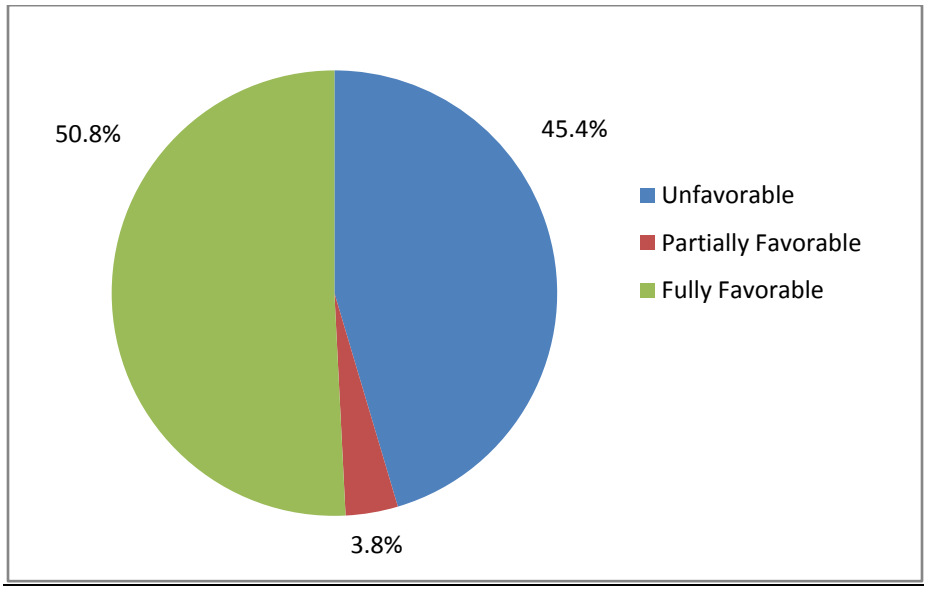
Appeal Category	Decided Claims	Percent
Outpatient	142,663	54%
Other/Unspecified	45,973	17%
Inpatient	45,535	17%
Home Health	14,248	5%
Skilled Nursing Facility (SNF)	8,935	3%
Ambulance	5,723	2%
Lab	1,701	1%
TOTAL	264,778	100%

Redetermination Categories – Part B

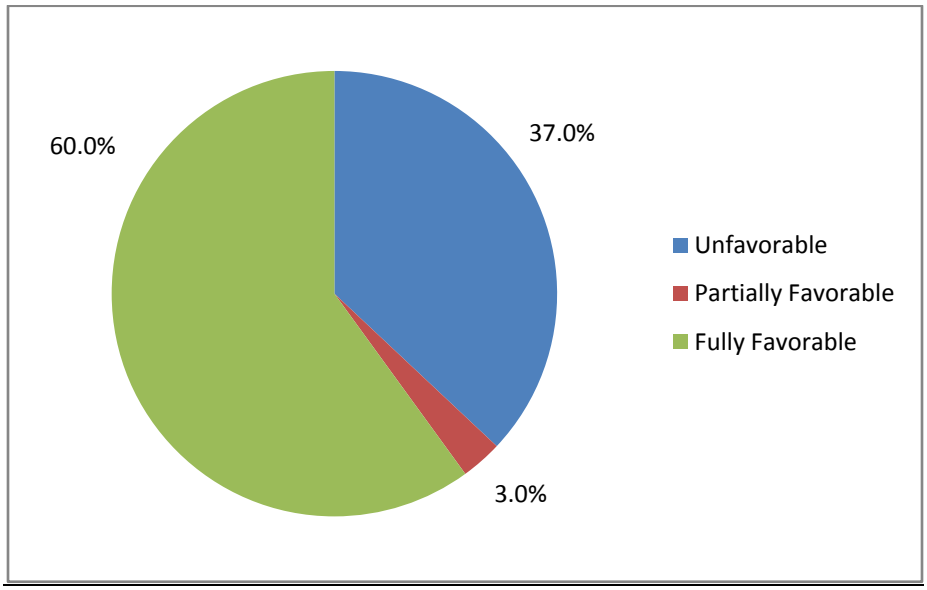
Appeal Category	Decided Claims	Percent
Physician	1,372,678	53%
Durable Medical Equipment (DME)	703,515	27%
Ambulance	226,577	9%
Other/Unspecified	188,471	7%
Lab	80,061	3%
TOTAL	2,571,302	100%

Redetermination Dispositions for 2008

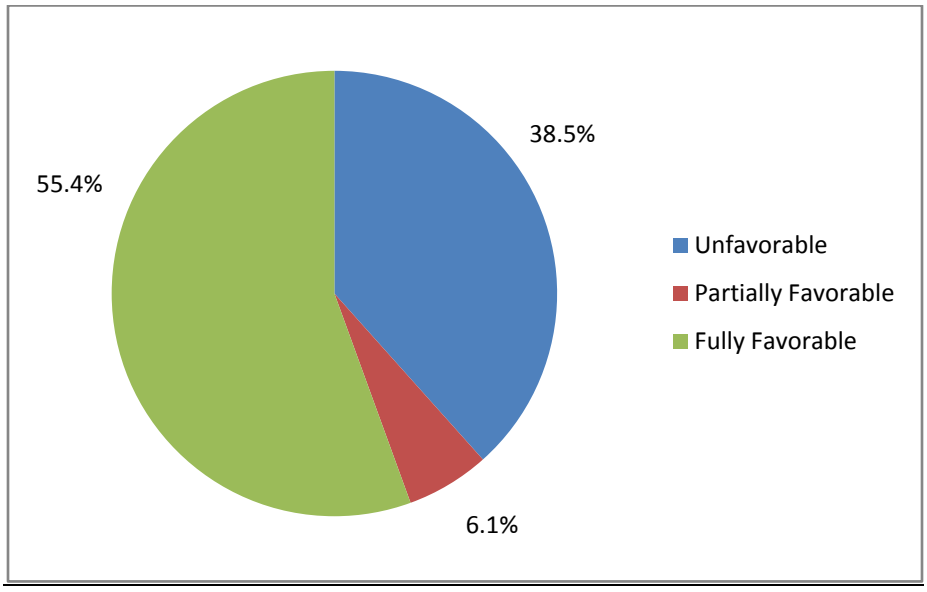
Part A Redeterminations



Part B Redeterminations

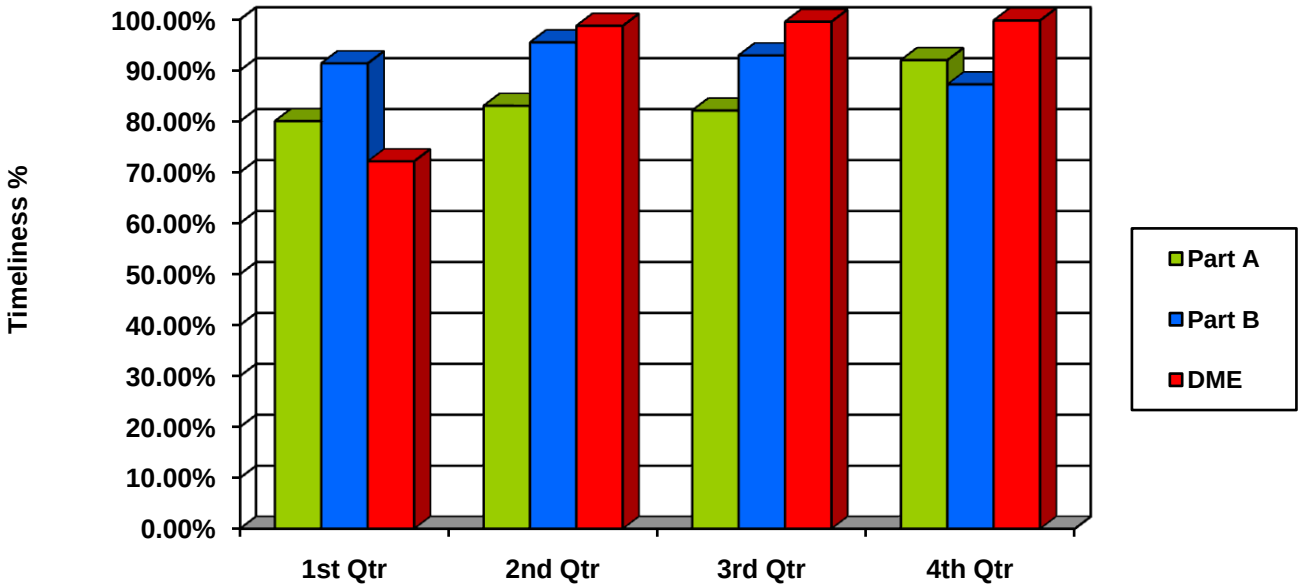


DME Redeterminations



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. Cases that were dismissed or misrouted were excluded from the calculations above.

2008 Redetermination Timeliness



Note: Generally, a redetermination must be processed within 60 days to be considered timely.

Reconsiderations

All reconsiderations are adjudicated by the Qualified Independent Contractors (QICs). In 2008, there were three Part A QICs, two Part B QICs, and one DME QIC. In 2008, the QICs processed 482,989 appeals. The QICs processed 76,051 Part A, 299,111 Part B, and 107,827 DME appeals.

Please click the following link for more information on reconsiderations:
http://www.cms.hhs.gov/OrgMedFFSAppeals/03_ReconsiderationbyaQualifiedIndependentContractor.asp#TopOfPage

Top 10 Part A Reconsideration Categories for 2008

Appeal Category	Decided Claims	% of Total
Acute Inpatient Hospital	**21,063**	**27.7%**
Home Health	**8,535**	**11.2%**
Outpatient Services	**7,976**	**10.5%**
Hospice	**5,510**	**7.2%**
Skilled Nursing Facility	**4,958**	**6.5%**
Other/Unspecified	**3,320**	**4.4%**
Level 1 Dismissal	**2,577**	**3.4%**
Drugs	**2,526**	**3.3%**
Medicare Secondary Payer	**2,510**	**3.3%**
Outpatient Therapies in a Comprehensive Outpatient Rehabilitation Facility	**2,384**	**3.1%**

Top 10 Part B Reconsideration Categories for 2008

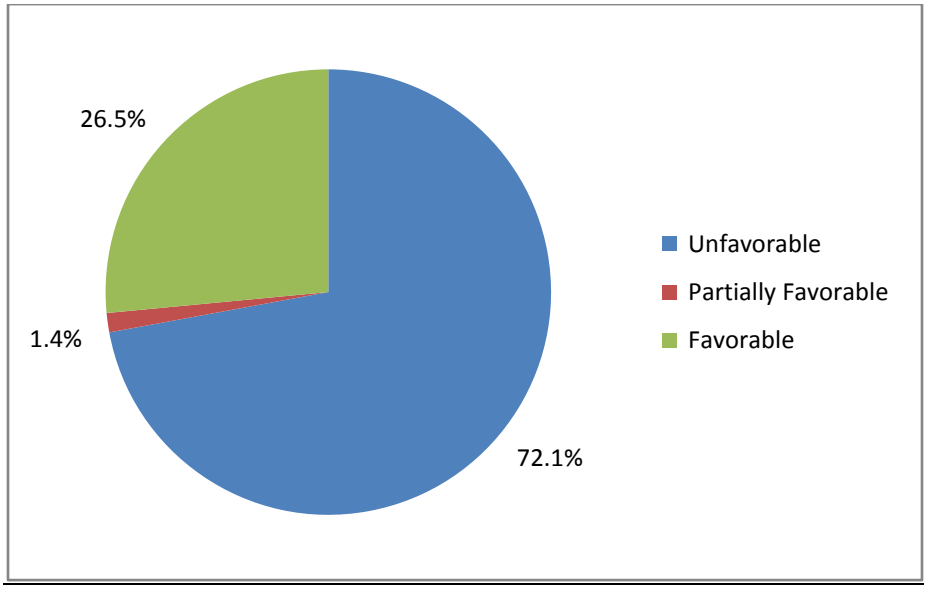
Appeal Category	Decided Claims	% of Total
Other/Unspecified	**92,988**	**31.1%**
Physician Services	**56,164**	**18.8%**
Practitioner Services	**45,117**	**15.1%**
Ground Transportation	**15,566**	**5.2%**
Level 1 Dismissal	**8,967**	**3.0%**
Respiratory/Cardiovascular Surgery	**5,531**	**1.8%**
Office-based Lab/X-Ray	**5,529**	**1.8%**
Imaging/Radiology	**4,165**	**1.4%**
Office E/M Services	**4,162**	**1.4%**
General Surgery Dealing with Skin, Muscles, and Bone	**2,956**	**1.0%**

Top 10 DME Reconsideration Categories for 2008

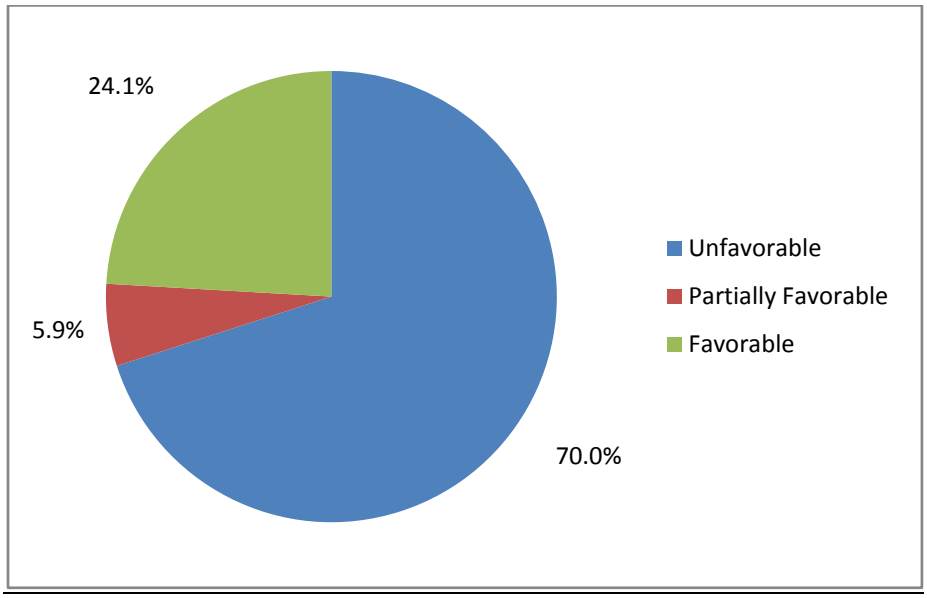
Appeal Category	Decided Claims	% of Total
Durable Medical Equipment	**70,088**	**65.0%**
Other/Unspecified	**16,877**	**15.7%**
General DME	**9,038**	**8.4%**
Medical/Surgical Supplies	**1,748**	**1.6%**
Oxygen and Supplies	**1,198**	**1.1%**
Wheelchairs/Power Operated Vehicles	**784**	**0.7%**
Drugs Administered Through DME	**271**	**0.3%**
Orthotics and Prosthetics	**269**	**0.2%**
Enteral/Parenteral Nutrition	**253**	**0.2%**
Hospital Beds	**217**	**0.2%**

Reconsideration Dispositions for 2008

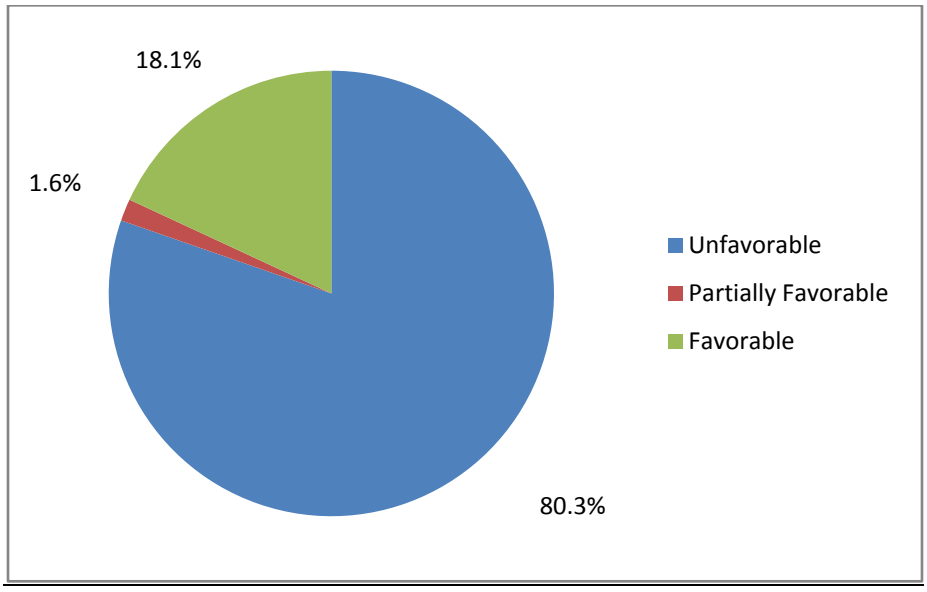
Part A Reconsiderations



Part B Reconsiderations



DME Reconsiderations



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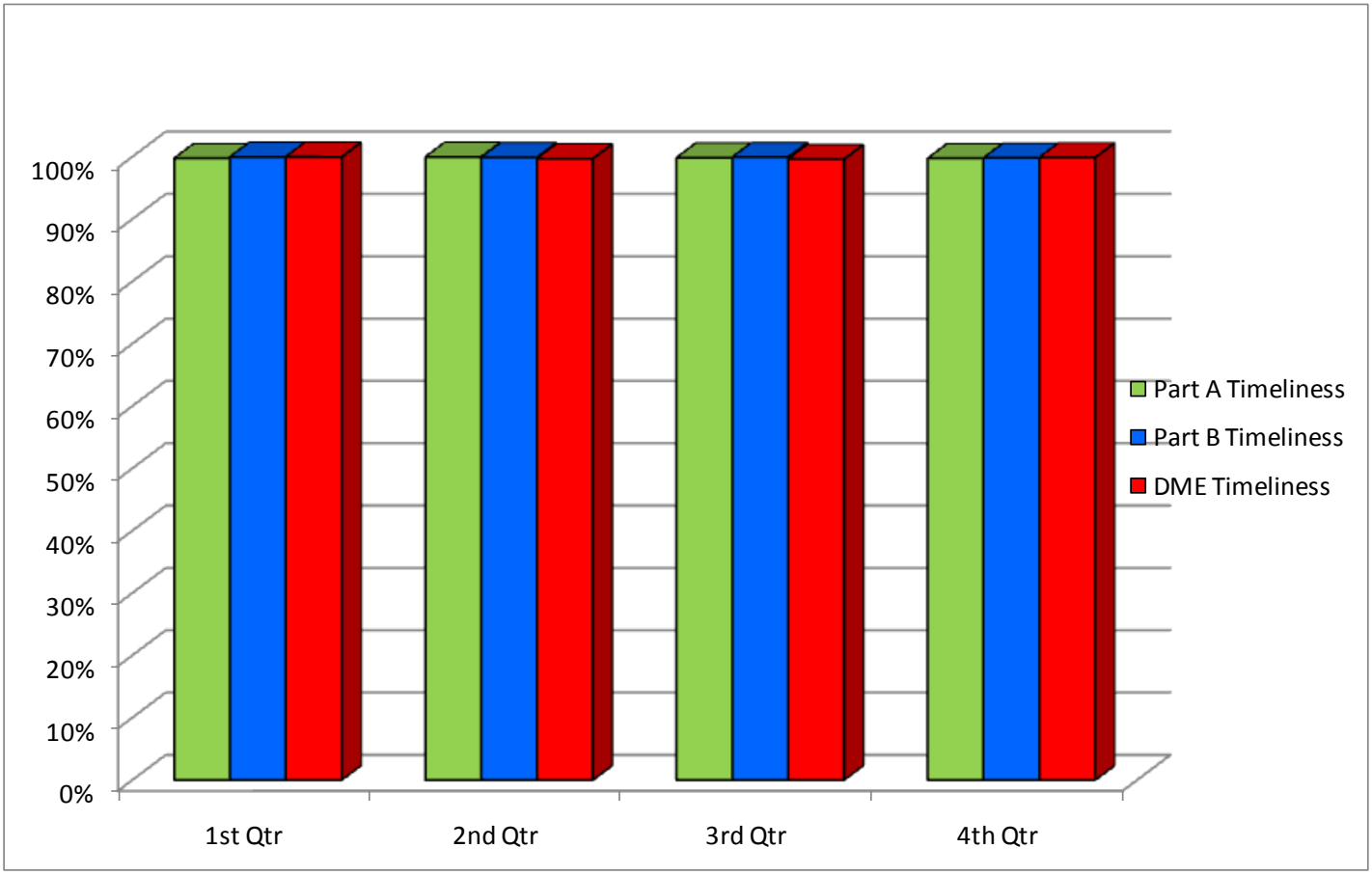
2008 Reconsideration Timeliness



Note: Generally, a reconsideration must be processed within 60 days to be considered timely.