Fact Sheet
Original Medicare (Fee-For-Service) Appeals Data – 2011

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 $130 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 $1,350 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 Calendar Year (CY) 2011, FIs and MACs processed over 200 million Part A claims[1] for services furnished by hospitals, skilled nursing facilities, home health agencies, and other providers. Of these Part A claims, approximately 14.6 million were denied (e.g., services not covered, services not medically necessary, etc.). FIs and MACs processed approximately 381,400 Part A redeterminations in 2011, of that about 2.6 percent of these denials resulted in requests for an appeal.

Carriers and MACs processed over 835 million Part B claims, of which 86 million were denied. In addition, MACs processed over 75 million durable medical equipment (DME) claims of which 10 million were denied. Carriers and MACs processed approximately 2.6 million Part B and DME redeterminations in CY 2011, of that about 2.7 percent of these denials resulted in requests for an appeal.

Please click on the following link for more information on redeterminations.
http://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/RedeterminationbyaMedicareContractor.html

[1] While these include claims for Medicare Parts A and B, for ease of reference, we refer to appeals of these types of claims as "Part A."

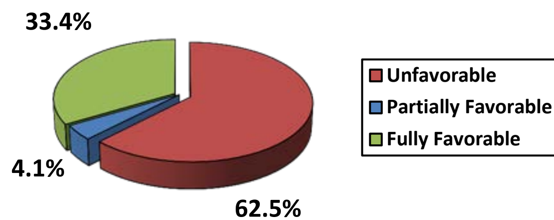
CY 2011 Redetermination Categories

Redetermination Categories – Part A		
Appeal Category	**Decided Claims**	**Percent**
Outpatient	**192,451**	**50%**
Inpatient	**66,010**	**17%**
Home Health	**61,943**	**16%**
Other (Acute Hospital, Hospice, etc.)	**43,887**	**12%**
Skilled Nursing Facility (SNF)	**12,323**	**3%**
Ambulance	**4,097**	**1%**
Lab	**713**	**1%**
TOTAL	**381,424**	**100%**

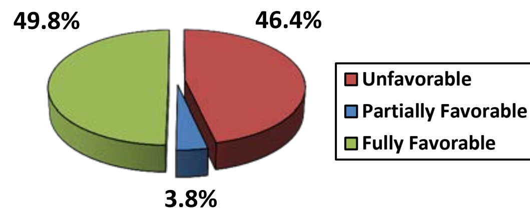
Redetermination Categories – Part B		
Appeal Category	**Decided Claims**	**Percent**
Physician	**1,445,935**	**55%**
Durable Medical Equipment (DME)	**686,417**	**26%**
Ambulance	**210,093**	**8%**
Other (Preventative Services, Vision, etc.)	**167,339**	**7%**
Lab	**100,878**	**4%**
TOTAL	**2,610,662**	**100%**

Redetermination Dispositions for CY 2011

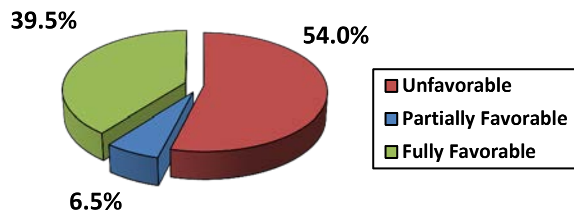
Part A Redeterminations



Part B Redeterminations

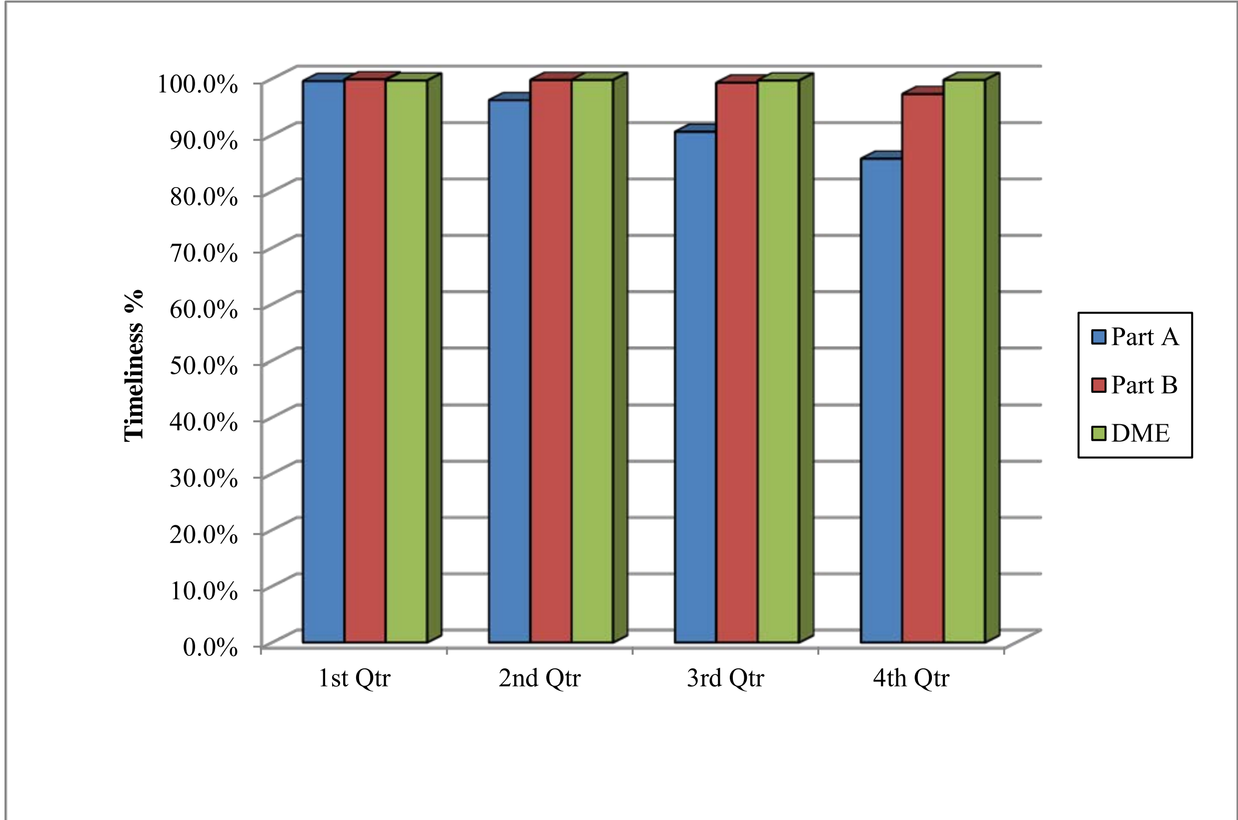


DME Redeterminations



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.

CY 2011 Redetermination Timeliness



Note: Generally, redeterminations must be issued within 60 days of the request for appeal.

Reconsiderations

All reconsiderations are adjudicated by the Qualified Independent Contractors (QICs). In CY 2011, there were two Part A QICs, two Part B QICs, and one DME QIC. The QICs processed approximately 509,000 appeals in 2011.

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 CY 2011

Appeal Category	Decided Claims	% of Total
Home Health	27,382	27.1%
Acute Inpatient Hospital	19, 262	19.1%
Outpatient Therapies/CORF	11,337	11.2%
Outpatient Hospital/ASC	10,254	10.1%
Skilled Nursing Facility	8,669	8.6%
Hospice	6,923	6.8%
Drugs	3,904	3.9%
Pathology/Laboratory	3,481	3.4%
Imaging/Radiology	2,977	2.9%
Ground Transportation	1,903	1.9%

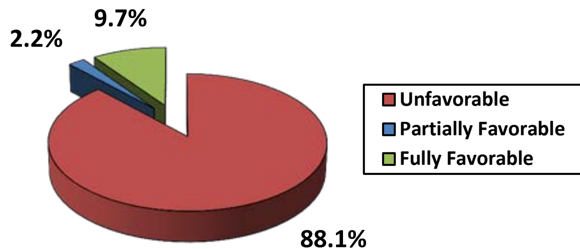
Top 10 Part B Reconsideration Categories for CY 2011

Appeal Category	Decided Claims	% of Total
Ground Transportation	40,741	29.1%
Technical Denial	17,420	12.4%
Integum'y/Musculoskeletal Surgery	14,723	10.5%
Imaging/Radiology	11,391	8.1%
Other (Preventative Care, Dental, etc.)	10,359	7.4%
Radiation/Chemo/Infusion	5,676	4.0%
Outpatient Therapies / CORF AC Dismissal	4,532	3.2%
Respiratory/Cardiovascular Surgery	3,999	2.9%
Drugs	3,836	2.7%
Eligibility	3,744	2.7%

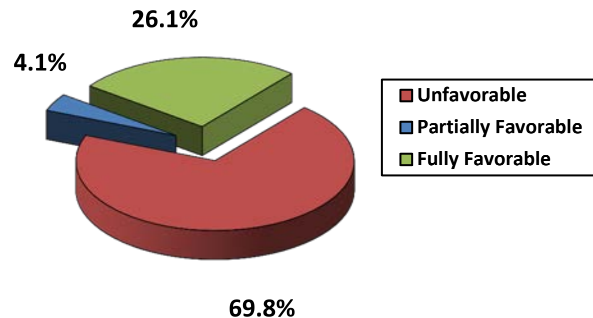
Top 10 DME Reconsideration Categories for CY 2011		
Appeal Category	**Decided Claims**	**% of Total**
Surgical Dressings	29,867	23.1%
Oxygen	14,528	11.2%
Glucose Monitors	12,091	9.4%
Respiratory-Miscellaneous	11,089	8.6%
Miscellaneous DMEPOS	10,352	8.0%
Power Mobility Devices	6,615	5.1%
Ostomy & Urology	5,577	4.3%
Neg. Pressure Wound Therapy	5,194	4.0%
Pneumatic Compressor	4,969	3.8%
Enteral/Parenteral Nutrition	4,875	3.8%

Reconsideration Dispositions for CY 2011

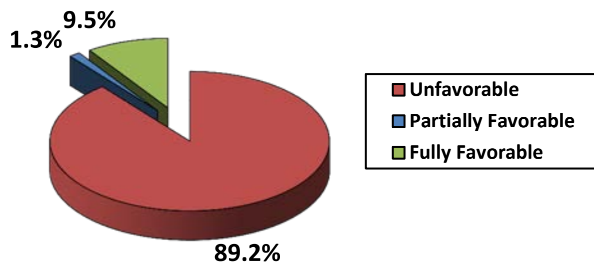
Part A Reconsiderations



Part B Reconsiderations



DME Reconsiderations



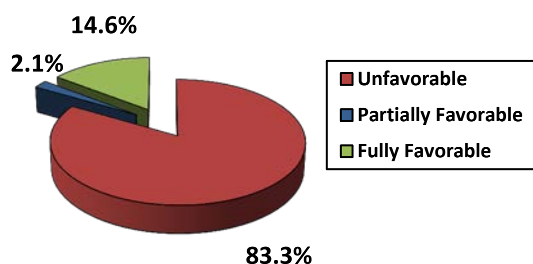
Note: A "favorable" decision means that the appeal was successful and the claim in dispute was paid. An "unfavorable" decision means that an appellants' appeal was denied. Calculation of the rates above excludes cases that were dismissed.

Specialty Contractor Reconsideration Dispositions

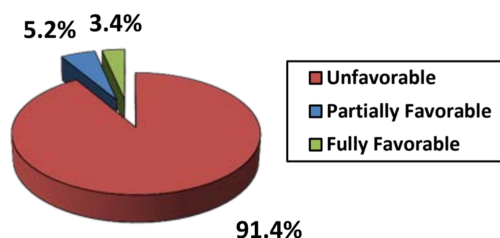
As part of the overall reconsideration workload, several special initiatives exist that can impact the volume of claims in the appeals process. The Recovery Audit Contractors (RACs) who pursue Medicare overpayments for items or services that were incorrectly paid, and the Zone Program Integrity Contractors (ZPICs) [formerly known as Program Safeguard Contractors (PSCs)] who pursue overpayments related to alleged fraudulent activity are two of those initiatives that are tracked. For more information on these programs, please visit the RAC program website at http://www.cms.gov/recovery-audit-program and the Medicare Program Integrity Manual for the ZPICs at http://www.cms.gov/manuals/downloads/pim83c04.pdf.

Specialty Contractor Reconsiderations for CY 2011

National RAC Reconsiderations[2]



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 a total of 17,725 National RAC appeals and 21,473 ZPIC appeals in CY2011.

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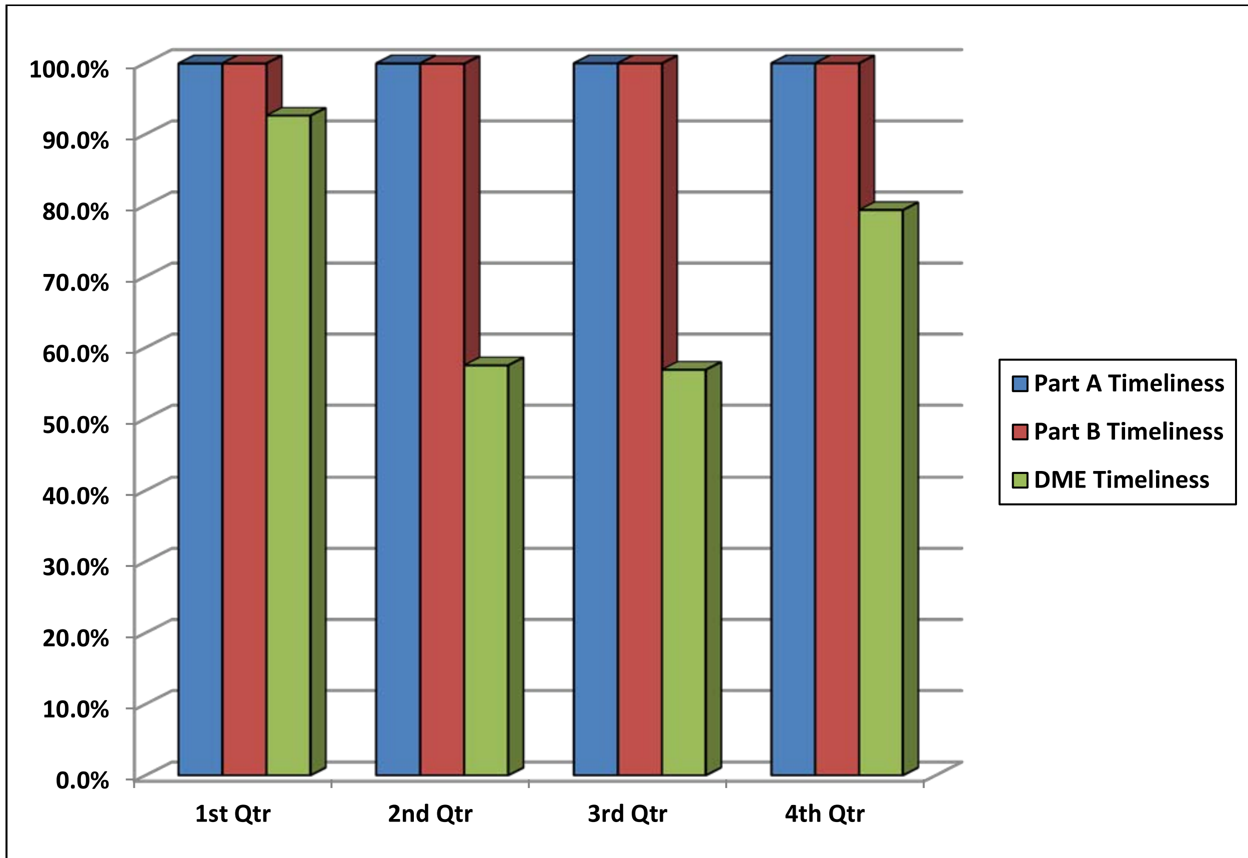
[2] Data for the RACs is also available on the RAC program website at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Recovery-Audit-Program/Recent_Updates.html.

CY 2011 Reconsideration Timeliness



Note: Generally, reconsiderations must be issued within 60 days of the request for appeal.