

Original Medicare Claim Appeals Data – 2025

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 found on the Medicare Summary Notice (MSN) mailed to Medicare beneficiaries periodically after they receive Medicare Part A and Part B-covered services or durable medical supplies. The MSN provides the total amount beneficiaries may be billed and explains how to file an appeal. The providers and suppliers of services that file claims on behalf of Medicare beneficiaries are a party and therefore 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 Original Medicare 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 \$190 for ALJ hearing requests filed in calendar year 2025.
 - 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 \$1,900 to file an appeal in Federal District Court in calendar year 2025.

*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>.

Redetermination Data

Category	Part A*	Part B	DME
Total Claims Processed at Initial Determination	200 million	911 million	51 million
Claims Denied at Initial Determination	16 million	89 million	7 million
Claim Denial Rate at Initial Determination	8%	10%	13%
Denied Claims Appealed to MAC	314,000	2.20 million	
Appeal Rate of Denied Claims	2%	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.

2025 Redetermination Categories

Redetermination Categories – Part A

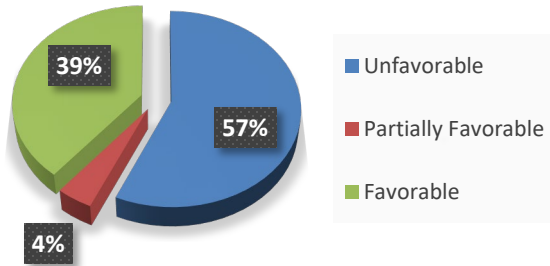
Appeal Category	Decided Claims	Percent
Drugs	77,463	25%
Pathology / Laboratory	43,882	14%
Imaging / Radiology	29,822	10%
Other Surgery	26,556	8%
Hospice	23,133	7%
Home Health	21,009	7%
Outpatient Hospital / Ambulatory Surgical Center (ASC)	19,253	6%
Skilled Nursing Facility	16,830	5%
Acute Inpatient Hospital	12,161	4%
Outpatient Therapies / Comprehensive Outpatient Rehabilitation Facility (CORF)	10,848	3%
Other categories	32,907	10%
Total	313,864	100%

Redetermination Categories – Part B

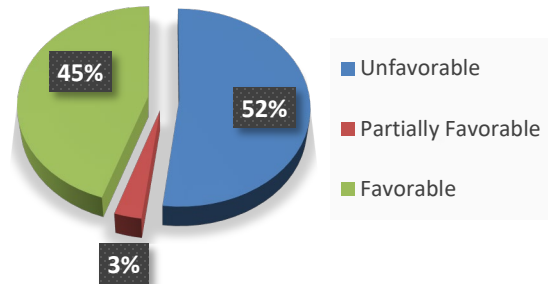
Appeal Category	Decided Claims	Percent
Physician	1,591,016	72%
Durable Medical Equipment (DME)	341,414	16%
Lab	108,548	5%
Other (Preventative Services, Vision, etc.)	96,186	4%
Ambulance	62,121	3%
Total	2,199,285	100%

Redetermination Dispositions for 2025

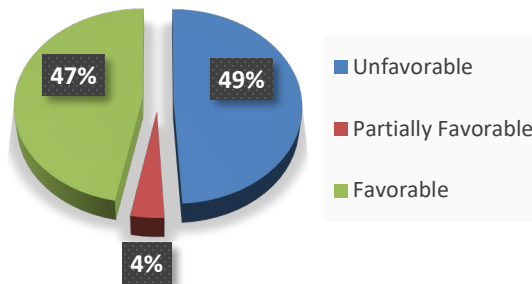
Part A Redetermination



Part B Redetermination



DME Redetermination



Note: A "favorable" decision means that all of the issues in the appeal were resolved in favor of the appellant. A "partially favorable" decision means that some but not all of the issues in the appeal were resolved in favor of the appellant. An "unfavorable" decision means that none of the issues in the appeal were resolved in favor of the appellant.

Calculation of the rates above excludes cases that were dismissed.

Reconsideration Data

Category	Part A	Part B	DME
Number of QICs	2	2	1
Reconsiderations Processed*	360,000		
Timeliness of Appeals Processing at QIC Level	100%	100%	100%

*Reconsiderations processed count is in claims appealed to the QICs.

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 2025

Appeal Category	Decided Claims	% of Total
MSP (Medicare Secondary Payer)	68,477	45%
Skilled Nursing Facility	16,595	11%
Hospice	12,005	8%
AC (Administrative Contractor) Dismissal	10,486	7%
Home Health	10,218	7%
Drugs	7,888	5%
Outpatient Hospital / ASC	5,893	4%
Outpatient Therapies / CORF	3,552	2%
Imaging / Radiology	2,721	2%
Acute Inpatient Hospital	2,597	2%

Top 10 Part B Reconsideration Categories for 2025

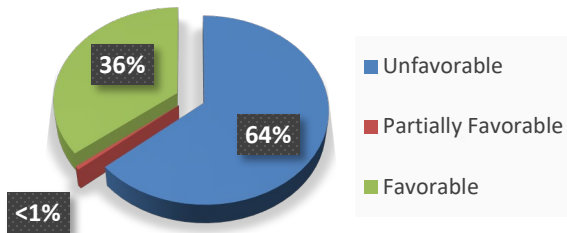
Appeal Category	Decided Claims	% of Total
Pathology / Laboratory	23,551	17%
Outpatient Therapies / CORF	18,859	13%
Imaging / Radiology	12,788	9%
Integumentary /Musculoskeletal Surgery	11,903	8%
Drugs	8,594	6%
Ground Transportation	8,415	6%
Nervous System Surgery	8,196	6%
Medical / Surgical Supplies	8,069	6%
Other	7,693	5%
AC Dismissal	7,138	5%

Top 10 DME Reconsideration Categories for 2025

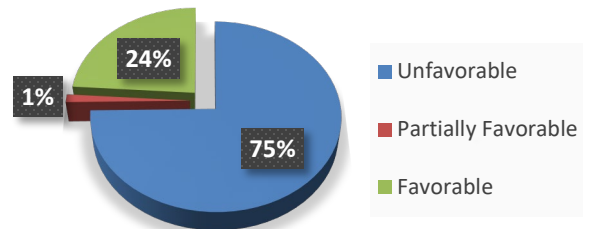
Appeal Category	Decided Claims	% of Total
Orthoses	10,712	17%
Miscellaneous Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)	7,349	12%
Respiratory - Miscellaneous	5,902	10%
Wheelchair Seat Option Accessories	4,690	8%
Glucose Monitors	4,594	7%
Negative Pressure Wound Therapy	3,090	5%
Ostomy & Urological	2,908	5%
Oxygen	2,902	5%
Infusion Pumps	2,891	5%
Surgical Dressings	2,876	5%

Reconsideration Dispositions for 2025

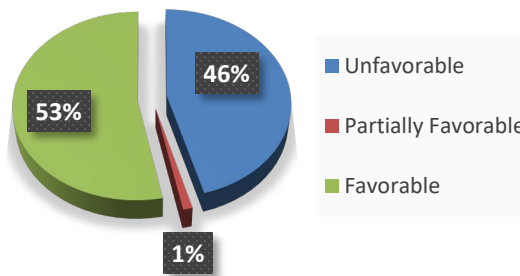
Part A Reconsiderations



Part B Reconsiderations



DME Reconsiderations



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

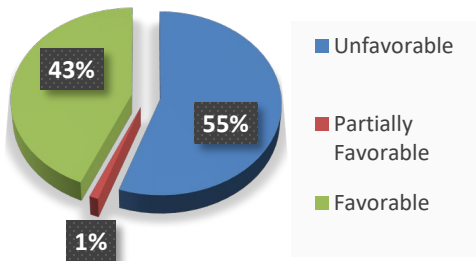
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Calculation of the rates above excludes cases that were dismissed.

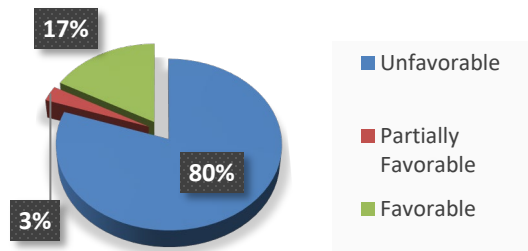
Specialty Contractor Reconsideration Dispositions for 2025

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 improper payments for items or services 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 Review Contractor Directory – Interactive Map at: <https://www.cms.gov/data-research/monitoring-programs/medicare-fee-service-compliance-programs/review-contractor-directory-interactive-map>.

RAC Reconsideration Dispositions



UPIC Reconsideration Dispositions



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

Note: A "favorable" decision means that all of the issues in the appeal were resolved in favor of the appellant. A "partially favorable" decision means that some but not all of the issues in the appeal were resolved in favor of the appellant. An "unfavorable" decision means that none of the issues in the appeal were resolved in favor of the appellant.

Calculation of the rates above excludes cases that were dismissed. There were 11,889 RAC appeals (in claims) and 23,295 UPIC appeals (in claims) processed in 2025.