Fact Sheet

Original Medicare (Fee-For-Service) Appeals Data - 2009

**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 2009, FIs and Part A MACs processed over 192 million claims\* for services furnished by hospitals, skilled nursing facilities, home health agencies, and other providers. Of these claims, approximately 14.3 million were denied (e.g., services not covered, services not medically necessary, etc.). FIs and Part A MACs carried out approximately 223,000 Part A redeterminations in 2009, meaning that about 1.1 percent of these denials resulted in requests for an appeal.

Carriers and Part B MACs processed over 917 million claims, of which 104 million were denied. DME MACs processed over 74 million claims of which 10 million were denied. Carriers, Part B MACs and DME MACs carried out approximately 2.4 million Part B redeterminations in 2009, meaning that about 1.2 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 Parts A & B, for ease of reference, we refer to appeals of these types of claims as “Part A.”

2009 Redetermination Categories

Redetermination Categories –

Part A

Redetermination Categories –

Part B

|  |  |  |
| --- | --- | --- |
| **Appeal Category** | **Decided Claims** | **Percent** |
| **Physician** | **1,562,323** | **64%** |
| **Durable Medical Equipment (DME)** | **461,694** | **19%** |
| **Ambulance** | **168,184** | **7%** |
| **Other (Preventative Services, Vision, etc.)** | **176,299** | **7%** |
| **Lab** | **87,473** | **3%** |
| **TOTAL** | **2,458,901** | **100%** |

|  |  |  |
| --- | --- | --- |
| **Appeal Category** | **Decided Claims** | **Percent** |
| **Outpatient** | **142,851** | **64%** |
| **Other (Acute Hospital, Hospice, etc.)** | **33,845** | **15%** |
| **Inpatient** | **11,930** | **5%** |
| **Home Health** | **18,326** | **8%** |
| **Skilled Nursing Facility (SNF)** | **8,143** | **4%** |
| **Ambulance** | **5,967** | **3%** |
| **Lab** | **1,468** | **1%** |
| **TOTAL** | **222,530** | **100%** |

Redetermination Dispositions for 2009

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.

2009 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 2009, there were three Part A QICs, two Part B QICs, and one DME QIC. The QICs processed approximately 452,000 appeals in 2009.

Please click on 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 2009

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| --- | --- | --- |
| **Appeal Category** | **Decided Claims** | **% of Total** |
| 06-Outpatient Therapies / CORF | 9,375 | 15.5% |
| 03-Acute Inpatient Hospital | 8,643 | 14.3% |
| 08-Home Health | 7,159 | 11.9% |
| 41-Outpatient Hospital / ASC | 7,083 | 11.7% |
| 24-Skilled Nursing Facility | 6,301 | 10.4% |
| 11-Hospice | 5,421 | 9.0% |
| 42-Acute Inpatient Rehabilitation | 3,292 | 5.5% |
| 32-Drugs | 2,926 | 4.9% |
| 80-MSP | 2,309 | 3.8% |
| 07-Ground Transportation | 1,771 | 2.9% |

Top 10 Part B Reconsideration Categories for 2009

|  |  |  |
| --- | --- | --- |
| **Appeal Category** | **Decided Claims** | **% of Total** |
| 50-Other (Preventative Services, Vision, etc.) | 90,428 | 30.6% |
| 65-Dermatological and Musculoskeletal Surgery | 25,895 | 8.8% |
| 07-Ground Transportation | 24,147 | 8.2% |
| 31-Imaging/Radiology | 21,638 | 7.3% |
| 60-Office E/M Services | 16,326 | 5.5% |
| 66-Respiratory/Cardiovascular Surgery | 13,109 | 4.4% |
| 39-Level 1 Dismissal | 12,748 | 4.3% |
| 79-Technical Denial | 10,728 | 3.6% |
| 32-Drugs | 10,393 | 3.5% |
| 30-Pathology/Laboratory | 10,100 | 3.4% |

Top 10 Part DME Reconsideration Categories for 2009

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| --- | --- | --- |
| **Appeal Category** | **Decided Claims** | **% of Total** |
| 55-Miscellaneous DMEPOS (additional oxygen/wheelchair supplies, etc.) | 36,414 | 38.0% |
| 51-Medical/Surgical Supplies | 20,044 | 20.9% |
| 54-Manual Wheelchairs | 12,382 | 12.9% |
| 53-Oxygen | 10,011 | 10.4% |
| 58-Enteral/Parenteral Nutrition | 3,983 | 4.2% |
| 57-Drugs Miscellaneous | 3,083 | 3.2% |
| 56-Orthoses | 2,955 | 3.1% |
| 52-Hospital Bed & Support Surfaces | 2,942 | 3.1% |
| 89-Positive Airway Pressure Device | 1,166 | 1.2% |
| 59-Glucose Monitors | 999 | 1.0% |

Reconsideration Dispositions

Part A

Part B

DME

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.

2009 Reconsideration Timeliness

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