

Original Medicare (Fee-For-Service) Appeals Data – 2024

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 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 \$180 for ALJ hearing requests filed in calendar year 2024.
 - 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 \$1,840 to file an appeal in Federal District Court in calendar year 2024.

*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	196 million	891 million	52 million
Claims Denied at Initial Determination	16 million	93 million	7 million
Claim Denial Rate at Initial Determination	8%	10%	14%
Denied Claims Appealed to MAC	275,000	2.03 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.

2024 Redetermination Categories

Redetermination Categories – Part A

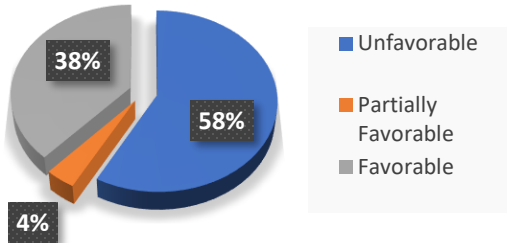
Appeal Category	Decided Claims	Percent
Drugs	58,981	21%
Pathology / Laboratory	40,270	15%
Imaging / Radiology	24,996	9%
Other Surgery	24,027	9%
Hospice	23,929	9%
Home Health	18,646	7%
Outpatient Hospital / Ambulatory Surgical Center (ASC)	18,080	7%
Skilled Nursing Facility	12,651	5%
Outpatient Therapies / Comprehensive Outpatient Rehabilitation Facility (CORF)	11,603	4%
Acute Inpatient Hospital	11,054	4%
Other categories	31,116	11%
Total	275,353	100%

Redetermination Categories – Part B

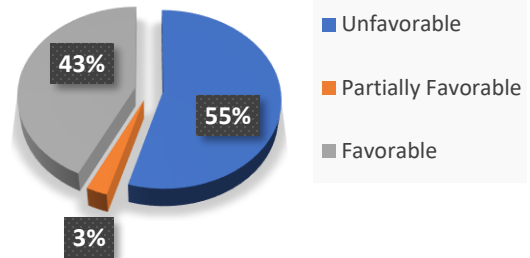
Appeal Category	Decided Claims	Percent
Physician	1,433,910	71%
Durable Medical Equipment (DME)	350,888	17%
Lab	98,929	5%
Ambulance	69,274	3%
Other (Preventative Services, Vision, etc.)	76,610	4%
Total	2,029,611	100%

Redetermination Dispositions for 2024

Part A Redetermination

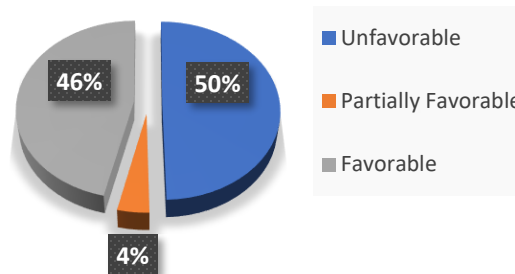


Part B Redetermination



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

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*	418,000		
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 2024

Appeal Category	Decided Claims	% of Total
Medicare Secondary Payer (MSP)	91,191	50%
Hospice	25,682	14%
Skilled Nursing Facility	11,991	7%
Administrative Contractor (AC) Dismissal	11,417	6%
Home Health	9,524	5%
Outpatient Hospital / ASC	6,743	4%
Drugs	5,887	3%
Outpatient Therapies / CORF	3,463	2%
Acute Inpatient Hospital	2,903	2%
Other Surgery	2,561	1%

Top 10 Part B Reconsideration Categories for 2024

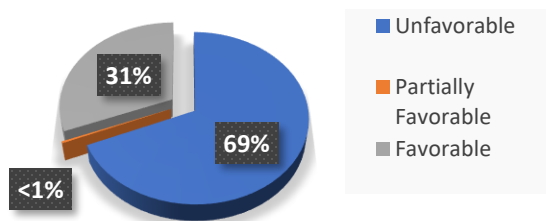
Appeal Category	Decided Claims	% of Total
Integumentary / Musculoskeletal Surgery	29,424	17%
Pathology / Laboratory	17,124	10%
Vision Services	14,525	8%
Imaging / Radiology	13,684	8%
Ground Transportation	10,245	6%
Other	9,940	6%
Outpatient Therapies / CORF	9,254	5%
Nervous System Surgery	8,983	5%
AC Dismissal	8,822	5%
Eligibility	7,875	5%

Top 10 DME Reconsideration Categories for 2024

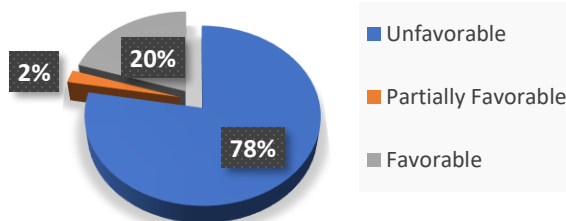
Appeal Category	Decided Claims	% of Total
Orthoses	10,004	18%
Miscellaneous Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)	5,790	10%
Respiratory - Miscellaneous	4,880	9%
Glucose Monitors	4,498	8%
Pneumatic Compressor	4,001	7%
Negative Pressure Wound Therapy	3,526	6%
Enteral/Parenteral Nutrition	2,838	5%
Manual Wheelchairs	2,751	5%
Ostomy & Urological	2,639	5%
Oxygen	2,065	4%

Reconsideration Dispositions for 2024

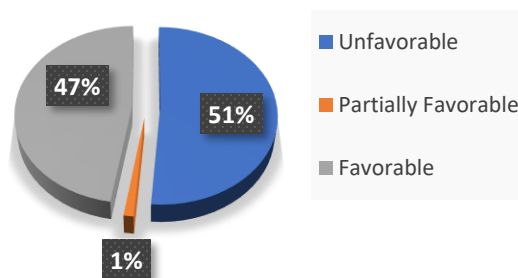
Part A Reconsiderations



Part B Reconsiderations



DME Reconsiderations



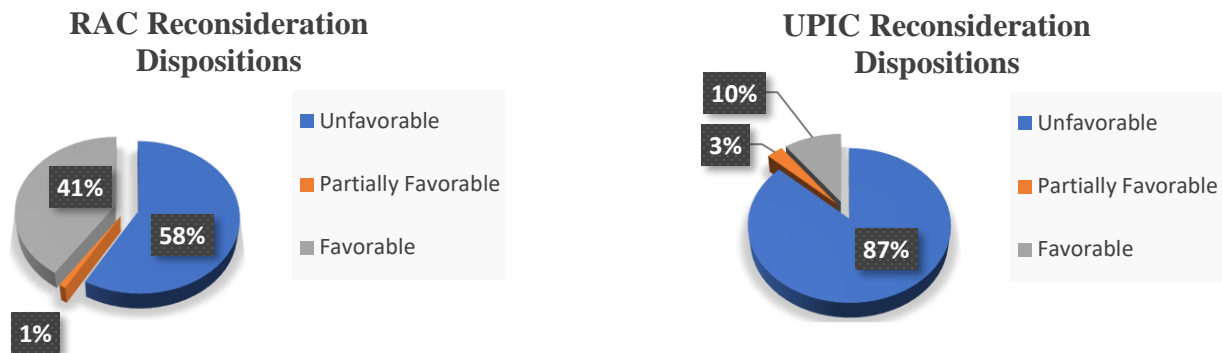
Disposition percentages may not add up to 100% due to rounding.

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.

Specialty Contractor Reconsideration Dispositions for 2024

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>.



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 12,378 RAC appeals (in claims) and 19,964 UPIC appeals (in claims) processed in 2024.