Fact Sheet
Original Medicare (Fee-For-Service) Appeals Data - 2007

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 2007, FIs and MACs processed over 186 million claims for services furnished by hospitals, skilled nursing facilities, home health agencies, and other providers. Of these claims, approximately 14.5 million were denied (e.g., services not covered, services not medically necessary, etc.). FIs and MACs carried out approximately 240,000 Part A redeterminations in 2007, meaning that about 1.7 percent of these denials resulted in requests for an appeal.

Carriers and MACs processed over 978 million claims, of which 155 million were denied. Carriers and MACs carried out approximately 2.5 million Part B redeterminations in 2007, representing about 1.6 percent of all denied Part B claims.

Please click on the following link for more information on redeterminations.
http://www.cms.hhs.gov/OrgMedFFSAppeals/02_Redetermination%20by%20a%20Medicare%20Contractor.asp

*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."

Redetermination Categories

Appeal Categories – Part A

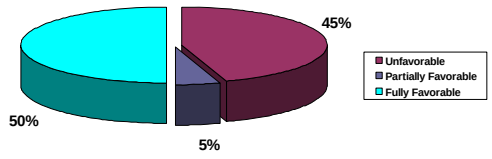
Appeal Category	Decided Claims	Percent
Outpatient	160,528	67%
Other (Acute Hospital, Hospice, etc.)	34,574	14%
Inpatient	15,110	6%
Home Health	13,621	6%
Skilled Nursing Facility (SNF)	7,884	3%
Ambulance	6,176	3%
Lab	2,428	1%
TOTAL	240,321	100%

Appeal Categories – Part B

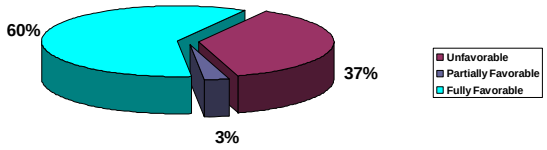
Appeal Category	Decided Claims	Percent
Physician	1,450,822	58%
Durable Medical Equipment (DME)	623,081	25%
Ambulance	218,869	9%
Other (Preventative Services, Vision, etc.)	134,090	5%
Lab	78,301	3%
TOTAL	2,505,163	100%

Redetermination Dispositions

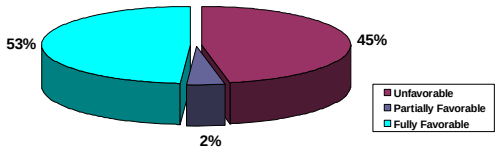
Part A



Part B

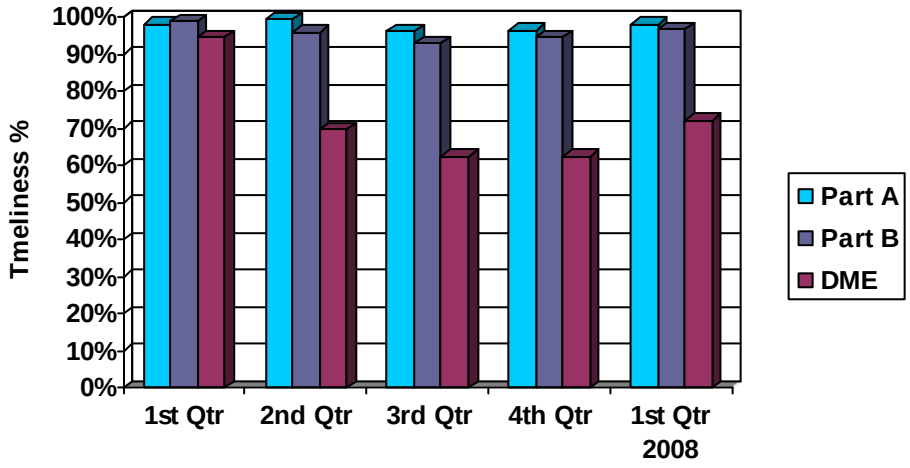


DME



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. Calculation of the reversal rates above excludes cases that were dismissed.

Redetermination Timeliness



Note: Redeterminations must be issued within 60 days of the request for appeal.

Reconsiderations

All reconsiderations are adjudicated by the Qualified Independent Contractors (QICs). There are two Part A QICs, two Part B QICs, and one DME QIC. The QICs processed approximately 400,000 appeals in 2007.

Please click on the following link for more information on reconsiderations.
http://www.cms.hhs.gov/OrgMedFFSAppeals/03_Reconsideration%20by%20a%20Qualified%20Independent%20Contractor.asp

Top 10 Part A Categories

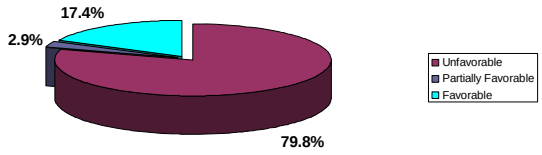
Appeal Category	Decided Claims	% of Total
Outpatient Services	9,925	26.3%
Skilled Nursing Facility (SNF)	5,470	14.5%
Laboratory	4,125	10.9%
Home Health	3,167	8.4%
Other (Acute Hospital, Mental Health, etc.)	2,253	6.0%
Hospice	2,206	5.8%
Drugs	2,184	5.8%
Hospital Inpatient	2,168	5.7%
Diagnostic Imaging	1,938	5.1%
Transportation	1,317	3.5%

Top 10 Part B Categories

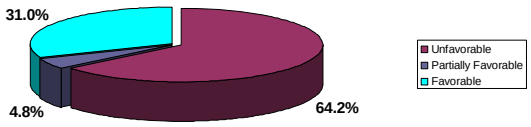
Appeal Category	Decided Claims	% of Total
Physician Services	81,908	24.2%
Other (Preventative Services, Vision, etc.)	80,130	23.7%
Durable Medical Equipment	77,061	22.8%
Practitioner Services	61,640	18.2%
Transportation	24,466	7.2%
Clinic/Lab/X-Ray	3,346	1.0%
Outpatient Services	1,630	0.5%
Medical Supplies	1,488	0.4%
Prosthetics/Orthotics	593	0.2%
Drugs	431	0.1%

Reconsideration Dispositions

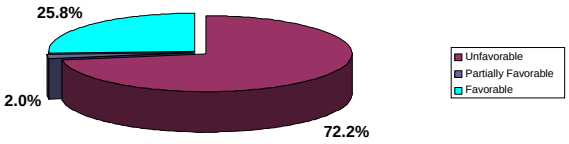
Part A



Part B



DME



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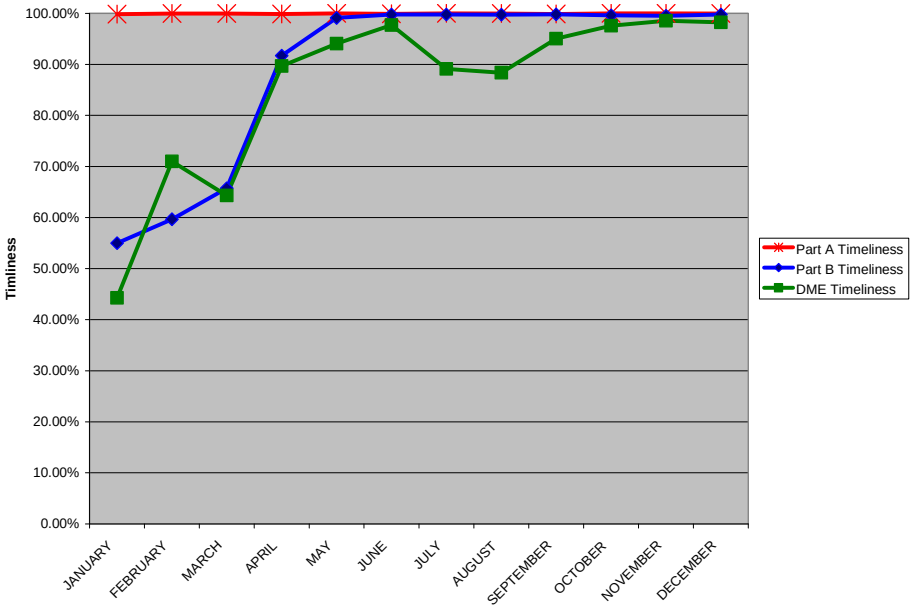
Reconsideration Timeliness



Note: Reconsiderations must be issued within 60 days of the request for an appeal.