Fact Sheet
Original Medicare (Fee-For-Service) Appeals Data - 2010

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 $1,300 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 2010, FIs and Part A MACs processed over 195 million claims* for services furnished by hospitals, skilled nursing facilities, home health agencies, and other providers. Of these claims, approximately 14.1 million were denied (e.g., services not covered, services not medically necessary, etc.). FIs and Part A MACs carried out approximately 295,000 Part A redeterminations in 2010, meaning that about 1.1 percent of these denials resulted in requests for an appeal.

Carriers and Part B MACs processed over 906 million claims, of which 93 million were denied. DME MACs processed over 75 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 2010, meaning that about 2.6 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."

2010 Redetermination Categories

Redetermination Categories – Part A

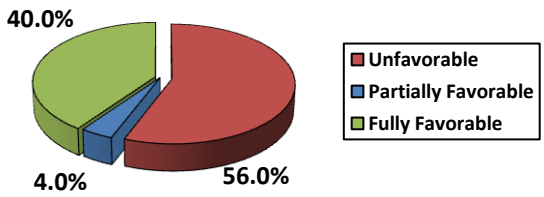
Appeal Category	Decided Claims	Percent
Outpatient	175,456	59%
Other (Acute Hospital, Hospice, etc.)	45,900	16%
Inpatient	10,365	4%
Home Health	47,645	16%
Skilled Nursing Facility (SNF)	10,568	4%
Ambulance	4,100	1%
Lab	1,141	0%
TOTAL	295,175	100%

Redetermination Categories – Part B

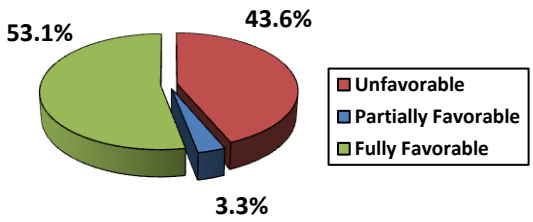
Appeal Category	Decided Claims	Percent
Physician	1,386,627	59%
Durable Medical Equipment (DME)	531,226	22%
Ambulance	185,115	8%
Other (Preventative Services, Vision, etc.)	161,487	7%
Lab	95,177	4%
TOTAL	2,359,632	100%

Redetermination Dispositions for 2010

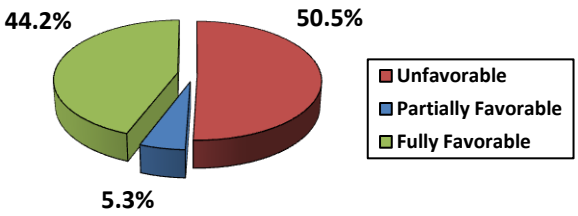
Part A Redeterminations



Part B Redeterminations

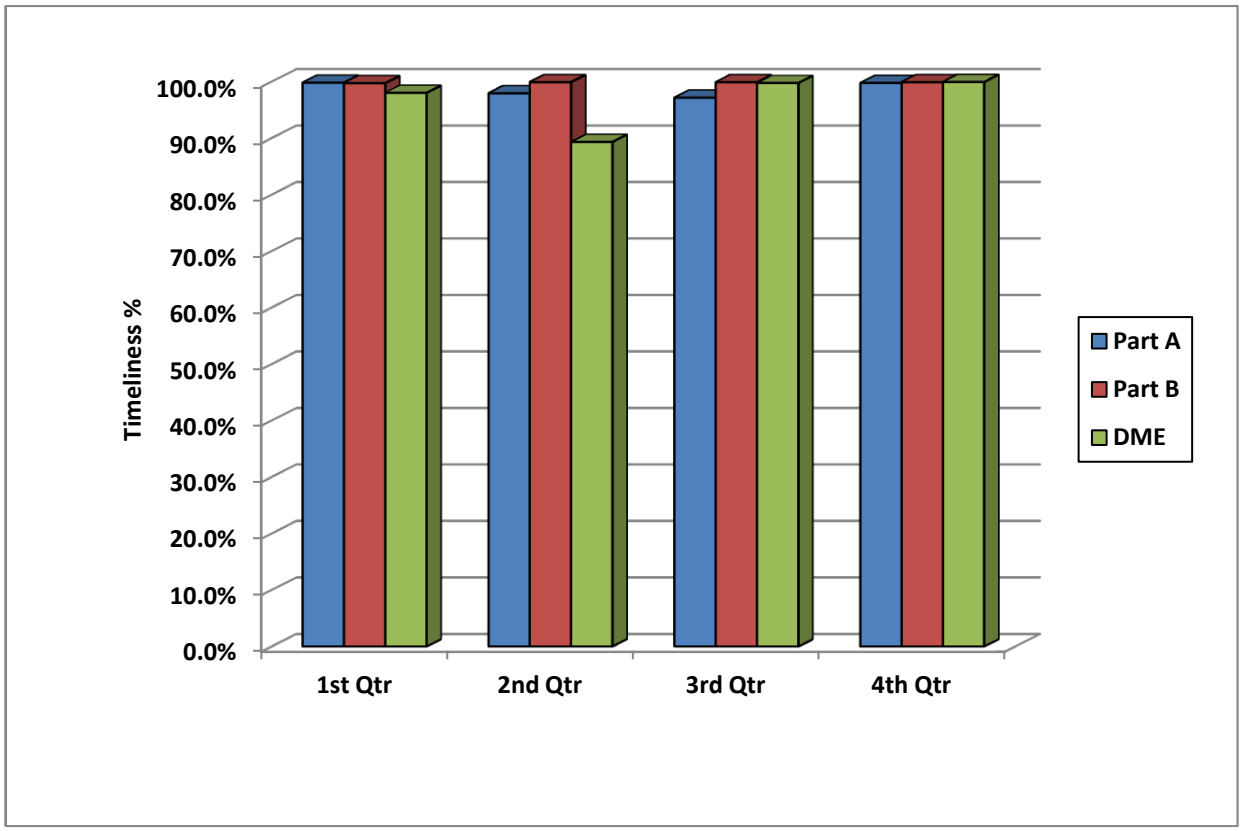


DME Redeterminations



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.

2010 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 2010, there were two Part A QICs, two Part B QICs, and one DME QIC. The QICs processed approximately 499,000 claims in 2010.

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 2010

Appeal Category	Decided Claims	% of Total
Home Health	23,882	31.3%
Outpatient Therapies/CORF	14,248	18.6%
Outpatient Hospital/ASC	8,210	10.7%
Skilled Nursing Facility	7,882	10.3%
Hospice	4,452	5.8%
Acute Inpatient Hospital	3,023	4.0%
Drugs	2,702	3.5%
Ground Transportation	2,172	2.8%
Imaging/Radiology	1,932	2.5%
Air Ambulance	1,727	2.3%

Top 10 Part B Reconsideration Categories for 2010

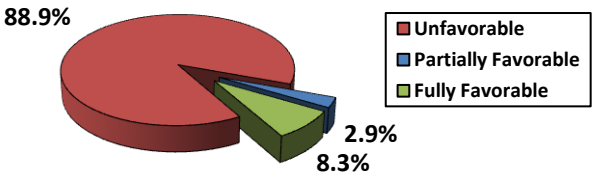
Appeal Category	Decided Claims	% of Total
Other (Preventative Care, Dental, etc)	74,806	24.4%
Ground Transportation	33,460	10.9%
Imaging/Radiology	22,802	7.4%
Technical Denial	20,425	6.7%
Integum'y/Musculoskeletal Surgery	19,576	6.4%
Office E/M Services	16,675	5.4%
Pathology/Laboratory	12,982	4.2%
Outpatient Therapies / CORF	11,977	3.9%
Respiratory/Cardiovascular Surgery	11,339	3.7%
Vision Services	9,736	3.2%

Top 10 DME Reconsideration Categories for 2010

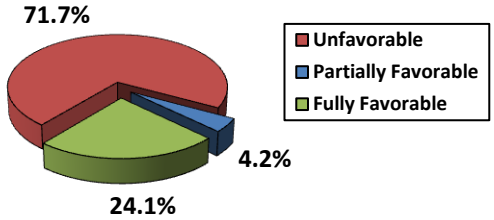
Appeal Category	Decided Claims	% of Total
Surgical Dressings	21,937	19.3%
Miscellaneous DMEPOS	19,036	16.8%
Oxygen	9,422	8.3%
Power Mobility Devices	9,014	7.9%
Manual Wheelchairs	7,198	6.3%
Glucose Monitors	6,704	5.9%
Respiratory-Miscellaneous	6,060	5.3%
Pneumatic compressor	4,115	3.6%
Enteral/Parenteral Nutrition.	4,054	3.6%
Orthoses	3,885	3.4%

Reconsideration Dispositions

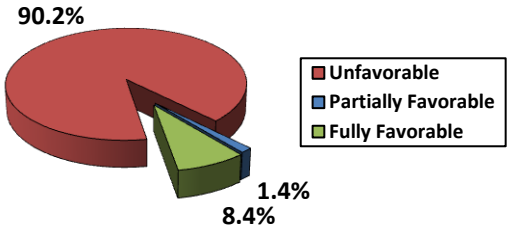
Part A Reconsiderations



Part B Reconsiderations



DME Reconsiderations

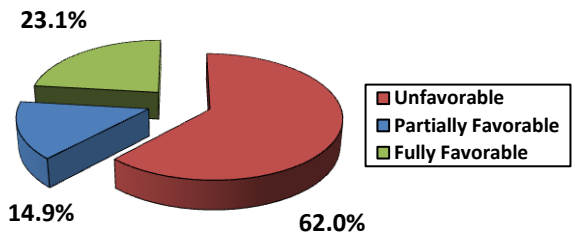


Note: A "favorable" decision means that the appeal was successful and the claim in dispute was paid. An "unfavorable" decision means that an appellants' appeal was denied. Calculation of the rates above excludes cases that were dismissed.

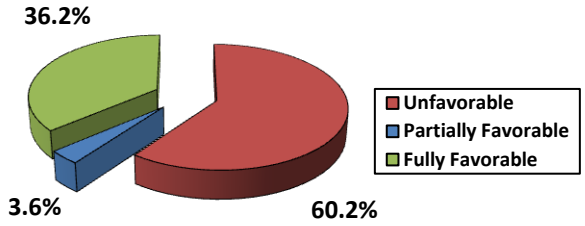
Specialty Contractor Reconsideration Dispositions

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.

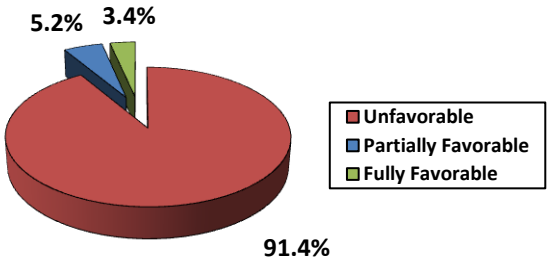
Demonstration RAC Reconsiderations



National RAC Reconsiderations

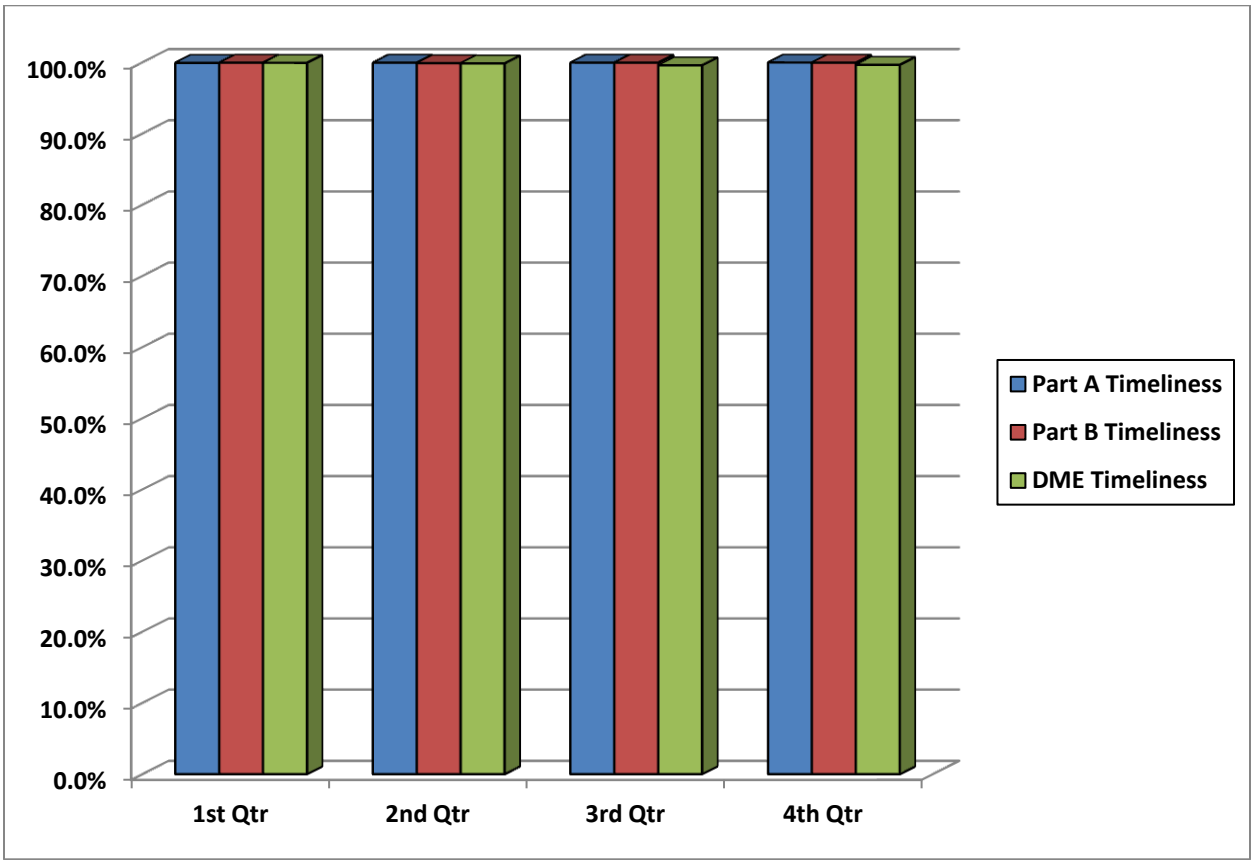


ZPIC Reconsiderations



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 147 RAC Demonstration claims, 505 National RAC claims, and 21,169 ZPIC claims in CY2010.

2010 Reconsideration Timeliness



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