Program Memorandum Intermediaries/Carriers

Department of Health & Human Services (DHHS) Centers for Medicare & Medicaid Services (CMS)

Transmittal AB-03-067 **Date: MAY 9, 2003**

CHANGE REQUEST 2740

SUBJECT: Revision to CR 2170: Appeals Quality Improvement and Data Analysis Activities

This is a revision of Change Request (CR) 2170, Transmittal AB-02-122 which was originally issued on August 28, 2002 with an implementation date of October 1, 2003. On December 24, 2002 a joint signature letter was released. The letter indicated that the activities described in CR 2170 would not be required in FY 2003 due to the Continuing Resolution. The FY 2003 Program Management activities received an appropriation and the funds for CR 2170 have been restored to the FY 2003 budget. Implementation of the activities described in CR 2170, and modified in this PM must be implemented in FY 2003 for the period of April 1, 2003 through September 30, 2003.

The purpose of this PM is to make a revision of the effective date and the implementation date of CR 2170. These instructions should be implemented retroactively to the effective date.

The following, in italics, is the original instruction found in CR 2170 and shall remain the same for the remainder of the fiscal year (FY). The only exception to the original instruction is found in Section IV dealing with the due dates of the reports.

I. Introduction

There are administrative costs associated with conducting each level of appeal, with the cost increasing at each subsequent level. Therefore, you should try to resolve appeals at the lowest level possible. Establishing and maintaining a Quality Improvement program based on a Data Analysis program is an operational tool to help you achieve the goal of identifying and eliminating unnecessary appeals. Such a tool can assist you in identifying deficiencies in the appeals process and enable you to take the necessary steps to correct them. A well developed Quality Improvement/Data Analysis program also allows you to provide feedback to other program areas, including provider education, program integrity, and medical review. These instructions supercede the Medicare Carriers Manual § 12040. All costs associated with conducting the Quality Improvement and Data Analysis activities described in sections II and III of this PM are to be reported under CAFMII code 12090 in accordance with the FY 2003 Budget Performance Requirements (BPRs).

II. Workload Data Analysis Program

The basis of an effective Quality Improvement program is a Data Analysis program. Data analysis involves collecting relevant data, analyzing the data, identifying trends and aberrancies, and making conclusions based on the data collected. In order to perform adequate data analysis, you must, at a minimum, gather data from a 10% or 100 per month (whichever is less) random sample of reviews and reconsiderations. For Hearing Officer (HO) hearings, you must, at a minimum, gather data from a 10% or 50 per month (whichever is less) random sample, and for Administrative Law Judge (ALJ) cases, at a minimum, a 10% or 10 per month (whichever is less) random sample. Data must be collected from each level of appeal as follows:

1. *Reconsideration Determinations- Your Data Analysis on reconsiderations should focus on identifying:*
    - *The reasons for full or partial reversals, such as:*
        - *Submission of documentation that should have been submitted with the initial claim*
    - *Claims that were denied due to medical review edits*
    - *Providers who submit a high volume of requests for reconsiderations and whose initial claim denials are frequently reversed at the reconsideration level*

- *Reasons for dismissals*
- *Types of services and/or issues that are appealed most frequently*
- *The percentage of reconsiderations that result in full reversals, partial reversals, and complete affirmations (e.g. no change was made) decisions*

2. *Review Determinations- Your Data Analysis on reviews should focus on identifying:*
    - *The reasons for full or partial reversals, such as:*
        - *Initial claims processing system errors, if applicable (see MCM Part 2 §§5104(B)(8) or MIM Part 2 §§ 2958(B)(8) & 2959(B)(4) on claims errors that should be handled as inquiries regardless of the right to appeal)*
        - *Initial claims processing errors made by the physician/supplier/provider, if applicable (see MCM Part 2 §§5104(B)(8) & 5105(B)(4) or MIM Part 2 §§ 2958(B)(8) & 2959(B)(4) on claims errors that should be handled as inquiries regardless of the right to appeal)*
        - *Submission of documentation that should have been submitted with the initial claim*
    - *Claims that were denied due to medical review edits*
    - *Providers, suppliers and/or physicians who submit a high volume of requests for reviews and whose initial claim denials are frequently reversed at the review level*
    - *Reasons for dismissals*
    - *Types of services and/or issues that are appealed most frequently*
    - *The percentage of reviews that result in full reversals, partial reversals, complete affirmations (e.g. no change was made) and decisions*

3. *HO Hearing Decisions- Your Data Analysis on HO hearings should focus on identifying:*
    - *The reasons for full or partial reversals, such as:*
        - *Reviewer errors;*
        - *Submission of documentation that should have been submitted with the initial claim; and*
    - *Claims that were denied due to medical review edits*
    - *Providers, suppliers and/or physicians who submit a high volume of requests for HO hearings and whose initial claim denials are frequently reversed at the HO Hearing level*
    - *Reasons for dismissals*
    - *Types of services and/or issues that are appealed most frequently*
    - *The percentage of hearings that result in full reversals, partial reversals, and complete affirmations (e.g. no change was made) decisions*

4. *ALJ Decisions- Your Data Analysis on ALJ Decisions should Focus on identifying:*

    - *Reversals where it appears that the contractor hearing officer or reconsideration adjudicator made an error;*
    - *Reversals that reference §1879 of the Act as the reason for the reversal; and*
    - *Reversals from ALJs who frequently disagree with your determinations or HO decisions.*

III. <u>Quality Improvement Activities</u>

Your Quality Improvement program must involve three general functions:

1. *Corrective Action - A Quality Improvement program takes corrective actions in response to any problems identified by the results of your Data Analysis program. Examples of corrective actions that may take place as a result of Data Analysis include:*
    - *Educating providers, physicians, suppliers, intermediary/carrier staff, and/or beneficiaries;*
    - *Correcting claims processing errors, if applicable;*
    - *Reevaluating contractor policy that results in a high reversal rate; and*
    - *Evaluating the effectiveness of edits.*

***NOTE**: Some corrective actions only require you to notify the appropriate program area of what action(s) need to be taken. The costs and workload associated with corrective actions must be assigned to the appropriate area (e.g. Provider education activities that result from data analysis are charged to MIP PCOM and/or* LPAT*).*

2. *Quality Control Checks- The second function of a Quality Improvement program involves quality control checks. This includes performing quality checks on decision letters for accuracy and responsiveness, tone/clarity, and accuracy and correctness (see MCM Part 2 §§ 5104(A)(2) & 5105(A)(2) and MIM Part 2 §§ 2958(A)(2) & 2959(A)(2) on Guidelines for High Quality Written Responses to Inquiries). On a monthly basis, perform quality checks on at least a 5 % or 25 case sample (whichever is less) of decision letters at each level of appeal. For reviews and reconsiderations, check only partially or wholly unfavorable determinations. The findings of the quality checks should be communicated to the appropriate staff as part of the internal feedback function.*

   Examples of assessment criteria for quality checks of appeal decision letters include:

   <u>Accuracy & Responsiveness</u>
   - *All issues raised by the appellant were addressed*
   - *Claim was adjusted correctly*
   - *Determination made was correct*
   - *Decision was sent to all parties*
   - *Decision was effectuated timely*
   - *Privacy of parties was protected*
   - *Decision letter contains:*
     - *Description of the issues*
     - *Rationale*
     - *Offers to provide copies of Medicare statute, regulations, and guidelines used in determination*
     - *Liability determination, if necessary*
     - *Appropriate language for further appeal rights*
     - *A statement that third parties may be available to help with subsequent appeals*

   <u>Tone/Clarity</u>
   - *Issue was clearly stated*
   - *Jargon or inappropriate abbreviations were not used*
   - *Tone is professional and customer friendly*

   <u>Accuracy & Correctness</u>
   - *Spelling*
   - *Grammar*
   - *Punctuation*
   - *Capitalization*
   - *Medical Terminology*

3. *Internal Feedback System-The on-going Internal Feedback System has four components: (1) The first involves communicating the results of Data Analysis to the employees affected as part of an internal feedback system (claims processing, medical review, appeals adjudicators, and professional relations staff). You must send copies of the findings from your data analysis to the manager of the claims processing units for use in the claims examiner education and training process. Also, send copies of the reversal analyses and any supporting statistics to the Medical Review manager for use in the Medical Review strategy and to evaluate the effectiveness of Medical Review edits. In addition to providing feedback to other units, you should make the results of Data Analysis available to all appeals adjudicators.*

   (2) The second involves giving appeals adjudicators an opportunity to see why their cases were overturned in subsequent levels of appeal in order to improve future decisions. You must develop and implement some type of feedback on reconsideration/review determinations, HO hearing decisions, and ALJ decisions to the staff responsible for conducting the prior level of appeal.

(3) The third component in the internal feedback system involves providing appeals adjudicators with feedback from the quality control checks.

(4) The last component of the internal feedback system involves ALJ decisions. For ALJ Decisions you must:

- *Notify your CMS Regional Office (RO) if you find a pattern of ALJ reversals that disagrees with CMS's policy.*
- *Make sure at least one copy of the findings from your analysis of ALJ reversals is sent to the manager of the HO hearing unit for Part B cases or the manager of the Part A appeal unit for part A cases. The manager will circulate a copy to all of the HOs or reconsideration adjudicators.*
- *In those cases where the HO or reconsideration adjudicator is located off-site, make copies available to each HO or reconsideration adjudicator.*
- *If there are continued reversals of CMS's policy, the policy needs to be reexamined and brought to the attention of your RO.*

IV. Submitting Reports to CMS

CMS will periodically request all documentation from your Quality Improvement and Data Analysis programs in addition to your summary report. Your summary report should include the following items:

Data Analysis

- *Types of initial determinations that are appealed most often (denial due to lack of documentation or Certificate of Medical Necessity (CMN), frequency exceeded, fraud/abuse, non-covered service, etc.)*
- *Types of services most frequently appealed*
- *Most frequent reasons for reversals*
- *Most frequent reasons for dismissals*
- *An estimate of the total number of full reversals, partial reversals and complete affirmations decisions with the percentage breakdown*

Quality Improvement

- *A description of what efforts or corrective actions you have taken to minimize appeal problems in the period (Note: your approach may change periodically)*
- *An explanatory narrative of the results of your analysis (e.g., trends you have discovered)*
- *A summary of the findings of quality checks on appeal determinations*
- *A summary of the impact of your quality improvement program (e.g., changes in trends, decreases in number of reversals, decreases in appeal requests, etc.)*

You must submit a summary report to your RO according to the following schedule:

OLD SCHEDULE	
Months to Include in Report	*Due Date*
October *November* *December* *January*	*February 15th*
February *March* *April* *May*	*June 15th*
June *July* *August* *September*	*October 15th*

NEW SCHEDULE	
Months to Include in Report	Due Date
October November December January February March	NA
April May June July August September	October 15th

Accordingly, the first report after the implementation date of this PM will be for the period starting on April 1, 2003 and ending on September 30, 2003 and is due on October 15, 2003.

In general, your approach to quality improvement should be evolving and adaptable to the issues that you are dealing with at your site and in the current claims/appeals environment. As you find and resolve issues, your focus should change to another area requiring attention. Similarly, your methods of resolving problems should change periodically. While the reports have standard information requirements, the contents will change as improvements are made and new issues surface.

The *effective date* for this Program Memorandum (PM) is April 1, 2003.

The *implementation date* for this PM is July 24, 2003.

These instructions should be implemented within your current operating budget.

This PM may be discarded after May 9, 2004.

If you have any questions, contact Jennifer Eichhorn at JEichhorn@cms.hhs.gov or 410-786-9531 , Lisa Childress at LChildress@cms.hhs.gov or 410-786-6956, Karyn Claggett at KClaggett@cms.hhs.gov or 410-786-7536, or your local regional office.