CMS Manual System

Pub. 100-06 Medicare Financial Management

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

Transmittal 45 **Date: MAY 28, 2004**

CHANGE REQUEST 3246

I. SUMMARY OF CHANGES: This change request adds Medicare Intermediary Manual §§3881-3890. These instructions should have been incorporated in chapter 6 (Workload Reporting), of Pub. 100-06, but were erroneously omitted during the manual conversion.

MANUALIZATION - EFFECTIVE DATE: N/A
***IMPLEMENTATION DATE: N/A**

Disclaimer for manual changes only: The revision date and transmittal number apply only to the red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will only receive the new/revised information, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS:
(R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	6/Table of Contents
N	6/90/Monthly Intermediary Part A and Part B Appeals Report (Form CMS-2591)
N	6/90.1/Purpose and Scope
N	6/90.2/Due Date
N	6/100/Completion of Items on Form CMS 2591
N	6/100.1/Heading
N	6/100.2/Section A- Intermediary Appeal Requests
N	6/100.3/Section B- Part B Hearing Results
N	6/100.4/Section C- Part A and Part B ALJ Hearings
N	6/100.5/Section D- Limitation of Liability
N	6/100.6/Section E- Part A and Part B Reopenings
N	6/110/Checking Reports
N	6/110.1/Exhibit 1
N	6/110.2/Exhibit 2
N	6/110.3/Exhibit 3
N	6/110.4/Exhibit 4
N	6/110.5/Exhibit 5
N	6/110.6/Exhibit 6

***III. FUNDING:**

These instructions shall be implemented within your current operating budget.

IV. ATTACHMENTS:

	Business Requirements
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

***Medicare contractors only**

Medicare Financial Management Manual
Chapter 6 - Workload Reporting

Table of Contents
(Rev. 45, 05-28-04)

90 - Monthly Intermediary Part A and Part B Appeals Report (Form CMS 2591)

(Rev. 45, 05-28-04)

At the end of each month, prepare and transmit to CMS a report summarizing activity on Part A reconsiderations, Part A Administrative Law Judge (ALJ) hearings, Part B reviews, and Part B hearings during the month. Complete a separate report for each office assigned a separate intermediary number.

Form CMS-2591 is subject to the Paperwork Reduction Act and requires approval by the Office of Management and Budget (OMB). OMB approval has been requested.

90.1 - Purpose and Scope

(Rev. 45, 05-28-04)

The CMS-2591 (see §3890 - Exhibits 1 thru 6) enables CMS to tabulate data for administrative purposes on the following information:

- *The number of reconsiderations, reviews and hearings requested, completed, and pending;*
- *The number of reconsiderations, reviews and hearings resulting in affirmations or reversals of previous determinations;*
- *The number of reconsiderations, reviews and hearings involving waiver of liability determinations, and dollar amount of charges allowed;*
- *Data on timeliness; and*
- *The number of Part A and Part B reopenings.*

90.2 - Due Date

(Rev. 45, 05-28-04)

Transmit the CMS-2591 to CO via PC or terminal. Use instructions in the Contractor Reporting of Operational and Workload Data (CROWD) System User's Guide.

The report is due as soon as possible after the end of the reporting month but no later than the 15th of the month following the end of the reporting month.

100 - Completion of Items on Form CMS-2591

(Rev. 45, 05-28-04)

100.1 - Heading

(Rev. 45, 05-28-04)

Enter your ID number in the space provided. In addition, indicate the reporting month and calendar year, i.e., 1292 for December 1992.

100.2 - Section A - Intermediary Appeal Requests

(Rev. 45, 05-28-04)

This part concerns data from Part A and Part B appeals processes. The number of appeals requested (received), completed, and pending reflects the status of the workload as of the last day of the reporting month. Base data on actual counts of each activity and not on sampling or other estimating techniques.

Appeals fall into the following categories:

1. Part A Reconsideration.--This is the first level of appeal following denial of a Part A claim. It is a re-evaluation of the facts and findings of a claim to determine whether the initial decision was correct. (See §3781.)

Do not count duplicate reconsideration requests or reconsideration requests received before you have made an initial determination on a claim. Do not count telephone requests for reconsiderations or inquiries. Count one reconsideration per request received. With the exception of line 7 of the CMS-2591, do not count the number of claims or beneficiaries involved in the requests.

2. Part B Review.--This is the first formal level of appeal following denial of a Part B claim. It is a second look by a different employee at the claim and supporting evidence. (See §§3792 ff.)

3. Part B Hearing.--This is an independent determination resulting from an appeal of your review decision. This independent determination is rendered by a Hearing Officer (HO) you assigned. The amount in controversy must be at least $100. (See §§3794ff.)

Definition of Columns:

Column (1) *TOTAL--All Part A reconsiderations. Column 1 must equal the sum of columns 2, 3 and 4.*

Column (2) *SNF.--All skilled nursing facility reconsiderations.*

Column (3) *HHA/HOSPICE.--All home health agency and hospice reconsiderations.*

Column (4) *OTHER.--All other Part A reconsiderations.*

Column (5) *PART B REVIEWS.--Count one review per request received (i.e., Form CMS-1964 or equivalent written request). Do not count duplicate review requests or review requests received before you have made an initial determination on a claim. With the exception of line 7 of the CMS-2591, do not count the number of claims or beneficiaries involved in the requests. (Report claim counts in line 7.)*

Column (6) *PART B HEARINGS.--Count one hearing per request received (i.e., Form CMS-1965 or equivalent written request). Include hearings requested that do not meet the minimum $100 requirements and are subsequently dismissed. With the exception of line 7 of the CMS-2591, do not count the number of claims or beneficiaries involved in the requests. (Report claim counts in line 7.) Do not count hearing requests that qualify for a Part B ALJ hearing. (Part B intermediary hearings are those Part B hearings that a hearing officer adjudicates, as opposed to an ALJ). See definition for Section C.*

Do not count requests for HO hearings received after you rendered an on-the-record (OTR) decision in lines 1-44 of the report. Count these cases only in lines 45, 46, 47, 48 and 50 as appropriate.

Line 1. Opening Pending.--Show under columns 1-4, the number of reconsiderations reported on line 19 as the closing pending on the previous month's report. Show under column 5 the number of reviews reported on line 30 as the closing pending on the previous month's report. Show under column 6 the number of hearings reported on line 40 as the closing pending on the previous month's report.

Line 2. Adjustments to Pending.--If it is necessary to revise the pending figure for the close of the previous month because of inventories or reporting errors, enter the adjustment. Report requests received near the end of the reporting month and placed under control in the subsequent month as received in the reporting month, not as requests received in the subsequent month. If some cases were not counted in the proper month's receipts, count them as adjustments to the opening pending in the subsequent month.

If line 3 of the current month differs from the closing pending of the previous month, there must be an entry in line 2 for the current month. Precede the entry by a "+" or "-", as appropriate.

Line 3. Adjusted Pending.--Enter the result of line 1 + line 2 (taking into account the "-" sign, if any).

Line 4. Requests Received.--Show, under the appropriate columns, the number of requests for reconsiderations, reviews, and Part B intermediary hearings received during the reporting month. Include requests transferred to you by other intermediaries if you incur administrative costs for processing the appeals and you report the cost on the Interim Expenditure Report (Form CMS-1523).

If an appellant submits one request involving several different claims (and several different beneficiaries), count it as one request. If an appellant submits more than one request (for different claims) at different times, count each request.

NOTE: *See definition of column (6) for instructions on hearings requested subsequent to OTR decisions.*

Line 4A. Medical Necessity Documentation Denials.--Show the number of requests included in line 4 that involved initial claim denials for lack of medical documentation.

Line 5. Requests Transferred.--Show under columns 1 thru 5 the number of reconsiderations and review requests you transferred to other contractors because you did not process the original claim(s). Report under column 6 the number of Part B hearing requests transferred to other contractors because the claimant is not within your geographical area (See §3794.3B) or transferred to ROs because the issues are outside the HO's responsibilities. (See §3794.2.) For columns 1-6, if you have reported a reconsideration, review or Part B hearing as transferred, do not report any information regarding it on lines 6-51. The transfer is the final action.

Line 6. Requests Cleared.--Show, under the appropriate columns, the total numbers of reconsiderations, reviews, and Part B hearings completed during the month. Report all completed appeals, regardless if final outcome was affirmation, reversal, withdrawal, or dismissal.

Consider a reconsideration or review cleared when the final determination (EOMB or other notice, including dismissal) is printed or typed, or upon notification of withdrawal by the appellant. In the case of a reversal, consider the case cleared when you initiate the adjustment action.

A Part B hearing may be considered cleared when the decision is signed, or the following conditions exist:

- *The claimant indicates that he/she is satisfied with the On-The-Record (OTR) decision;*
- *The claimant indicates after the OTR decision that he/she wishes to proceed with an ALJ hearing (if the amount in controversy is $500 or more);*
- *The HO dismisses the hearing request; or*
- *The appellant withdraws the hearing request.*

Do not consider a hearing completed upon release of an OTR decision unless the appellant specifically requested an OTR hearing. Do not count the OTR hearing as completed until you have completed all follow-up actions as required in §3794.9. If as a result of the follow-up actions, the appellant requests an in-person or telephone hearing after release of the OTR decision, the OTR hearing and decision are not counted on the report with the exception noted below. If the appellant does not appear for the subsequent hearing, dismiss the hearing. (See §3794.3K.) For processing time purposes, the case is completed when you dismiss it; however, the decision to record in lines 9-11 is the OTR decision.

NOTE: *If you close a reconsideration, review or hearing after the end of a reporting month but before the report is due on the fifteenth of the subsequent month, do not count it until the subsequent month's report.*

Line 7. No. of Claims Involved.--Show on line 6 the total number of claims involved in the appeals reported as cleared during the month. For example, if you process one HHA reconsideration decision which involves five claims, report five claims under column (3), or if you process decisions for two Part B hearings in the month, one of which involved three claims and the other seven, report 10 claims under column (6).

Line 8. Amount in Controversy.--For Part B hearings reported as affirmed (line 9) or reversed (line 11) during the month, show the total dollar amount in controversy on the initial requests. The amount in controversy is the difference between the amount billed (less any reductions required by legislation, e.g., Gramm-Rudman-Hollings) and the amount you originally allowed less any unmet deductible and coinsurance amounts. In effect, the amount in controversy is the amount of payment that the claimant would receive if the denial(s) was fully reversed. Show results rounded to the nearest dollar.

Line 9. Affirmations.--Under the appropriate columns, show the number of completed reconsiderations, reviews, and Part B hearings in which the previous determinations were completely upheld; i.e., no change was made. All parts of all claims in a case must be upheld in order for the case to be counted as an affirmation. An OTR hearing decision does not count as a previous decision if the appellant subsequently requests an in-person or telephone hearing. If the in-person/telephone hearing is dismissed because the appellant did not appear, or the request was withdrawn, use the OTR decision to determine if the case is counted here. (See line 11 for partial affirmations. Do not include them here.)

If you uphold your original determination, but pay under limitation of liability, count the determination as an affirmation. Report the appropriate information in Section D of the CMS-2591.

Line 10. Dism./Withdr.--Report, under the appropriate column, the number of completed reconsiderations, reviews, and Part B hearings that were withdrawn by the appellant or dismissed (before determination) by you or the HO. Report here and in lines 4 and 6 an appeal that is requested and withdrawn or dismissed within the same month. If the appellant requests an in-person or telephone hearing after receiving an OTR decision, and you dismiss the hearing because the appellant failed to appear, the OTR decision is the final decision, not the dismissal. Similarly, for a withdrawal, use the OTR decision.

A dismissal at the reconsideration or review level is done when written correspondence has been identified as an appeal request, but the claimant does not have the right to an appeal. Misrouted correspondence and duplicate requests are not dismissals.

If you have incorrectly counted such correspondence as an appeal on a previous report, use line 2 (adjustments to pending) to correct the count. Do not count a duplicate request for appeal anywhere on the report. Likewise, do not count on the report a request for appeal received before an initial claim determination has been rendered. (Consider the request an inquiry.)

Line 11. Reversals (Full or Part).--Under the appropriate columns, show the total number of completed reconsiderations, reviews, and Part B hearings in which at least part of the prior determination was reversed. That is, a change was made and some or all of the new determination was in favor of the appellant.

If a reconsideration, review, or Part B hearing involves several claims, and the initial determinations for some are affirmed and some are reversed, consider the decision a reversal. An OTR hearing decision does not count as a previous decision if the appellant subsequently requests an in-person or telephone hearing. If the in-person/telephone hearing is dismissed because the appellant did not appear, or the request was withdrawn, use the OTR decision to determine if the case is counted here.

Line 12. Amount Awarded.--For cases included in line 11, show the amount of submitted charges for services where the determination was reversed. Show charges prior to application of the deductible and coinsurance. Round results to the nearest dollar.

Processing and Pending Times.--This deals with processing and pending times for Part A and Part B appeals.

Computing Time to Process Part A Reconsiderations and Part B Reviews for (Lines 13-18 and 25-29)

For lines 13-18 and 25-29, use the matrix below to determine the number of days from receipt to completion of reconsiderations and reviews. The date of receipt in all cases is the day the processing contractor received it in its corporate mailroom.

Situation	***Date Completed***
• *The appellant withdraws the request.*	*The date you were notified of the withdrawal.*
• *You dismiss the request or affirm the original determination.*	*The date of the notice.*
• *You process the request to a reversal.*	*The date when you submit the claim to CWF if payment can be made without further development, or when you initiate development; e.g., when you must ascertain whether or not the provider has refunded payment to the beneficiary.*

Computing Time to Process Part B Hearings for Lines 35-39

For lines 35-39, use the matrix below to determine the number of days from receipt to completion of Part B hearings. The date of receipt, in all cases, is the day you receive the appeal request in its corporate mailroom. In out-of-area cases, it is the date that the second intermediary receives the request.

Situation	***Date Completed***
An OTR decision is made and the appellant accepts the decision or decided to go directly to an ALJ hearing.	*The date of the OTR decision.*
An OTR decision is made and the appellant chooses in a timely fashion to proceed with the in-person or telephone hearing.	*The date of the second decision. If the appellant appears, and you dismiss the hearing, use the date of notice of dismissal.*
An in-erson or telephone hearing is held without an OTR decision.	*The date of the decision.*
The appellant withdraws the hearing request.	*The date you are notified of the withdrawal.*
The HO dismisses the hearing request.	*The date of the dismissal notice.*

RECONSIDERATIONS

Line 13. Processing Time - Average.--Report under the appropriate columns the average number of days from receipt of the reconsideration to the date of completion.

To compute the average number of days from request to completion, divide the total days elapsed for all requests cleared in the month by the number of requests cleared. Round results to the nearest day. Calculate the days elapsed for an individual request by subtracting the Julian date of receipt from the Julian date of completion. If the request is cleared in the year following the year of receipt, add 365 or 366 to the result, as appropriate. (Otherwise, you will get a negative number.) If a case is cleared the same day it is received, consider it to require 1 day.

NOTE: *Include all cases cleared, regardless of whether they were affirmed, reversed, dismissed, or withdrawn.*

Line 14. Reconsiderations Completed 1-45 Days.--Show the number of reconsiderations that required 1-45 days, to complete. If a case is cleared the same day it is received, consider it to require 1 day.

Line 15. Reconsiderations Completed 46-60 Days.--Show the number of reconsiderations that required 46-60 days to complete.

Line 16. Reconsiderations Completed 61-90 Days.--Show the number of reconsiderations that required 61-90 days to complete.

Line 17. Reconsiderations Completed 91-120 Days.--Show the number of reconsiderations that required 91-120 days to complete.

Line 18. Reconsiderations Completed over 120 Days.--Show the number of reconsiderations that required more than 120 days to complete.

Line 19. Closing Pending Reconsiderations.--Show, under the appropriate columns, the total number of reconsiderations that have not been completed by the end of the reporting month.

Line 20. Reconsiderations Pending 1-45 Days.--Show the number of reconsiderations included in line 19 that have been pending 1-45 days, inclusive, at the end of the reporting month.

Line 21. Reconsiderations Pending 46-60 Days.--Show the number of reconsiderations included in line 19 that have been pending 46-60 days, inclusive, at the end of the reporting month.

Line 22. Reconsiderations Pending 61-90 Days.--Show the number of reconsiderations included in line 19 that have been pending 61-90 days, inclusive, at the end of the reporting month.

Line 23. Reconsiderations Pending 91-120 Days.--Show the number of reconsiderations included in line 19 which have been pending 91-120 days, inclusive, at the end of the reporting month.

Line 24. Reconsiderations Pending Over 120 Days.--Show the number of reconsiderations included in line 19 which have been pending more than 120 days at the end of the reporting month.

REVIEWS

Line 25. Processing Time - Average.--Report here the average number of days from the receipt of the review to the date of completion.

To compute the average number of days from request to completion, divide the total days elapsed for all requests cleared in the month by the number of requests cleared. Round results to the nearest day. Calculate the days elapsed for an individual request by subtracting the Julian date of receipt from the Julian date of completion.

If the request is cleared in the year following the year of receipt, add 365 or 366 to the result, as appropriate. (Otherwise, you will get a negative number.) If a case is cleared the same day it is received, consider it to require 1 day.

NOTE: *Include all cases cleared, regardless of whether they were affirmed, reversed, dismissed, or withdrawn.*

Line 26. Reviews Completed in 1-30 Days.--Show the number of cases that required 1-30 days to complete. If a case is cleared the same day it is received, consider it to require 1 day.

Line 27. Reviews Completed in 31-45 Days.--Show the number of reviews that required 31-45 days to complete.

Line 28. Reviews Completed in 46-60 Days.--Show the number of reviews that required 46-60 days to complete.

Line 29. Reviews Completed in 61+ Days.--Show the number of reviews that required more than 60 days to complete.

Line 30. Closing Pending-Reviews.--Show the total number of reviews that have not been completed by the end of the reporting month.

Line 31. Reviews Pending 1-30 Days.--Show the number of reviews included in line 30 that have been pending 1-30 days, inclusive, at the end of the reporting month.

Line 32. Reviews Pending 31-45 Days.--Show the number of reviews included in line 30 that have been pending 31-45 days, inclusive, at the end of the reporting month.

Line 33. Reviews Pending 46-60 Days.--Show the number of reviews included in line 30 that have been pending 46-60 days, inclusive, at the end of the reporting month.

Line 34. Reviews Pending Over 60 Days.--Show the number of reviews included in line 30 that have been pending more than 60 days at the end of the reporting month.

PART B HEARINGS

Line 35. Hearing Processing Time - Average.--Report the average number of days from receipt of the hearing request to date of completion. See methodology under line 25.

Line 36. Hearings Completed in 60 Days.--Show the number of hearings that required 1-60 days to complete. If a case is cleared the same day it is received, consider it to require 1 day.

Line 37. Hearings Completed in 61-90 Days.--Show the number of hearings that required 61-90 days to complete.

Line 38. Hearings Completed 91-120 Days.--Show the number of hearings that required 91-120 days to complete.

Line 39. Hearings Completed Over 120 Days.--Show the number of hearings that required more than 120 days to complete.

Line 40. Closing Pending-Hearings.--Show the total number of hearings that have not been completed by the end of the reporting month. You may not consider a hearing completed upon release of an OTR decision unless the appellant specifically requested an OTR hearing. See definition for line 6.

Line 41. Hearings Pending 1-60 Days.--Show the number of hearings included in line 40 that have been pending 1-60 days, inclusive, at the end of the reporting month.

Line 42. Hearings Pending 61-90 Days.--Show the number of hearings included in line 40 which have been pending 61-90 days, inclusive, at the end of the reporting month.

Line 43. Hearings Pending 91-120 Days.--Show the number of hearings included in line 40 which have been pending 91-120 days, inclusive, at the end of the reporting month.

Line 44. Hearings Pending Over 120 Days.--Show the number of hearings included in line 40 that have been pending more than 120 days at the end of the reporting month.

100.3 - Section B-Part B Hearings Results

(Rev. 45, 05-28-04)

Section B deals with data on Part B hearings completed during the month. Base data shown on actual counts of each activity and not derived from sampling or other estimating techniques.

HEARINGS FALL INTO THE FOLLOWING CATEGORIES:

Column (1) — *On-the-Record with No Subsequent Hearing.--Include in column 1 hearings held where the appellant originally requested an OTR hearing, indicates that he/she is satisfied with the OTR decision, that he/she wishes to proceed with an ALJ hearing (if the amount in controversy is $500 or more), or fails to respond to the OTR within the required time frame. In addition, if the appellant requests an in-person or telephone hearing subsequent to an OTR decision, but the hearing is dismissed or withdrawn, include it here and not in columns (2) or (3).*

Column (2) — *All Telephone.--Include in column 2, hearings where the appellant requested and had a telephone hearing subsequent to an OTR hearing decision, or a telephone hearing was held without a prior OTR decision. Count all telephone hearings including those where the appellant did not follow-up timely to the OTR notice, but later requested a telephone hearing.*

Column (3) — *All In-Person.--Include in column 3 hearings where the appellant requested and had an in-person hearing subsequent to an OTR hearing decision, or an in-person hearing was held without a prior OTR decision. Count all in-person hearings including those where the appellant did not follow-up timely to the OTR notice but later requested an in-person hearing.*

Column (4) — *Number in 120 Days.--For the total cases included in line 47, columns 2 and 3, (e.g., the sum) show for lines 49-51 the numbers that were completed within 120 days of receipt. Use the methodology shown above the explantion for line 13 to determine the completion date. Where an OTR decision is made and the appellant chooses to not follow-up timely and later requests either an in-person or telephone hearing, completion time for this second reported hearing is measured from the date of receipt of original request to the date of the second decision. If the appellant does not appear, dismiss the hearing in accordance with §3794.3k, and use the date of notice of dismissal as your date completed.*

Line 45. Reversals.--Under the appropriate columns, show the number of OTR, telephone, and in-person hearings completed in the month in which at least part of the review determination was reversed i.e., a change was made and some, or all, of the new determination was in favor of the appellant. (See the definition for line 11.)

Line 46. Affirmations.--Under the appropriate columns, show the number of OTR, telephone, and in-person hearings completed in the month in which the review determination was completely upheld, i.e., no change was made. All parts of all claims must be upheld in order for the case to be counted as an affirmation. (See the definition for line 9.)

Line 47. Total Decisions.--Show the total number of hearing decisions completed during the month that resulted in a reversal or affirmation, excluding dismissals and withdrawals.

Line 48. Number in 120 Days.--For cases included in line 47, show the number that were completed within 120 days of receipt. See methodology for column 4 to determine the completion date.

Line 49. No Previous OTR Held.--For cases included in line 47, columns (2) and (3), report the number where you held the telephone or in-person hearing without first making an OTR decision, i.e., the OTR hearing was bypassed.
In column (4), report the number of cases included in either column (2) or (3) which were completed within 120 days.

Line 50. Previous OTR Counted.--For the cases included in line 47, columns (2) and (3), report the number where you included the OTR count on a previous report. In column (4), report the number of cases included in either column (2) or (3) that were completed within 120 days.

Cases reported in line 50 are those where an OTR decision was made and the appellant either accepted the OTR decision, did not respond timely, or decided to go directly from the OTR decision to an ALJ hearing. Then, subsequent to this OTR decision "acceptance," the appellant changed his/her mind and decided that he/she wanted a telephone or in-person hearing. Do not include these cases in line 6.

Line 51. Previous OTR Not Counted.--For cases included in line 47, columns (2) and (3), report the number where you did not include the OTR count on a previous report. These are cases where you made the OTR decision first, and the appellant indicated in a timely fashion (see §3794.9) that he/she wanted a telephone or in-person hearing. In column (4), report the number of cases included in either column (2) or (3) that were completed within 120 days.

100.4 - Section C - Part A and B ALJ Hearings

(Rev. 45, 05-28-04)

Use Section C to report requests for ALJ hearings, including those expected to be dismissed for failure to meet the amount in controversy requirement or for any other reason, such as the lack of a fair hearing in Part B cases.

ALJ HEARINGS FALL INTO THE FOLLOWING CATEGORIES:

Column (1) TOTAL.--All Part A ALJ hearing requests as originally filed. Column 1 must equal the sum of columns 2, 3 and 4.

Column (2) SNF.--All skilled nursing facility (SNF) hearings.

Column (3) HHA/HOSPICE.--All home health agency (HHA) and hospice hearings.

Column (4) OTHER.--All other hearings.

Column (5) PART B.--All Part B ALJ hearings.

Line 52. Opening Pending.--Show the number of ALJ hearings reported on Line 67 as the closing pending on the previous month's report.

Line 53. Adjustments to Pending.--See definition for line 2. If line 54 of the current month differs from data in line 67 of the previous month, there must be an entry in line 53 for the current month. Precede the entry by a "+" or "-" as appropriate.

Line 54. Adjusted Pending.--Show the result of line 52 + line 53 (taking into account the "-" sign, if any).

Line 55. Requests Received.--Show the number of ALJ hearings requested during the month. (See §3797)

Line 56. Requests Forwarded to ALJ.--Show the number of ALJ hearing requests forwarded to ALJs during the month. Consider the case forwarded when all necessary material has been mailed to the ALJ.

Line 57. No. of Claims Involved.--Show the number of claims involved in the ALJ hearing requests forwarded to ALJs as reported on line 56.

Line 58. In 1-7 Calendar Days.--Show the number of ALJ hearing requests forwarded to ALJs within 7 calendar days from receipt of the request in the corporate mailroom to mailing of the necessary information. Show data for all cases mailed during the month. The number must be less than, or equal to, the number shown in line 56.

Line 59. In 1-14 Calendar Days.--Show the number of ALJ hearing requests forwarded to ALJs within 14 calendar days from receipt of the request in the corporate mailroom to mailing of the necessary information to the ALJ. Show data for all cases mailed during the month. Note that the number in this line must be less than or equal to the number shown in line 56.

Line 60. Average Time to Forward.--Report the average number of calendar days from receipt of the ALJ request to the date of mailing of the necessary information. Use the methodology discussed in §3888.2 for line 13.

Line 61. Completed.--Show the number of ALJ hearing requests completed during the month. Consider a case completed when you have received the completed decision from the ALJ for all parts of the case.

Line 62. Amount in Controversy.--For ALJ hearings reported as affirmed (line 63) or reversed (line 65), during the month, show the total dollar amount in controversy according

to the initial ALJ hearing request. This should be the amount remaining after previous appeals decisions. Round results to the nearest dollar.

Line 63. Affirmations.--Show the number of completed ALJ hearings in which the previous determination was completely upheld, i.e., no change was made. All parts of all claims in a case must be upheld in order for the case to be counted as an affirmation. See line 65 for partial affirmations. (Do not include partial affirmations on this line.)

If the prior determination was upheld, but payment was made under limitation of liability, count the ALJ hearing determination as an affirmation. Report the appropriate information in lines 77 and 78.

Line 64. Dismissals/Withdrawals.--Show the number of completed hearings that were withdrawn by the appellant or dismissed (before determination) by the ALJ. Report an appeal that was requested and withdrawn or dismissed within the same month here and in lines 55, 56, and 61.

Line 65. Reversals (Full or Part).--Show the total number of completed ALJ hearings in which at least part of the prior determination was reversed; i.e., a change was made and some or all of the new determination was in favor of the appellant. For example, if an ALJ hearing involved several claims, and the initial determinations for some were affirmed and some were reversed, consider the decision to be a reversal.

Line 66. Amount Awarded.--For cases included in line 65, show the amount of submitted charges for services where the determination was reversed. Show charges prior to application of the deductible and coinsurance. Round results to the nearest dollar.

Line 67. Closing Pending.--Show the total number of ALJ hearing requests that were not completed by the end of the reporting month. Consider a case transferred to an ALJ as pending until you have received the completed decision from the ALJ for all parts of the case.

ALJ DISPOSITIONS

Line 68. Number of Dispositions.--Report the number of dispositions rendered by the ALJ(s) in cases reported as cleared for the month in Line 61. There will usually be more ALJ dispositions than cases counted in line 61. Do not count a case in line 61 until the ALJ has cleared all of the claims included in the request for hearing.

EXAMPLE: *You forwarded one request to an ALJ involving 20 claims. The ALJ dismisses 10 claims at once. A month later, the ALJ decides to affirm the original decision on 5 others as one group. The other five claims receive separate determinations. This would be counted as seven dispositions.*

Line 69. Affirmations.--Of those dispositions shown in line 68, report the number of decisions rendered by the ALJ(s) that were completely upheld.

Line 70. Dismissals/Withdrawals.--Of those dispositions shown in line 68, report the number of dismissals and withdrawals issued by the ALJ(s).

Line 71. Reversals.--Of those dispositions shown in line 68, report the number of decisions rendered by the ALJ (s) in which at least part of the prior determination was reversed.

EFFECTUATION OF ALJ DECISIONS

Line 72. Total Effectuations.--Show the number of ALJ hearing decisions for which you initiated effectuation during the month. Consider effectuation of a decision to be initiated when you:

- *Submit the claim to CWF if payment can be made without further development; or*

- *Initiate development, e.g., when you must determine whether or not the provider has refunded payment to the beneficiary.*

Line 73. Number 1-7 Days.--Show the number of cases where you effectuated the decision within 7 days. Effectuation days include day of receipt of the decision in your corporate mailroom.

Line 74. Number 8-15 Days.--Show the number of cases where you effectuated the decision within 8-15 days.

Line 75. Number 16-30 Days.--Show the number of cases where you effectuated the decision within 16-30 days.

Line 76. Number Over 30 Days.--Show the number of cases where you effectuated the decision in more than 30 days.

LIMITATION OF LIABILITY DETERMINATION IN ALJ CASES

Line 77. No. Waived - Ben. and Prov..--Show the number of claims in ALJ hearings during the reporting month where the liability of both the beneficiary and provider was limited.

Line 78. Amount Awarded.--For claims included in line 77, show the amount of the submitted charges for services where the liability was limited (including non-covered services where the liability of the beneficiary and provider are limited.) Show charges prior to application of the deductible and coinsurance. Round results to the nearest dollar.

100.5 - Section D - Limitation of Liability (Claim Counts)

(Rev. 45, 05-28-04)

Section D concerns requests involving limitation of liability determinations in Part A reconsiderations, Part B reviews and Part B hearings. To include a claim in lines 79-82, you must have originally denied it or reduced it for medical necessity or custodial care reasons.

Lines 80-82 are mutually exclusive; i.e., a claim meeting the above conditions may be counted on only one of three lines. Therefore, ensure that the sum of the number of the claims recorded on each of these lines equals the total number of claims considered for limitation of liability during the period as reported on line 79.

The counts in lines 79-82 reflect counts of claims. Report cases corresponding to the claims counted in Section A, as appropriate. If a claim is considered for limitation of liability at the initial claim level, do not count it at the review or hearing level unless you change the limitation of liability decision.

Categorize claims for the columns shown in Section D according to the adjudication level at which limitation of liability is considered or granted.

If you make several different limitation of liability decisions on the same claim, use the highest numbered line (out of 80-82) on the report that applies to that claim. Count the claim only once. For example, if you waive both the beneficiary and provider liability on any part of the claim, count the claim on line 82.

Line 79. Total Number Considered.--Show, under the appropriate columns, the number of claims, meeting the conditions above, for which limitation of liability was considered during the month.

Line 80. No. Considered - Not Waived.--Show, under the appropriate columns the number of claims that meet the conditions above, on which limitation of liability was considered, but was not granted to the beneficiary. This also includes cases where only provider liability is waived.

Line 81. No. Waived - Ben. Only.--Show, under the appropriate columns, the numbers of claims that meet the conditions above, where the liability of only the beneficiary was limited.

Line 82. No. Waived - Ben. and Prov.--Show, under the appropriate columns, the numbers of claims where the liability of both the beneficiary and provider was limited.

Line 83. Amount Awarded.--For cases included in line 82, show the amount of the submitted charges for services where liability was limited (including noncovered services where liability of the beneficiary and provider are limited). Show charges prior to application of the deductible and coinsurance. Round results to nearest dollar.

100.6 - Section E - Part A and Part B Reopenings (Claims)

(Rev. 45, 05-28-04)

Report the number of Part A and Part B claims involved in reopenings completed during the month. See §3795 for discussion of what constitutes a reopening. Include reopenings which do not result in revisions. Claims review, reconsideration, Part B hearings, and ALJ hearings undertaken as part of the appeal process are not reopenings.

PART A REOPENINGS FALL INTO THE FOLLOWING CATEGORIES:

Column (1) Total.--All reopenings completed.

Column (2) Pre-Recon.--All reopenings of initial claim determinations. If a claim has been through a reconsideration, do not count it here.

Column (3) Post-Recon.--All reopenings of reconsideration determinations. If a claim has been through any type of hearing, do not count it here.

Column (4) Post-ALJ Hearing.--All reopenings of ALJ hearing determinations. Once a claim has been through an ALJ hearing, count it here if it is reopened.

Line 84. Total Number.--Show the number of claims in which the reopening of a claim, reconsideration, or hearing determination was completed, whether or not the determination was revised.

Line 85. Unfavorable to Claimant.--Of the claims shown in line 84, show the number which resulted in a revision of a previously favorable decision.

Line 86. No Change.--Of the claims shown in line 84, show the number of claims that you reopened, but on which you did not change the initial determination.

Line 87. Favorable to Claimant.--Of the claims shown in line 84, show the number which resulted in a favorable revision of a previously unfavorable decision.

Line 88. Amount Awarded.--For cases included in line 87, show the amount of the submitted charges for services which involved a revision of a previously unfavorable decision. Show charges prior to application of the deductible and coinsurance. Round results to the nearest dollar.

PART B REOPENINGS FALL INTO THE FOLLOWING CATEGORIES:

Column (1) Total.--All reopenings completed.

Column (2) Pre-Review.--All reopenings of initial claim determinations. If a claim has been through a review, or any type of hearing, do not count it here.

Column (3) *Post-Review.--All reopenings of review determinations. If a claim has been through any type of hearing, do not count it here.*

Column (4) *Post-Hearing.--All reopenings of hearing determinations, regardless of the type of hearing; e.g., intermediary HO or ALJ. Once a claim has been through a hearing, count it here if it is reopened.*

Line 89. Total Number.--Show the number of claims in which the reopening of a claim, review or hearing determination was completed, whether or not the determination was revised.

Line 90. Unfavorable to Claimant.--Of the claims shown in lines 89, show the number which resulted in an unfavorable revision of a previously favorable decision.

Line 91. No Change.--Of the claims shown in line 89, show the number of claims that you reopened, but on which you did not change the initial determination.

Line 92. Favorable to Claimant.--Of the claims shown in line 89, show the number which resulted in a favorable revision of a previously unfavorable decision.

Line 93. Amount Awarded.--For cases included in line 92, show the amount of the submitted charges for services that involved a revision of a previously unfavorable decision. Show charges prior to application of the deductible and coinsurance. Round results to the nearest dollar.

110 - Checking Reports

(Rev. 45, 05-28-04)

Before you send the report toCMS, check for completeness and arithmetical accuracy. Use the following checklist for an arithmetical check for each column:

- *Column 1 = Column 2 + Column 3 + Column 4 for lines 1-7, 9-12, 14-24, 52-59, and 61-93.*
- *Line 1 for columns 1-4 must be equal to line 19 of the previous month.*
- *Line 1 Column 5 must be equal to line 30 of the previous month.*
- *Line 1 Column 6 must be equal to ine 40 of the previous month.*
- *Line 1 + line 2 = line 3.*
- *Line 3 + line 4 - line 5 - line 6 = line 19 for columns 1-4.*
- *Line 3 + line 4 - line 5 - line 6 for column 5 = line 30.*
- *Line 3 + line 4 - line 5 - line 6 for column 6 = line 40.*
- *Line 4A must be less than or equal to line 4.*
- *Line 6 = line 9 + line 10 + line 11.*
- *Line 6 = line 14 + line 15 + line 16 + line 17 + line 18 for column 1-4.*
- *Line 6, column 5 = line 26 + line 27 + line 28 + line 29.*
- *Line 6, column 6 = line 36 + line 37 + line 38 + line 39.*

- *Line 7 must be greater than or equal to line 6.*
- *Line 9 + line 11 for column 6 must be less than or equal to the sum of columns 1, 2, and 3 for line 47.*
- *Line 19 = line 20 + line 21 + line 22 + line 23 + line 24.*
- *Line 30 = line 31 + line 32 + line 33 + line 34.*
- *Line 40 = line 41 + line 42 + line 43 + line 44.*
- *Line 47 = line 45 + line 46 for columns 1-3.*
- *Line 47 = line 49 + line 50 + line 51 for columns 2 and 3 only.*
- *Line 48 must be less than or equal to line 47 for columns 1, 2, and 3.*
- *Line 49 (column 4) must be less than or equal to line 49 (column 2) + line 49 (column 3).*
- *Line 50 (column 4) must be less than or equal to the sum of line 50 (column 2) + line 50 (column 3).*
- *Line 51 (column 4) must be less than or equal to the sum of line 51 (column 2) + line 51 (column 3).*
- *Line 52 must be equal to line 67 of the previous month.*
- *Line 54 = line 52 + line 53.*
- *Line 54 + line 55 - line 61 = line 67.*
- *Line 57 must be greater than or equal to line 56.*
- *Line 58 must be less than or equal to line 56.*
- *Line 59 must be less than or equal to line 56.*
- *Line 59 must be greater than or equal to line 58.*
- *Line 61 = line 63 + line 64 + line 65.*
- *Line 62 must be greater than or equal to 500 times the sum of lines 63 and 65 in Column (5) only (each case must involve at least $500 per case).*
- *Line 66 must be greater than or equal to line 65 (must award at least $1 per case).*
- *Line 68 = line 69 + line 70 + line 71.*
- *Line 72 = line 73 + line 74 + line 75 + line 76.*
- *Line 78 = must be greater than or equal to line 77 (at least $1 per claim).*
- *Line 79 = line 80 + line 81 + line 82.*
- *Line 83, must be greater than or equal to line 82 (at least $1 per claim).*
- *Line 84 = line 85 + line 86 + line 87.*
- *Line 88 must be greater than or equal to line 87 (at least $1 per claim).*
- *Line 89 = line 90 + line 91 + line 92.*

o Line 93 must be greater than or equal to line 92 (at least $1 per claim).

Public reporting burden for this collection of information is estimated to average 2 hours per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden to Office of Financial Management, CMS, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project Washington, DC 20503.

110.1 - Exhibit 1

(Rev. 45, 05-28-04)

Medicare Program - Intermediary Part A and Part B Appeals Report - Form CMS-2591, Screen 1.

INTERMEDIARY APPEALS REPORT

INTERMEDIARY ID	***REPORTING PERIOD***					
	PART A RECONSIDERATIONS				***PART B***	
A. INTERMEDIARY APPEAL REQUESTS	***TOTAL (1)***	***SNF (2)***	***HHA/ HOSPICE (3)***	***OTHER (4)***	***REVIEWS (5)***	***HEARINGS (6)***
1. OPENING PENDING						
2. ADJUSTMENTS TO PENDING						
3. ADJUSTED PENDING						
4. REQUESTS RECEIVED						
4A. MED. NEC. DOC. DENIALS						
5. REQUESTS TRANSFERRED						
6. REQUESTS CLEARED						
7. NO. OF CLAIMS INVOLVED						
8. AMOUNT IN CONTROVERSY						
9. AFFIRMATIONS						
10. DISMISSAL/WITHDRAWALS						
11. REVERSALS (FULL OR PART)						
12. AMOUNT AWARDED						

Form CMS-2591 Screen 1

110.2 - Exhibit 2

(Rev. 45, 05-28-04)

Medicare Program - Intermediary Part A and Part B Appeals Report - Form CMS-2591, Screen 2.

INTERMEDIARY APPEALS REPORT

INTERMEDIARY ID	***REPORTING PERIOD***
	PART A RECONSIDERATIONS

A. INTERMEDIARY APPEAL REQUESTS	TOTAL	SNF	HHA/HOSPICE	OTHER
	(1)	(2)	(3)	(4)
PROCESSING TIMES				
13. AVERAGE				
14. NO. COMPLETED 1-45 DAYS				
15. NO. COMPLETED 46-60 DAYS				
16. NO. COMPLETED 61-90 DAYS				
17. NO. COMPLETED 91-120 DAYS				
18. NO. COMPLETED OVER 120 DAYS				
PENDING TIMES				
19. CLOSING PENDING				
20. NO. PENDING 1-45 DAYS				
21. NO. PENDING 46-60 DAYS				
22. NO. PENDING 61-90 DAYS				
23. NO. PENDING 91-120 DAYS				
24. NO. PENDING OVER 120 DAYS				

Form CMS-2591 Screen 2

110.3 - Exhibit 3

(Rev. 45, 05-28-04)

Medicare Program - Intermediary Part A and Part B Appeals Report - Form CMS-2591, Screen 3

INTERMEDIARY APPEALS REPORT

INTERMEDIARY ID	REPORTING PERIOD			
A. INTERMEDIARY APPEAL REQUESTS REVIEWS	PART B APPEALS			
	Reviews			Hearings
	(1)	HEARINGS		(2)
PROCESSING TIMES		PROCESSING TIMES		
25. AVERAGE		35. AVERAGE		
26. NO. 1-30 DAYS		36. NO. 1-60 DAYS		
27. NO. 31-45 DAYS		37. NO. 61-90 DAYS		
28. NO. 46-60 DAYS		38. NO. 91-120 DAYS		
29. NO. OVER 60 DAYS		39. NO. OVER 120 DAYS		
PENDING TIMES		PENDING TIMES		
30. CLOSING PENDING		40. AVERAGE		
31. NO. 1-30 DAYS		41. NO. 1-60 DAYS		
32. NO. 31-45 DAYS		42. NO. 61-90 DAYS		
33. NO. 46-60 DAYS		43. NO. 91-120 DAYS		
34. NO. OVER 60 DAYS		44. NO. OVER 120 DAYS		
B. PART B HEARING RESULTS	OTR With No Subsequent (1)	All Telephone Hearings (2)	All In-Person Hearings (3)	Number In 120 Days (4)
45. REVERSALS				

46. AFFIRMATIONS				
47. TOTAL DECISIONS				
48. NBR IN 120 DAYS				
49. NO PREV. OTR HELD				
50. PREV. OTR COUNTED				
51. PREV. OTR NOT CNTD				

Form CMS-2591 Screen 3

110.4 - Exhibit 4

(Rev. 45, 05-28-04)

Medicare Program - Intermediary Part A and Part B Appeals Report - Form CMS-2591, Screen 4

INTERMEDIARY APPEALS REPORT

INTERMEDIARY ID	***REPORT PERIOD***				
C. PART A AND B ALJ HEARINGS	***PART A***				
	Total (1)	***SNF (2)***	***HHA/Hospice (3)***	***Other (4)***	***Part B (5)***
52. OPENING PENDING					
53. ADJUSTMENTS TO PENDING					
54. ADJUSTED OPENING PENDING					
55. REQUESTS RECEIVED					
56. REQUESTS FRWD. TO ALJ					
57. NO. OF CLAIMS INVOLVED					
58. NO. IN 7 CALENDAR DAYS					
59. NO. IN 14 CALENDR DAYS					
60. AVG. TIME TO FORWARD					
61. COMPLETED					
62. AMT. IN CONTROVERSY					
63. AFFIRMATIONS					
64. DISMISSALS/WITHDRAWALS					
65. REVERSALS (FULL/PART)					
66. AMOUNT AWARDED					
67. CLOSING PENDING					

Form CMS-2591 Screen 4

110.5 - Exhibit 5

(Rev. 45, 05-28-04)

Medicare Program - Intermediary Part A and Part B Appeals Report - Form CMS-2591, Screen 5

INTERMEDIARY APPEALS REPORT

INTERMEDIARY ID	***REPORT PERIOD***				
	PART A				
C. PART A AND B ALJ HEARINGS	***Total (1)***	***SNF (2)***	***HHA/Hospice (3)***	***Other (4)***	***PART B (5)***
DISPOSITIONS					
68. NUMBER OF DISPOSITIONS					
69. AFFIRMATIONS					
70. DISMISSALS/WITHDRAWALS					
71. REVERSALS (FULL OR PART)					
EFFECTUATIONS					
72. TOTAL EFFECTUATIONS					
73. NO. 1-7 DAYS					
74. NO. 8-15 DAYS					
75. NO. 16-30 DAYS					
76. NO. OVER 30 DAYS					
LIMITATION OF LIABILITY					
77. WAIVED - BEN & PROV.					
78. AMOUNT AWARDED					

D. LIMITATION OF LIABILITY (CLAIM COUNTS)	***PART A RECONSIDERATIONS***				***PART B***	
	Total (1)	***SNF (2)***	***HHA/ Hospice (3)***	***Other (4)***	***Reviews (5)***	***Hearings (6)***
79. TOTAL NUMBER CONSIDERED						
80. CONSIDERED - NOT WAIVED						
81. WAIVED - BEN. ONLY						
82. WAIVED - BEN. & PROV.						
83. AMOUNT AWARDED						

Form CMS-2591 Screen 5

110.6 - Exhibit 6

(Rev. 45, 05-28-04)

Medicare Program - Intermediary Part A and Part B Appeals Report - Form CMS-2591, Screen 6

INTERMEDIARY APPEALS REPORT

INTERMEDIARY ID	***REPORT PERIOD***			
E. REOPENINGS (Claims Count) PART A	***TOTAL (1)***	***PRE-Recon (2)***	***Post-Recon (3)***	***Post-ALJ Hearing (4)***
84. TOTAL				
85. UNFAVORABLE TO CLAIMANT				
86. NO CHANGE				

87. FAVORABLE TO CLAIMANT				
88. AMOUNT AWARDED				
PART B	***TOTAL***	***Pre-Review***	***Post-Review***	***Post-Hearing***
89. TOTAL				
90. UNFAVORABLE TO CLAIMANT				
91. NO CHANGE				
92. FAVORABLE TO CLAIMANT				
93. AMOUNT AWARDED				

Form CMS-2591 Screen 6