Program Memorandum Intermediaries/Carriers

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

Transmittal AB-03-052 **Date: MAY 2, 2003**

CHANGE REQUEST 2330

SUBJECT: Managing Medicare Appeals Workloads in FY 2003

This Program Memorandum (PM) provides updates to transmittal AB-02-034, Change Request 1392, issued on March 20, 2002. The purpose of this PM is to provide guidance to contractors in managing potential appeals workload backlogs in fiscal year (FY) 2003. This PM applies to all Medicare appeals workloads, including reconsiderations, reviews, hearing officer hearings, Administrative Law Judge (ALJ) hearings, and agency referrals. This PM supercedes PM AB-02-034, Change Request 1392 and the Medicare Carriers Manual §12045.

Standard Operating Procedures

The priorities set forth in this PM are to be used by contractors as a guide in establishing standard operating procedures for managing an appeals workload when the budget amount is insufficient to adequately perform the required functions. In general, contractors should use a first-in, first-out method to process appeals and manage workload; however, during times of limited resources it may become necessary to prioritize the processing of appeals to more efficiently manage the workload. While CMS continues to recommend the priorities listed in this PM, there may be instances where contractors find it more effective and efficient to prioritize in a different manner. Also, contractors may choose to establish standard operating procedures for managing an appeals workload that deviate from the priorities listed in this PM. In both these cases, contractors should submit a copy of their prioritization plan to the regional office (RO) and obtain written approval from their RO for this variation within 30 days of the implementation date of this PM.

Execution of Workload Prioritization

Whenever it appears that the budget amount is insufficient to adequately perform the required functions and the need for additional funds can be adequately documented, contractors shall submit a Supplemental Budget Request (SBR) in accordance with Chapter 2 of the Medicare Financial Management Manual, §120. As a result of an SBR, or during the course of CMS' evaluation of a contractor's SBR, CMS may find it necessary that the contractor execute prioritization of workload in accordance with this PM or in accordance with the contractor's standard operating procedures. The contractor should discuss possible alternatives for resolution in the SBR. If it becomes necessary to abate activities, contractors must submit proper notification in accordance with the terms of the Cost of Administration Article in the Contract/Agreement and begin processing work in accordance with this PM until a final agreement is reached between the contractor and CMS. As a result of an abatement, CMS may find it necessary that the contractor continue processing work in accordance with this PM.

Priority 1-- Finalize effectuation of all ALJ decisions and Departmental Appeals Board (DAB) decisions and respond to requests from the DAB for case files in the timeframes prescribed below.

Priority 2-- Adjudicate all requests for telephone appeals (if applicable) in the timeframes prescribed below.

Priority 3-- Adjudicate written reconsiderations, reviews, and Hearing Officer (HO) hearings from beneficiaries or their appointed beneficiary representatives in the timeframes prescribed below.

Priority 4-- Adjudicate written requests for reconsiderations, reviews, and HO hearings from providers, suppliers, or other appellants, including States or their third party agents, that are submitted with necessary documentation in the timeframes prescribed below.

Priority 5-- Adjudicate written requests for reconsiderations, reviews, and HO hearings from providers, suppliers, or other appellants, including States or their third party agents, that are submitted without necessary documentation in the timeframes prescribed below.

Priority 6-- Prepare, assemble, and forward Part A and Part B ALJ hearing case files that contain necessary documentation in the timeframes prescribed below.

Priority 7-- Prepare, assemble, and forward Part A and Part B ALJ hearing case files that do not contain necessary documentation in the timeframes prescribed below.

Priority 8-- Submit agency referrals to the DAB.

Type of Appeal	**Completion Standard**
Written and Telephone Reviews (completed by intermediaries and carriers)	**95 percent of requests for review must be completed within 45 days of receipt of the request in the corporate mailroom.** (SSA §1842(b)(2)(B)(i)). Consider a review complete/cleared: · For **affirmations**, upon the completion of the process that generates the decision letter for mailing to the parties. · For **partial reversals**, when all of the following actions have been completed: (1) the process that generates the decision letter for mailing to the parties is completed, and (2) the actions to initiate the adjustment action in the claims processing system are taken. When the adjustment action is completed, this action must be included on the next scheduled release of the MSN/RA. Appropriate follow-up action should be taken to ensure that the adjustment action results in the issuance of proper payment. · For **full reversals**, when the actions to initiate the adjustment action in the claims processing system are taken. When the adjustment action is completed, this action must be included on the next scheduled release of the MSN/RA. Appropriate follow-up action should be taken to ensure that the adjustment action results in the issuance of proper payment. · For **withdrawals and dismissals**, upon the completion of the process that generates the dismissal notice for mailing to the parties.
HO Hearings (completed by intermediaries and carriers)	**90 percent of all HO hearing decisions must be issued within 120 days of receipt of the request for HO hearing in the corporate mailroom**. (SSA §1842(b)(2)(B)(ii)) For **telephone or in-person hearings**, the HO must issue a decision no later than 30 days after the date the hearing was held. Consider a hearing complete/cleared: · For **on-the-record, telephone, or in-person hearings**, when the decision is signed. · For a **preliminary on-the-record hearings**, after the 14 calendar days for requesting the in-person or telephone hearing have passed. · For **dismissals and withdrawals**, upon the completion of the process that generates the dismissal notices for mailing to the parties.

	Effectuation: Initiate effectuation of HO hearing decisions within 30 calendar days of the date of the decision. "Initiate effectuation" means that the actions to initiate the adjustment action in the claims processing system are taken. When the adjustment action is completed, this action must be included on the next scheduled release of the MSN/RA. Appropriate follow-up action should be taken to ensure that the adjustment action results in the issuance of proper payment.
Reconsiderations (completed by intermediaries)	**75 percent of reconsiderations must be processed within 60 days of receipt in the corporate mailroom and 90 percent of reconsiderations must be processed within 90 days of receipt in the corporate mailroom.** (SSA §1816(f)(2)(A)(i)). Consider a reconsideration complete/cleared when: · For **affirmations**, upon the completion of the process that generates the decision letter for mailing to the parties to the parties. · For **partial reversals**, when all of the following actions have been completed: (1) the process that generates the decision letter for mailing to the parties is completed, and (2) when either: (a) the actions to initiate the adjustment action in the claims processing system are taken, or (b) written assurance is requested, if applicable (see MIM §3784.7). When written assurance is necessary, initiate the adjustment action in the claims processing system within 30 days of receipt of written assurance. When the adjustment action is completed, this action must be included on the next scheduled release of the MSN/RA. Appropriate follow-up action should be taken to ensure that the adjustment action results in the issuance of proper payment. · For **full reversals**, when either (1) the actions to initiate the adjustment action in the claims processing system are taken, or (2) written assurance is requested, if applicable (see MIM §3784.7). When written assurance is necessary, initiate the adjustment action in the claims processing system within 30 days of receipt of written assurance. When the adjustment action is completed, this action must be included on the next scheduled release of the MSN/RA. Appropriate follow-up action should be taken to ensure that the adjustment action results in the issuance of proper payment. · For **withdrawals and dismissals**, upon the completion of the process that generates the dismissal notice for mailing to the parties.
Part A and Part B ALJ Hearings	**Sending Requests to OHA:** · Forward all requests for an ALJ hearing to OHA within 21 calendar days of receipt of the request in the corporate mailroom. For aggregated cases which exceed 40 beneficiaries or claims, forward the case file within 45 days. **Effectuation:** · A **favorable ALJ decision that gives a specific amount to be paid** (with no agency referral to the DAB) is to be effectuated within 30 days of receiving the official ALJ decision (NOTE: You may receive an official decision from either the ALJ or from the ALJ clearinghouse. You must effectuate from whomever you receive first; however, if you are unable to effectuate because you need

	information from the case file to calculate the amount payable, you should effectuate when you receive the case file). · **A favorable ALJ decision where the amount payable must be computed** (with no agency referral to the DAB), is to be effectuated within 30 days from the date the amount to be paid was computed. The amount must be computed as soon as possible, but no later than 30 calendar days from after the date of receipt of the official ALJ decision (NOTE: You may receive an official decision from either the ALJ or from the ALJ clearinghouse. You must effectuate from whomever you receive first; however, if you are unable to effectuate because you need information from the case file to calculate the amount payable, you should effectuate when you receive the case file). · **Unfavorable ALJ decisions** (with no agency referral to the DAB) are to be effectuated within 30 days of the receipt of the case file from the ALJ clearinghouse. · For **Part A cases where written assurance is needed**, effectuate within 30 days of receiving written assurance, if necessary (see MIM 3786(E)). · If **clarification from the ALJ** is necessary, you should consider the clarification the final determination for purposes of effectuation. If clarification is needed from the provider/supplier (e.g., splitting charges) request clarification as soon as possible and compute the amount payable within 30 calendar days after the receipt of the necessary clarification. Consider the date of receipt of the clarifications the final determination for purposes of effectuation.
Agency Referrals (formerly protests)	All ALJ decisions determined to be appropriate for agency referral must be forwarded with the recommended draft agency referral memorandum and case file to the lead CMS RO for your region within 30 days from the date of the ALJ decision/dismissal. The lead RO may grant an extension to you beyond the 30-day time frame on a case by case basis. NOTE: Problems concerning time limitations, or non-receipt of case files should be brought to the attention of your RO in a memorandum separate from any agency referral.
DAB Decisions	Initiate effectuation within 30 days of your receipt of the DAB decision and complete effectuation within 60 days. For Part A cases, effectuate within 30 days of receiving written assurance, if necessary (see MIM §3786(E)).
Responding to Requests for Case Files	Forward the requested case file within 21 days to the DAB. If you are unable to locate a case file that falls under your jurisdiction, you must recreate the case file and send the file within 60 days. If you determine that the case file does not fall under your jurisdiction, you must notify the DAB in writing within 14 calendar days, with a copy to your RO.

For the purposes of this PM, backlogging an appeal occurs when a contractor is unable to process and/or adjudicate an appeal in the timeframes specified in the chart above. In the event that a contractor is unable to process an appeal within the timeframe established, CMS expects the contractor to control and, if applicable, acknowledge each appeal request.

Provider/Supplier Education

Providers and suppliers should be notified that failure to submit appropriate documentation, if any, that supports the contention that the initial determination was incorrect under Medicare coverage and payment policies may delay appeals development and determinations. You must inform your providers and suppliers of these instructions through posting on your website within two weeks of the receipt date of this PM and by publishing a summary of this instruction in your next regularly scheduled newsletter.

Contractors are instructed to use the following model language, or something similar, when communicating with providers and suppliers.

Model language to be used in communication with providers and suppliers:

> In an effort to manage incoming appeal requests in FY 2003 with the given resources, the Centers for Medicare & Medicaid Services (CMS) has provided guidance relative to processing appeals. Incoming appeal requests submitted **without** necessary supporting documentation will be given secondary priority to appeal requests submitted **with** appropriate documentation. Consequently, determinations or decisions on appeal requests that are submitted without appropriate documentation to support the contention that the initial determination was incorrect could possibly be delayed.

The *effective* date for this PM is April 1, 2003.

The *implementation* date for this PM is May 15, 2003.

These instructions should be implemented within your current operating budget.

This PM may be discarded May 2, 2004.

If you have any questions, contact Jennifer Eichhorn at (410) 786-9531, or by e-mail at JEichhorn@cms.hhs.gov.

Providers/suppliers are to contact their appropriate intermediary or carrier.