

---

# Program Memorandum Intermediaries/Carriers

---

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

Transmittal AB-03-139

Date: SEPTEMBER 12, 2003

---

CHANGE REQUEST 2854

**SUBJECT: Appeals Quality Improvement and Data Analysis Activities**

## **I. Introduction**

These instructions supersede Transmittal AB-02-122, CR 2170, Transmittal AB-03-67, CR 2740 and the Medicare Carriers Manual (MCM) §12040. All costs associated with conducting the Quality Improvement and Data Analysis activities described in sections II and III of this Program Memorandum (PM) are to be reported under CAFMII code 12090 in accordance with the FY 2004 Budget Performance Requirements..

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.

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.

## **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, whenever possible, you should use the entire universe of appeals to conduct the analysis. However, if you are unable to use the entire universe, you must, at a minimum, gather data from a 10 percent or 100 per month (whichever is less) randomly selected example of reviews and reconsiderations. For Hearing Officer (HO) hearings, you must, at a minimum, gather data from a 10 percent or 50 per month (whichever is less) randomly selected sample, and for Administrative Law Judge (ALJ) cases, at a minimum, a 10 percent or 10 per month (whichever is less) randomly selected sample. Data analysis should be performed, at minimum, on a monthly basis. Data analysis must be performed for each contractor site. Data should be collected from each level of appeal as follows:

1. **Reconsideration Determinations-** Your Data Analysis on reconsiderations shall focus on identifying:
  - The reasons for full or partial reversals, such as:
    - Submission of documentation that should have been submitted with the initial claim
    - Submission of documentation that was previously requested by Medical Review (MR) through an Additional Documentation Request (ADR)

- Claims that were denied due to medical review edits and the outcomes of these claims on appeal
  - 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
  - Types of services and/or issues that are overturned most frequently
  - The percentage of reconsiderations that result in full reversals, partial reversals, and complete affirmations (e.g., no change was made)
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,
    - Initial claims processing errors made by the physician/supplier/provider, such as incorrect diagnosis codes
    - Submission of documentation that should have been submitted with the initial claim
    - Submission of documentation that was previously requested by MR through an ADR
  - Claims that were denied due to medical review edits and the outcomes of these claims on appeal
  - 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
  - Types of services and/or issues that are overturned most frequently
  - The percentage of reviews that result in full reversals, partial reversals, and complete affirmations (e.g., no change was made)
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 and the outcomes of these claims on appeal
  - 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
  - Types of services and/or issues that are overturned most frequently
  - The percentage of hearings that result in full reversals, partial reversals, and complete affirmations (e.g., no change was made)
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. Quality Improvement Activities**

Your Quality Improvement program must involve four 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 identifying problems and referring issues to the appropriate must be charged to CAFM code 12090. If the corrective action is completed in the appeal unit without assistance of another unit, the cost is assigned to CAFM code 12090. However, if the problem is referred to another area for corrective action, the cost and workload associated with that action must be assigned to the appropriate code. For example, if a provider education issue is identified and referred to the provider communications unit and the staff in the provider communications unit generates a bulletin, the cost would not be an appeals cost.

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/correctness, responsiveness, and tone/clarity, (see MCM Part 2 §§5104(A)(2) & 5105(A)(2), MCM Part 3 §12010, and Medicare Intermediary Manual (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 percent or 25 case sample (whichever is less) of decision letters at each level of appeal. The sample of cases used for quality control checks can be chosen using a random method or by any other method at your discretion. 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:

#### Accuracy & Responsiveness

- 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

#### Tone/Clarity

- Issue was clearly stated
- Jargon or inappropriate abbreviations were not used
- Tone is professional and customer friendly

#### Accuracy & Correctness

- Spelling
- Grammar
- Punctuation
- Capitalization

- Medical Terminology

3. **Internal Feedback System**-The on-going Internal Feedback System has four components:

(A) The first component 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/provider education). 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 MR strategy and to evaluate the effectiveness of MR edits. You should also participate in periodic meetings held by your provider/supplier communication unit to provide input on areas that need provider/supplier education (For more information, see MCM, Part 2, §5107(A)(1) or MIM, Part 2, §2965(A)(10)). In addition to providing feedback to other units, you should make the results of your Data Analysis available to all appeals adjudicators.

(B) The second component 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.

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

(D) 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' 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' policy, the policy needs to be reexamined and brought to the attention of your RO.

4. **RO Examination of Review, Reconsideration, and Hearing Officer Hearing Decision Letters**- The fourth function of the Quality Improvement program involves **RO examination of decision letters**. At some point during the Fiscal Year (FY), the RO may contact you to make arrangements for a review of a sample of review, reconsideration, and/or hearing officer hearing decision letters. The sample will consist of at least ten (10) of each type of decision letter and will take place at the RO. The date of the review and quantity of the sample size are at the discretion of the RO. The RO may, at its discretion, arrange to review your decision letters at multiple times during the FY. The review is limited to the decision letter only.

The RO will evaluate all decision letters to determine:

- Overall clarity, responsiveness, and accuracy
- Completeness of the summary of facts and issues
- Adequacy of the rationale/explanation of the decision
- Accuracy of reference to applicable laws regulations

#### **IV. Submitting your Summary Report to CMS**

The Summary Report is a brief synopsis of the outcomes of your Quality Improvement and Data Analysis Program. Below is a list of items that should be included in your Summary Report. 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 (e.g., 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 affirmation 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.)

### **Costs** (Only required on the last report of the FY)

- All costs associated with your workload data analysis program, including associated number of FTEs
- All cost associated with your quality improvement activities, including associate number of FTEs
- A breakout of costs associated with this PM versus cost of all other appeals Quality Improvement activities you performed prior to these instructions (e.g., MCM §12040)

You must submit your Summary Report to your RO according to one of the following schedules:

<b>Months to Include in Report</b>	<b>Due Date</b>
October November December January	March 15 <sup>th</sup>
February March April May	July 15 <sup>th</sup>
June July August September	November 15 <sup>th</sup>

<b>Months to Include in Report</b>	<b>Due Date</b>
October November December	February 15 <sup>th</sup>
January February March	May 15 <sup>th</sup>
April May June	August 15 <sup>th</sup>
July August September	November 15 <sup>th</sup>

Accordingly, the first report after the implementation date of this PM will be for the period starting on October 1, 2003 and ending on January 31, 2004 and is due on March 15, 2004 **or** will be for the period starting on October 1, 2003 and ending on December 31, 2003 and is due on February 15, 2004. Contractors must select a reporting cycle (3 or 4 times a year) and remain with that cycle for the entire FY. You may indicate which reporting cycle you intent to follow by sending a brief e-mail to your RO appeals Business Function Expert and to [AppealsOperations@cms.hhs.gov](mailto:AppealsOperations@cms.hhs.gov) by November 1, 2003.

**These instructions should be implemented within your current operating budget.**

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

**The *implementation date* for this PM is October 1, 2003.**

**This PM may be discarded after October 1, 2004.**

**If you have any questions, contact Jennifer Eichhorn at [JEichhorn@cms.hhs.gov](mailto:JEichhorn@cms.hhs.gov), Karyn Claggett at [KClaggett@cms.hhs.gov](mailto:KClaggett@cms.hhs.gov), or your local regional office.**