CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-06 Medicare Financial Management	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 130	**Date: AUGUST 31, 2007**
	Change Request 5555

SUBJECT: "Revisions" of the CROWD Report.

I. SUMMARY OF CHANGES: The CMS-2592 Appeals Report has been modified in response to questions and issues raised since the release of the original report.

NEW / REVISED MATERIAL
EFFECTIVE DATE: *January 1, 2008
IMPLEMENTATION DATE: January 7, 2008

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

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	Chapter / Section / Subsection / Title
R	6/Table of Contents
R	6/460/Monthly Statistical Report on Intermediary and Carrier Part A and Part B Appeals Activity Form (CMS-2592)
R	6/460.1/General
R	6/460.2/Section I - Redeterminations
R	6/460.3/Section II - Qualified Independent Contractor (QIC) Reconsiderations
R	6/460.4/Section III - Administrative Law Judge (ALJ) Results
R	6/460.5/Section IV - Medicare Appeals Council Effectuations
R	6/460.6/Clerical Error Reopenings
R	6/460.7/Validation of Reports

III. FUNDING:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2008 operating budgets.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-06	Transmittal: 130	Date: August 31, 2007	Change Request: 5555

SUBJECT: "Revisions" of the CROWD Report.

EFFECTIVE DATE: January 1, 2008

IMPLEMENTATION DATE: January 7, 2008

I. GENERAL INFORMATION

A. Background: This updates CR 5056. This CR contains revisions to the CMS-2592 Report in response to questions and comments received after the release of CR 5056.

B. Policy:

The BIPA and the MMA provisions have resulted in numerous changes to various levels of the Medicare fee for service appeals process. The CMS-2592 report was developed to capture workload data resulting from the implementation of the provisions. Numerous questions and issues were raised following implementation of the CMS-2592 Report. This CR incorporates minor revisions and corrections to the CMS-2592 Report in an effort to address the issues raised.

Contractors should continue to use the CMS-2591 and CMS- 2590 reports to capture data on appeal workloads received prior to the implementation date of the CMS- 2592 report. The CMS-2591 and 2590 reports will be used to record appeals related data received prior to the implementation of the CMS-2592 report until all pending appeals workloads have been completed.

The CMS-2591 and 2590 reports will continue to be used to capture reopenings data that is not clerical in nature, and as such, is not captured on the CMS-2592 report.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5555.1	The contractor shall enter data on requests for redetermination in the appropriate lines and columns in the new report being developed to track changes to the appeals process resulting from the implementation of the BIPA and the MMA.	x	x	x	x	x	x		x	x		
5555.2	The contractor shall enter data on requests for and effectuation of reconsideration decisions performed	x	X	x	x	x	x		x	x		

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	by the QIC in the appropriate lines and columns in the new report.											
5555.3	The contractor shall enter data on requests for and effectuation of Administrative Law Judge (ALJ) hearings in the appropriate lines and columns in the new report.	x	x	x	x	x	x		x	x		
5555.4	The contractor shall enter data on effectuation of Medicare Appeals Council reviews in the appropriate lines and columns in the new report.	x	x	x	x	x	x		x	x		
5555.5	The contractor shall enter data on clerical error reopenings in the appropriate lines and columns in the new report.	x	x	x	x	x	x		x	x		
5555.6	The contractor shall continue to enter data on the CMS-2591 and 2590 reports for all pending appeals data received prior to the implementation of the new CMS-2592 report.	x	x	x	x	x	x		x	x		
5555.7	The contractor shall continue to enter data for all non clerical error reopenings on the CMS- 2591 and 2590 reports.	x	x	x	x	x	x		x	x		
5555.8	Shared systems maintainers shall incorporate changes needed to run the CMS-2592 Report.								x	x		

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	None.											

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
5555.1, 5555.2, 5555.3, 5555.4, 5555.5, 5555.6, 5555.7, 5555.8	Information and decisions from individual cases and claims at the various levels of appeal are needed for contractors to input data into the CMS-2592 Report.
5555.1, 5555.2, 5555.3, 5555.4, 5555.5, 5555.6, 5555.7, 5555.8	Workload data from various lines and columns in the report will interface with the Contractor Administrative Budget and Financial Management system.
5555.1, 5555.2, 5555.3, 5555.4, 5555.5, 5555.6, 5555.7, 5555.8	Upon implementation of this CR, contractors will be required to use this form to report information on appeals workload data for the redetermination, QIC reconsideration, ALJ and Medicare Appeals Council referrals. The release will not impact Providers.
5555.1, 5555.2, 5555.3, 5555.4, 5555.5, 5555.6, 5555.7, 5555.8	This will revise and replace CR 5056.
5555.1, 5555.2, 5555.3, 5555.4, 5555.5, 5555.6, 5555.7, 5555.8	CMS will have to update the new version of the 2592 report in CROWD before it can be used by contractors.

B. For all other recommendations and supporting information, use this space:

V. CONTACTS

Pre-Implementation Contact(s):
Anita Denion (410) 786-7022
Kristie McCarthy (410) 786-7139

Post-Implementation Contact(s):
Anita Denion (410) 786-7022
Lisa Childress (410) 786-6956
Kristie McCarthy (410) 786-7139

VI. FUNDING

A. ***For Fiscal Intermediaries, Carriers, and the Durable Medical Equipment Regional Carrier (DMERC)*****:**
No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2008 operating budgets.

B. ***For Medicare Administrative Contractors (MAC)*****:**

The contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the Statement of Work (SOW). The contractor is not obligated to incur costs in excess of the amounts alloted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Medicare Financial Management Manual
Chapter 6 - Intermediary and Carrier Financial Reports

Table of Contents
(Rev.130, 08-31-07)

460 - Monthly Statistical Report on Intermediary and Carrier Part A and Part B Appeals Activity Form (CMS-2592)

(Rev. 130, Issued: 08-31-07, Effective: 01-01-08, Implementation: 01-07-08)

	Column 1	Column 2	Column 3
	Part A Services	**Part B Services**	**Part B Services**
	Processed by Intermediary	**Processed by Intermediary**	**Processed by Carrier**
Section I: Redeterminations			
1: Opening Pending			
2: Adjustments to Pending			
3: Adjusted Pending			
4: Requests Received			
5: Misrouted Requests Forwarded to Another Contractor			
6: Requests Cleared			
6.1 Number of Claims Cleared			
a. SNF			
b. Home Health			
c Inpatient Hospital			
d. Outpatient			
e. Lab			
f. Ambulance			
g. DME			
h. Physician			
i. Other			
7: Cleared -- Evidence Submitted after Request			
7.1: Number of Claims Involved			
a. SNF (Not Applicable)			
b. Home Health (Not Applicable)			
c. Inpatient Hospital (Not Applicable)			
d. Outpatient(Not Applicable)			
e. Lab (Not Applicable)			

f. Ambulance (Not Applicable)			
g. DME (Not Applicable)			
h. Physician (Not Applicable)			
i. Other (Not Applicable)			
8: Affirmations			
8a. Waiver of Liability Amount Paid (Not Applicable)			
8.1: Number of Claims Affirmed			
a. SNF			
b. Home Health			
c. Inpatient Hospital			
d. Outpatient			
e. Lab			
f. Ambulance			
g. DME			
h. Physician			
i. Other			
9: Partial Reversals			
9.1: Number of Claims Partially Reversed			
a. SNF			
b. Home Health			
c. Inpatient Hospital			
d. Outpatient			
e. Lab			
f. Ambulance			
g. DME			
h. Physician			
i. Other			
10: Full Reversals			
10.1 Number of Claims Fully Reversed			
a. SNF			
b. Home Health			
c. Inpatient Hospital			
d. Outpatient			
e. Lab			
f. Ambulance			
g. DME			
h. Physician			
i. Other			
11: Dismissals/Withdrawals			
11.1 Number of Claims Dismissed or Withdrawn			
a. SNF			
b. Home Health			
c Inpatient Hospital			
d. Outpatient			
e. Lab			
f. Ambulance			
g. DME			
h. Physician			
i. Other			
12: Number of Incomplete Redeterminations Requests Dismissed			
13:Medicare Approved Amount (Not Applicable)			

14: Redeterminations Processing Time –Average			
15: Redeterminations Completed in 1-60 days			
16: Redeterminations Completed in Over 60 days			
17: Redeterminations Processing Time- Average (Documentation Submitted Later)			
18: Redeterminations Completed in 1-60 days (Documentation Submitted Later)			
19: Redeterminations Completed in 61-74 days (Documentation Submitted Later)			
20: Redeterminations Completed in over 74 days (Documentation Submitted Later)			
21: Closing Pending Redeterminations			
22 Redeterminations Pending 1-30 days			
23: Redeterminations Pending 31-60 days			
24: Redeterminations Pending 61-74 Days			
25 Redeterminations Pending Over 74 days			
26: Total Effectuations			
26a: Number of Claims Involved			
27: Number Effectuated 1-30 Days			
28: Number Effectuated 31-60 Days			
29: Number Effectuated over 60 Days			
Section II: QIC Reconsiderations			
30: Opening Pending			
31: Adjustments to Pending			
32: Adjusted Opening Pending			
33: Requests For QIC Reconsideration Received by the Contractor			
33a.Misrouted Requests Forwarded to QIC			
33b. Misrouted Requests Forwarded Timely			
33c. Misrouted Requests Forwarded Untimely			

34. Requests from QIC for Case Files			
35: Number of Case Files Forwarded to QIC			
36: Number Forwarded in 1-5 days			
36a: Number Forwarded in 6 Days			
37: Number Forwarded in 7-8 Days			
37a: Number Forwarded in Over8 Days			
38: Average Time to Forward			
39. Pending Case File Requests			
40: Number of QIC Decisions Received from QIC			
41: Number of QIC Decisions that Need Effectuation			
41a. Number of Claims Involved			
42: Total Effectuations			
42a. Number of Claims Involved			
43. NumberEffectuated in 1-30 Days			
43a. Contractor Computed Amount			
44: Number Effectuated in 31-60 Days			
44a. Contractor Computed Amount			
45: Number Effectuated in Over 60 Days			
45a: Contractor Computed Amount			
46 Medicare Approved Amount (Not Applicable)			
46a. Waiver of Liability Amount Paid (Not Applicable)			
47: Closing Pending Reconsiderations			
Section III: ALJ Results			
48: Opening Pending			
49: Number of Appeal Requests for ALJ Hearing Misrouted to Contractor			
50: Number of ALJ Decisions Received from Administrative QIC			
51: Number of ALJ Decisions Received that Need Effectuation			
51a Number of Claims			

Involved			
52: Total Effectuations			
52a. Number of Claims Involved			
53: Number Effectuated in 1-30 Days			
54: Number Effectuated in 31-60 days			
55: Number Effectuated in Over 60 Days			
56: Medicare Approved Amount (Not Applicable)			
56a. Waiver of Liability Amount Paid(Not Applicable)			
57: Closing Pending ALJ Decisions			
Medicare Appeals Council Effectuations			
58: Medicare Appeals Council Effectuations			

Clerical Error Reopenings

1: Total Number of Clerical Error Reopenings Received			
2: Total Number of Clerical Error Reopenings Processed			
3. Total Number Processed – Own Motion			
4. Total Number Processed – Claimant Initiated			
5: Total Number of Clerical Error Reopenings Resulting from Contractor Error			
6: Total Number of Clerical Error Reopenings Resulting from Provider Error			
7. Reserved for Future Use			
8. Reserved for Future Use			
9. Medicare Approved Amount (Not Applicable)			
10.Clerical Error Reopenings Processed in 1-30 days			
11.Clerical Error Reopenings Processed in 31-60 days			
11.a Clerical Error Reopenings Processed in More than 60 days			
12: Total Number of Clerical Error Reopening Requests Pending			
13. Total Number of Higher Level Reopenings Requiring Adjustment by the Contractor			
14. Amount Awarded (Not Applicable)			

460.1 – General

(Rev. 130, Issued: 08-31-07, Effective: 01-01-08, Implementation: 01-07-08)

At the end of each month, the contractor prepares and transmits to CMS a report summarizing monthly activity on redeterminations processed by intermediaries and carriers, as well as those actions associated with reconsiderations, and Administrative Law Judge (ALJ) hearings and Part A and Part B Medicare Appeals Council effectuations that are processed by intermediaries and carriers. Contractors shall complete separate reports for each office where a separate intermediary or carrier number has been assigned.

NOTE: The report is NOT designed to be completed by the Qualified Independent Contractor (QIC) or the Administrative Qualified Independent Contractor (AdQIC). All data shall be entered by the contractor except for those lines that are indicated as "Not Applicable" (e.g., Medicare Approved Amount) The data in the "Not Applicable" lines are not required. Contractors shall continue to use the CMS-2591 and CMS-2590 reports to capture data on appeal workloads received prior to the implementation date of the CMS-2592 report. The CMS-2591 and 2590 reports will be used to record appeals related data received prior to the implementation of the CMS-2592 report until all pending appeals workloads have been completed. If a case was received prior to the implementation of the CMS-2592, and as such is captured on the CMS-2590 or CMS-2591, tracking for the case remains on the CMS-2590 or CMS-2591 until all levels of appeal for the case have been completed.

Note: The CMS-2591 and 2590 reports will continue to be used to capture reopenings data that is not clerical in nature, and as such, is not captured on the CMS-2592 report.

Form CMS-2592 is subject to the Paperwork Reduction Act and requires approval by the Office of Management and Budget (OMB). OMB approval has been requested.

Purpose and Scope.--The CMS-2592 enables CMS to tabulate data for administrative purposes on the following information.

- The number of redeterminations, reconsiderations, and ALJ hearings requested, completed, and pending;
- The number of redeterminations resulting in affirmations or reversals of previous determinations;
- Timeliness Data (including processing, forwarding and effectuation data at various levels of appeal); and,
- Clerical Error Reopenings Data

Unless specifically indicated, data on the CMS-2592 Report is captured in cases. Where noted, information is also requested in claims. Information on decisions is also requested, as applicable.

Due Date -Transmit the CMS-2592 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.

COMPLETION OF ITEMS ON FORM CMS-2592

Heading – This form is referenced as form 7 in the CROWD system. Complete the ADD/UPDATE/DELETE criteria screen with the appropriate information such as your ID Number including Business Segment Identifier (BSI), reporting month and calendar year, i.e., 12 2005 for December 2005.

General Information – Completing the Report

Refer to the information below when determining how to count and categorize data for reporting purposes.

Controlling Receipt of Cases - . In order to ensure that cases are processed timely, cases shall be date stamped or controlled in some way upon receipt. The date of receipt in all cases is the day the processing contractor received the request in its corporate mailroom. The days elapsed for an individual request are calculated using the number of days starting from the Julian date of case receipt through the Julian date of completion. Include the time required for the response to be mailed to the appellant. For example, a case that is received and processed on January 7 is considered to require1 day to clear. A case received on January 7 and cleared on January 8 is considered to require2 days to clear. Consider the day of receipt to be Day 1.

Cases that are not received in the mailroom (for example, requests from the QIC for case files received by fax or telephone) shall be controlled in some way to ensure that timeliness requirements are met.

Counting Cases -- If an appellant submits one request involving several different claims (and several different beneficiaries), count it as one case. If the contractor receives one envelope with multiple request forms and supporting documentation, count 1 case per request received. For example, if the envelope contains 10 separate request forms with supporting documentation, count as 10 cases.

Counting Part A, B of A and Part B Claims - If an appellant submits one request involving 5 different claims, count as 5 claims. If an appellant submits one request involving 1 claim, count as 1 claim. If the appellant submits two cases in the same envelope, of which one case has 3 claims and the other 4 claims, count as 2 cases with 7 claims. If an appellant submits a case containing 7 claims, of which 5 are requests for an appeal and the remaining 2 are determined to be reopenings, count the 5 appeal claims among the appeals workload. The remaining 2 claims shall not be counted among the appeals workload, but shall be counted as reopenings (see Line 1 of the Reopenings Section).

Counting Part A, B of A and Part B Cases Involving Appeals and Reopenings – If you receive a case involving multiple claims and some claims are subject to appeal but others must be handled as a reopening, count the case as an appeal. **Note**: Reopenings data is captured by claims only. Because of this, no case count is recorded for reopenings.

Additional Evidence Submitted After Request is Received -- If you receive a case for which additional documentation is submitted for some but not all of the claims, count the case among those recorded on Line 7 (Cleared - Evidence Submitted After Request).

When to Consider a Case Reversed -- Consider a case reversed when the initial determination is changed upon appeal, (e.g., the claim was denied at the initial determination level but is reversed when the case is appealed)

When to Consider a Case Completed – Consider a case to be completed when you complete the action that sets in motion correct payment of the claim, or for intermediaries or the A Macs , written assurance from the provider is requested for Part A cases, if applicable **and** you mail the decision letter to the appellant. Both actions shall be completed before you record the case completed for timeliness purposes. All redeterminations shall be processed **and <u>mailed</u>** by the 60th day (unless additional evidence is submitted by the party after the request is received, in which case the contractor has up to 14 additional days for each submission to process and mail the decision letter to the parties .

See Line 6.1 for additional guidance.

When to Consider a Case Effectuated – Consider effectuation of a decision to be completed when payment is issued to the appellant based on a fully favorable or partially favorable decision. If you enter the adjustment in the month of July, but payment is not issued to the appellant until August, the case is considered to be effectuated in August.

In instances where it is necessary for an intermediary to seek written assurance on Part A cases, payment cannot be made until the contractor receives written notice from the provider that payment made by the beneficiary, or on the beneficiary's behalf, has been refunded. Payment occurs only after such written notice from the provider is received.

Note: Considering a case to be completed is different from determining when a case is effectuated. Please note the distinctions in the previous paragraphs. It is possible for some overlap of completion and effectuation timeframes to occur.

460.2 - Section I – Redeterminations

(Rev. 130, Issued: 08-31-07, Effective: 01-01-08, Implementation: 01-07-08)

This section concerns data from Part A and Part B of A appeals processed by intermediaries, as well as Part B appeals processed by carriers.

Redeterminations. The number of redeterminations 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.

A redetermination is the first level of appeal following an initial determination of a Part A claim or Part B claim. It is a re-evaluation of the facts and findings of a claim to determine whether the initial decision was correct. (See the Medicare Claims Processing Manual, Publication 100-04, Chapter 29, Section 310.)

Do not count duplicate redetermination requests or redetermination requests received before you have made an initial determination on a claim. Do not count inquiries. Count

one redetermination per request received. With the exception of those lines for which claims counts are specifically requested in the report, count only cases. Do not count a duplicate request for appeal as a processed appeal. Duplicate requests can be reflected in Line 2 (Adjustment to Pending) of the CMS-2592 Report for the subsequent month.

Redeterminations fall into the following categories:

Column (1) Part A Cases- Use Column 1 to report information on Part A services processed by the intermediary.

Column (2) Part B of A Cases- Use Column 2 to report information on Part B services processed by the intermediary.

Column (3) Part B Cases- Use Column 3 to report information on Part B services processed by the carrier.

Line 1. Opening Pending - Show under columns 1-3, the number of redetermination cases reported on Line 21 as the closing pending redetermination cases on the previous month's report.

Line 2. Adjustments to Pending - CMS understands that it is often necessary to revise the categorization of data from the original categorization given when a case was initially received at the contractor. Likewise, it is often necessary to move data from one line to another in order to maintain accuracy. Prior to the submission of the monthly 2592 report to CMS, contractors are permitted to make changes to data during the reporting month to ensure that appeal workloads are accurately reflected.

Once the monthly 2592 report has been submitted to CMS, any changes to the closing pending figure of the report must be reflected in the Adjustments to Pending line of the subsequent month's report. If it is necessary to revise the pending figure for the close of the **previous** month's report because of inventories or reporting errors, enter the adjustment. If some cases were not counted in the proper month's receipts, count them as adjustments to the opening pending count in the subsequent month. Examples include any instances where something originally categorized as an appeal was determined not to be an appeal, or vice-versa. Duplicate requests for redetermination are also reflected here. If the contractor receives a request for appeal near the end of the reporting month but the case arrives too late to be reflected as a receipt in the CMS-2592 report for that month, count the case in the Adjustment to Pending line of the subsequent month's report. The purpose of the Adjustments to Pending line is to allow the contractor to modify Opening Pending counts, thereby correcting errors resulting from inventory or reporting problems that were identified after the submission of the CMS-2592 previous month's report to CMS.

Do not make adjustments to the Pending line or other lines of the 2592 report once the report has been submitted to CMS. If there is an entry for Line 2, it should be preceded 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 redeterminations received during the reporting month. Include requests

transferred to you by other intermediaries or carriers or remanded by the Qualified Independent Contractor (QIC).

NOTE: See the "Note" under Line 6 (Requests Cleared) regarding the handling of Medicare Secondary Payer (MSP) cases.

Line 5. Misrouted Requests Forwarded to Another Contractor - Show under columns 1 through 3 the number of redetermination requests the contractor forwarded to other contractors, because they were misrouted to you and you did not process the original claim(s). For columns 1-3, if you have reported a redetermination as forwarded, do not report any information regarding it on Lines 6-29. The forwarding of the misrouted request is the final action.

NOTE: This line is not intended for QIC reconsideration requests that were misrouted.

Line 6. Requests Cleared - Show, under the appropriate columns, the total number of redeterminations completed during the month. Report all completed redeterminations, regardless if the final outcome was an affirmation, reversal, withdrawal, or dismissal. Do not count cases that were transferred to another contractor because they were misrouted.

NOTE : Intermediaries should count received and completed MSP redetermination cases in Columns 1 of Lines 4 and 6, as appropriate, regardless of whether claims involved are Part A, Part B or a combination. Do not count or report claims involved in MSP cases. MSP cases should be counted in Lines 4, 6, 7, 8, 9, 10 and 11. Do not count MSP claims on Lines 6.1, 7.1, 8.1, 9.1, 10.1 and 11.1.

Carriers that handle MSP cases should count them in Column 3.

Line 6.1. Number of Claims Cleared – Show the total number of claims involved in Line 6.

NOTE: For Lines 6.1 through 11.1 (letters a through i) , enter the number and type of claim processed. If no claims from a certain claim type are processed, enter NA. Refer to instructions for the CMS-1565 and 1566, as well as appropriate sections of the Claims Processing Manual for guidance on determining the categories and types of claims processed by intermediaries, A/B MACs, carriers DMERCs and DME MACs.

Line 6.1a – Report the number of SNF claims included in Line 6.1. Line 6.1b – Report the number of Home Health claims included in Line 6.1. Line 6.1c – Report the number of Inpatient Hospital claims included in Line 6.1. Line 6.1d – Report the number of Outpatient claims included in Line 6.1. Line 6.1e – Report the number of Lab claims included in Line 6.1. Line 6.1f – Report the number of Ambulance claims included in Line 6.1. Line 6.1g – Report the number of DME claims included in Line 6.1. Line 6.1h – Report the number of Physician claims reported in Line 6.1. Line 6.1i – Report the number of Other claims or claims where the provider type cannot be determined based on the information on the claim included in Line 6.1.

Consider a redetermination cleared when:

- For affirmations, when all claims of the case are included in the decision and the decision letter is mailed to the parties
- For full and partial reversals:

(1) all claims within the case are included in the decision and the decision letter is mailed to the parties, and

(2) the contractor completes the action that sets in motion correct payment of the claim **or,** for intermediaries, written assurance from the provider for Part A cases is requested, if applicable.

- For withdrawals and dismissals, the dismissal notice is mailed to the parties.

Note that sending a letter to the mailroom does not constitute mailing the letter. Letters must be mailed to the appellant on or before the 60th day in order for the requirement to be met.

NOTE: Considering a case to be completed is different from determining when a case is effectuated. Please note the distinctions in the previous paragraphs.

Line 7. Cleared -- Evidence Submitted After Request - Of the cases reported in Line 6, show under the appropriate columns, the total number of redetermination cases for which additional documentation was submitted by the party on his or her own or when the documentation was requested by the contractor after the request was received

Line 7.1. Number of Claims Involved – Show the total number of claims involved in Line 6.1 for which evidence was submitted after the request was received.

Lines 7.1a through 7.1i are Not Applicable. Line 7.1a – Report the number of SNF claims included in Line 7.1. Line 7.1b – Report the number of Home Health claims included in Line 7.1. Line 7.1c – Report the number of Inpatient Hospital claims included in Line 7.1. Line 7.1d – Report the number of Outpatient claims included in Line 7.1. Line 7.1e – Report the number of Lab claims included in Line 7.1. Line 7.1f – Report the number of Ambulance claims included in Line 7.1. Line 7.1g – Report the number of DME claims included in Line 7.1. Line 7.1h – Report the number of Physician claims reported in Line 7.1. Line 7.1i - Report the number of Other claims or claims where the provider type cannot be determined based on the information on the claim included in Line 7.1.

Note about Lines 8-11:

Count the cases in the following manner:

- If a case has multiple claims and all are affirmed, count the case as an affirmation.
- If a case has multiple claims, some of which are affirmed and others are partially reversed, count the case as a partial reversal. Consider a case reversed when the initial determination is changed upon appeal, irrespective of a change in payment.
- If a case has multiple claims, some of which are partially reversed and others are fully reversed, count the case as a partial reversal. Consider a case reversed when the initial determination is changed upon appeal, irrespective of a change in payment.
  - If a case has multiple claims, all of which are fully reversed, count the case as a full reversal.
  - If a case has multiple claims, some of which are fully reversed and the others are dismissed or withdrawn, count the case as a full reversal.

- If a case has multiple claims, one of which is affirmed, one of which is a partial reversal and one of which is dismissed, count the case as a partial reversal.
- If a case has multiple claims which are fully reversed, affirmations and withdrawals/dismissals, count the case as a partial reversal.
- If a case has two claims, one of which is affirmed and the other is dismissed, count the case as an affirmation.

Full	Partial	Affirmation	Dismissal/ Withdrawal	=	Report As
X					Full
	X				Partial
		X			Affirmation
			X		Dismissal/ Withdrawal
X	X				Partial
X		X			Partial
X			X		Full
X	X	X			Partial
X	X	X	X		Partial
	X	X			Partial
	X		X		Partial
		X	X		Affirmation
	X	X	X		Partial

Line 8. Affirmations - Under the appropriate columns, show the number of completed redeterminations from Line 6 in which the previous determinations were completely upheld; i.e., no change was made. All claims in a case must be upheld in order for the case to be counted as an affirmation. In instances where claims some are affirmed, but all others are dismissed or withdrawn, count the case as an affirmation. (Do not include partial reversals in this line. See Line 9 for partial reversals). Include those instances where the decision was affirmed, but a change in liability was noted.

Line 8a. Waiver of Liability Amount Paid Not Applicable - Show the amount paid under waiver of liability, on the basis that the party did not know that the service wasn't payable under Medicare.

Line 8.1. Number of Claims Affirmed – Show the number of claims involved in Line 6.1 for which the decision was affirmed.

NOTE -- The following example is counted as an affirmation: A claim is denied at the initial determination level and a redetermination is requested. At the redetermination level, the denial is upheld but the denial is for a reason other than was determined to be applicable at the initial determination level. Count the claim as an affirmation.

Line 8.1a – Report the number of SNF claims included in Line 8.1. Line 8.1b – Report the number of Home Health claims included in Line 8.1. Line 8.1c – Report the number of Inpatient Hospital claims included in Line 8.1. Line 8.1d – Report the number of

Outpatient claims included in Line 8.1. Line 8.1e – Report the number of Lab claims included in Line 8.1. Line 8.1f – Report the number of Ambulance claims included in Line 8.1. Line 8.1g – Report the number of DME claims included in Line 8.1. Line 8.1h – Report the number of Physician claims reported in Line 8.1. Line 8.1i – Report the number of Other claims or claims where the provider type cannot be determined based on the information on the claim included in Line 8.1.

Line 9. **Partial Reversals** - Under the appropriate columns, show the number of completed redeterminations, from Line 6 in which part of the prior determination decision of the appealed lines was reversed. That is, a change was made and some part of the new determination was in favor of the appellant. **NOTE:** Consider a case reversed when the initial determination is changed upon appeal, irrespective of a change in payment.

Line 9.1. Number of Claims Partially Reversed – Show the number of claims involved in Line 6.1 for which the decision is partially reversed. Note: It is possible to have zero claims in Line 9.1, even when cases are recorded in Line 9.

Line 9.1a – Report the number of SNF claims included in Line 9.1. Line 9.1b – Report the number of Home Health claims included in Line 9.1. Line 9.1c – Report the number of Inpatient Hospital claims included in Line 9.1. Line 9.1d – Report the number of Outpatient claims included in Line 9.1. Line 9.1e – Report the number of Lab claims included in Line 9.1. Line 9.1f – Report the number of Ambulance claims included in Line 9.1. Line 9.1g – Report the number of DME claims included in Line 9.1. Line 9.1h – Report the number of Physician claims reported in Line 9.1. Line 9.1i – Report the number of Other claims or claims where the provider type cannot be determined based on the information on the claim included in Line 9.1.

Line 10. Full Reversals - Under the appropriate columns, show the total number of completed redeterminations from Line 6 in which the previous determination decision of the appealed lines was completely reversed. **NOTE:** Consider a case reversed when the initial determination is changed upon appeal, irrespective of a change in payment.

Line 10.1. Number of Claims Fully Reversed – Show the number of claims involved in Line 6.1 for which the decision is fully reversed.

Line 10.1a – Report the number of SNF claims included in Line 10.1. Line 10.1b – Report the number of Home Health claims included in Line 10.1. Line 10.1c – Report the number of Inpatient Hospital claims included in Line 10.1. Line 10.1d – Report the number of Outpatient claims included in Line 10.1. Line 10.1e – Report the number of Lab claims included in Line 10.1. Line 10.1f – Report the number of Ambulance claims included in Line 10.1. Line 10.1g – Report the number of DME claims included in Line 10.1. Line 10.1h – Report the number of Physician claims reported in Line 10.1. Line 10.1i – Report the number of Other claims or claims where the provider type cannot be determined based on the information on the claim included in Line 10.1.

Line 11. Dismissals/Withdrawals - Report, under the appropriate column, the number of cases from Line 6 that were withdrawn by the appellant or dismissed (before determination) by you. In order for a case to be recorded in Line 11, all claims in the case must be dismissed or withdrawn.

NOTE: Do not count cases that were dismissed because they were determined to be incomplete in Line 11. Cases that were dismissed because they were determined to be incomplete should only be counted in Line 12.

Line 11.1. Number of Claims Dismissed or Withdrawn – Show the number of claims involved in Line 6.1 which were dismissed or withdrawn.

Line 11.1a – Report the number of SNF claims included in Line 11.1. Line 11.1b – Report the number of Home Health claims included in Line 11.1. Line 11.1c – Report the number of Inpatient Hospital claims included in Line 11.1. Line 11.1d – Report the number of Outpatient claims included in Line 11.1. Line 11.1e – Report the number of Lab claims included in Line 11.1. Line 11.1f – Report the number of Ambulance claims included in Line 11.1. Line 11.1g – Report the number of DME claims included in Line 11.1. Line 11.1h – Report the number of Physician claims reported in Line 11.1. Line 11.1i – Report the number of Other claims or claims where the provider type cannot be determined based on the information on the claim included in Line 11.1.

Notes:

Misrouted correspondence and duplicate requests are not dismissals.

Line 12. Number of Incomplete Redetermination Requests Dismissed - Enter the number of cases that were dismissed because the request was incomplete. Report incomplete cases in Line 12 only if ALL the claims from the case are incomplete. For information on what constitutes an incomplete request, refer to the Medicare Claims Processing Manual, Publication 100-04; Chapter 29; Section 310.1

NOTE: If one redetermination request contains multiple claims and or line items and is split, report the case according to the overall disposition of the individual claims and/or line items. (In many instances, split cases will be reported as partially reversed).

Example: A supplier submits a redetermination request that contains one request with 50 claims involving different beneficiaries. The request contains a name and signature of the appellant/supplier, and the supporting documentation identifies individual claims of the beneficiaries, pertinent HIC numbers and the dates of service. However, for some of the claims, the supplier does not identify the specific services (among the several line items on the claim) that are disputed. The contractor should not dismiss the entire redetermination request. Rather, in this situation, the contractor issues dismissals (incomplete requests) with respect to the individual claims for which the requisite information is incomplete, and issues favorable and/or unfavorable decisions for the remaining claims, as appropriate. For the purposes of reporting, the case is reported according to the overall disposition of the individual claims and/or line items. If the case contains some affirmations, reversals and dismissals, count the case as partially reversed in Line 9.

Example: A supplier submits a redetermination request that contains one request with 50 claims involving different beneficiaries. The request is missing the signature of the appellant/supplier, but identifies the individual claims of the

beneficiaries, pertinent names and HIC numbers, dates of service and the items or services disputed. Since the signature is missing, the entire request would be dismissed as incomplete, and counted in Line 12 of the CMS-2592.

Do not count cases that were dismissed for reasons other than being incomplete on Line 12. Only count those instances for which the entire request is dismissed on Line 12.

Line 13. Medicare Approved Amount Not Applicable For cases included in Lines 9 and 10, show the Medicare Approved Amount for services where the initial determination was reversed at the redetermination level, either fully (Line 10) or partially (Line 9). 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 Redeterminations for (Lines 6 through 25)

For Lines 6-25, use the matrix below to determine the number of days from receipt to completion of redeterminations. The date of receipt in all cases is the day the processing contractor received the request in its corporate mailroom. In order to ensure that cases are processed timely, cases should also be date stamped or controlled in some way in the mailroom.

Situation	Date Completed
o The appellant withdraws the request.	The date the dismissal letter is mailed to the party.
o The contractor dismisses the request	The date the dismissal letter is mailed to the party.
o The contractor reverses the initial determination.	For both full and partial reversals, when the contractor completes the action that sets in motion correct payment of the claim and the contractor mails the decision letter to the party.
The contractor affirms the initial determination	The date the decision letter is mailed to the party.

REDETERMINATIONS

PROCESSING TIME: REDETERMINATIONS WITH DOCUMENTATION SUBMITTED TIMELY (Lines 14-16)

Line 14. Redetermination Processing Time – Average – Report, under the appropriate columns, the average number of days from receipt of the redetermination in the corporate mailroom to the date of completion. Do not include redeterminations where documentation is submitted after the request (i.e., a redetermination cannot be counted in both Line 14 and Line 17).

To compute the average number of days from request to completion, divide the total days elapsed for all requests (where the documentation was submitted timely) cleared in the month by the number of requests cleared. Round results to the nearest day. The days elapsed for an individual request are calculated using the number of days from the Julian date of case receipt through the Julian date of completion. Include the time required for the response to be mailed to the appellant. 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 one day. For example, a case that is received and processed on January 7 is considered to require one day to clear. A case received on January 7 and cleared on January 8 is considered to require2 days to clear.

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

Line 15. Redeterminations Completed in 1-60 Days - Show the number of redeterminations that required 1-60 calendar days to complete (based on the date of receipt of the request in the corporate mailroom). Do not include redeterminations reported in Lines 18-20.

Line 16. Redeterminations Completed in over 60 Days - Show the number of redeterminations that required more than 60 calendar days to complete (based on the date of receipt of the request in the corporate mailroom). Do not include redeterminations reported in Lines 18-20.

PROCESSING TIME: Redeterminations with DOCUMENTATION SUBMITTED AFTER REQUEST WAS RECEIVED (Lines 17-20)

NOTE: This section captures information in instances where the party submits additional documentation at the redetermination level on his or her own (without receiving a request for such documentation from the contractor) after the initial request

for redetermination is received. The contractor must receive the documentation before the 60 day timeframe is up in order for data to be entered into Lines 17-20.

Line 17. **Redeterminations Processing Time - Average (Documentation Submitted Later)** – For redeterminations where documentation/evidence is submitted after the request is received, report under the appropriate columns, the average number of days from receipt of the redetermination to the date of completion. Using redeterminations where documentation was submitted later as the basis, follow instructions in Line 14 to calculate the average processing time.

Line 18. Redeterminations Completed in 1-60 Days (Documentation Submitted Later) - Show the number of redeterminations from Line 6 where documentation/evidence is submitted after the request is received, and 1-60 calendar days were required to complete the case.

Line 19. Redeterminations Completed in 61-74 Days (Documentation Submitted Later) - Show the number of redeterminations from Line 6 where documentation/evidence is submitted after the request is received, and 61-74 calendar days were required to complete the case.

Line 20. Redeterminations Completed in over 74 Days (Documentation Submitted Later) - Show the number of redeterminations from Line 6 where documentation/evidence is submitted after the request is received, and more than 74 calendar days were required to complete the case.

Pending Time Frames

Line 21. Closing Pending Redeterminations - Show, under the appropriate columns, the total number of redeterminations that have not been completed by the end of the reporting month. Note: Do not include pending effectuations in this line.

Line 22. Redeterminations Pending 1-30 Days – Show the number of redeterminations included in Line 21 that have been pending for 1-30 days, inclusive, at the end of the reporting month.

Line 23. Redeterminations Pending 31-60 Days - Show the number of redeterminations included in Line 21 that have been pending 31-60 days, inclusive, at the end of the reporting month.

Line 24. Redeterminations Pending 61-74 Days - Show the number of redeterminations included in Line 21 which have been pending 61-74 days, inclusive at the end of the reporting month.

Line 25. Redeterminations Pending Over 74 Days - Show the number of redeterminations included in Line 21 which have been pending more than 74 days at the end of the reporting month.

EFFECTUATION OF REDETERMINATION DECISIONS

Line 26. Total Effectuations - Show the number of redetermination cases for which you effectuated a decision during the month. Consider effectuation of a decision to be completed when you issue payment to the appellant based on a fully favorable or partially

favorable decision. Include effectuation of affirmations where changes in liability are at issue. Do not include cases for which no effectuation is required.

Notes: Considering a case to be completed is different from determining when a case is effectuated. Please refer to the distinctions in the introductory sections of the2592 report ("When to Consider a Case Completed" and "When to Consider a Case Effectuated").

In instances where it is necessary for an intermediary to seek written assurance for Part A cases, payment cannot be made until the contractor receives written notice from the provider that payment made by the beneficiary, or on the beneficiary's behalf, has been refunded. Payment occurs only after such written notice from the provider is received.

Line 26a. Number of Claims Involved – Show the number of claims involved in Line 26.

Line 27. Number Effectuated 1-30 Days - Show the number of claims from Line 26a where you effectuated the decision within 30 calendar days of the date of the decision.

Line 28. Number Effectuated 31-60 Days - Show the number of claims from Line 26a where you effectuated the decision within 31- 60 calendar days of the date of the decision.

Line 29. Number Effectuated Over 60 Days - Show the number of claims from Line 26a where you effectuated the decision in more than 60 calendar days of the date of the decision.

460.3 - Section II - Qualified Independent Contractor (QIC) Reconsiderations

(Rev. 130, Issued: 08-31-07, Effective: 01-01-08, Implementation: 01-07-08)

- Use Section II to report requests for reconsideration.

Reconsiderations, the second level of appeal, are processed by the QIC. This section of the report captures information related to several distinct pieces associated with the reconsideration process. While requests for reconsideration should be sent directly by the appellant to the QIC, it is probable that some requests will be sent to intermediaries, A/B MACs, carriers and DME MACs, requiring the need for forwarding the request, and the associated case file, to the QIC. In those instances where the requests for reconsideration are sent directly to the QIC as required, the QICs will have to request case file information from the contractor before the reconsideration can be conducted. In addition, the contractor will effectuate QIC decisions, as appropriate.

QIC RECONSIDERATIONS FALL INTO THE FOLLOWING CATEGORIES:

Column (1) Part A Cases- Use Column 1 to record information on reconsiderations of redeterminations for Part A services processed by the intermediary.

Column (2) Part B of A Cases Use Column 2 to record information on reconsiderations of redeterminations for Part B services processed by the intermediary.

Column (3) Part B Cases- Use Column 3 to record information on reconsiderations of redeterminations for Part B services processed by the carrier.

Line 30. Opening Pending - Show the number of closing pending reconsiderations reported on Line 47 on the previous month's report.

Line 31. 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.

Line 32. Adjusted Opening Pending - Show the result of Line 30 + Line 31 (taking into account the "-" sign, if any).

Line 33. Requests for QIC Reconsideration Received by the Contractor - Show the number of QIC reconsiderations received by the contractor during the month. Although the requests for reconsideration should be sent directly to the QIC, some requests may be sent directly to the contractor in error, and as such, are considered to be "misrouted". Enter the number reconsideration requests sent by the appellant or their representative directly to the contractor. The contractor must forward these requests, along with the associated case file, to the QIC.

Line 33a. Misrouted Requests Forwarded to QIC –Show the number of misrouted reconsideration requests that were forwarded to the QIC, along with the associated case file, during the month. Do not include duplicate requests for reconsideration in this line.

Line 33b. Misrouted Requests Forwarded Timely – Of the number reflected in Line 33a, show the number forwarded to the QIC in 1-30 calendar days.

Line 33c. Misrouted Requests Forwarded Untimely – Of the number reflected in Line 33a, show the number forwarded to the QIC in more than 30 calendar days.

Line 34. Requests from QIC for Case Files: Upon receipt of the request for reconsideration, the QIC must contact the contractor to request the case file. Show the number of requests for case files received by the contractor from the QIC during the month. Requests can be received in the corporate mailroom, by telephone or by fax. Consider the date of receipt as the date you receive the QIC request for the case file.

Line 35. Number of Case Files Forwarded to QIC - Show the number of reconsideration case files forwarded to QICs during the month. Consider the case forwarded when all necessary material has been mailed to the QIC.

Line 36. Number Forwarded in 1--5 Days – Show the number of Reconsideration case files forwarded to the QIC in 1-5 calendar days from the date of receipt of the QIC request to mailing of the necessary information to the QIC. Show data for all cases mailed during the month.

Line 36a. Number Forwarded In 6 Days - Show the number of Reconsideration case files forwarded to the QICs in 6 calendar days from the date of receipt of the QIC request to mailing of the necessary information to the QIC. Show data for all cases mailed during the month.

Line 37. Number Forwarded In 7 -8 Days - Show the number of Reconsideration case files forwarded to the QICs in 7 -8 calendar days from the date of receipt of the QIC

request to mailing of the necessary information to the QIC. Show data for all cases mailed during the month.

Line 37a. Number Forwarded In Over 8 Days - Show the number of Reconsideration case files forwarded to QICs in over8 calendar days from the date of receipt of the QIC request to mailing of the necessary information to the QIC. Show data for all cases mailed during the month.

Line 38. Average Time to Forward - The average number of calendar days from date of the QIC request to the date you mail the necessary information. Refer to instructions contained in Line 14 to determine average time to forward.

Line 39. Pending Case File Requests – Show the number of case files yet to be forwarded to the QIC. This could include requests received from, but not yet sent to the QIC, as well as those reconsideration requests sent to the contractor instead of the QIC.

Disposition of QIC Decisions

Line 40. Number of QIC Decisions Received From QIC- Show the number of Reconsideration requests completed by the QIC and returned to the contractor during the month.

Line 41. Number of QIC Decisions That Need Effectuation - Show the number of Reconsideration decisions from Line 40 which must be effectuated.

41a. Number of Claims Involved: Show the number of claims involved in Line 41.

EFFECTUATION OF QIC DECISIONS

Line 42. Total Effectuations - Show the number of Reconsideration decisions for which you effectuated a decision during the month. Consider effectuation of a decision to be completed when you issue payment to the appellant based on a fully favorable or partially favorable decision. Include effectuation of affirmations where changes in liability are at issue. Do not include cases for which no effectuation is required.

NOTE: Considering a case to be completed is different from determining when a case is effectuated. Please refer to the distinctions in the introductory sections of the2592 report ("When to Consider a Case Completed," and "When to Consider a Case Effectuated").

NOTE: If the QIC's decision is favorable to the appellant and gives a specific amount to be paid, effectuation must occur within 30 calendar days of the date of receipt the QIC decision. If the decision is favorable but the amount to be paid must be computed, effectuation must occur within 30 days after the amount is computed. The amount must be computed as soon as possible, but no later than 30 calendar days of the date of receipt of the QIC's decision.

NOTE: In instances where it is necessary for an intermediary or A MAC to seek written assurance for Part A cases, payment cannot be made until the contractor receives written notice from the provider that payment made by the beneficiary, or on the beneficiary's behalf, has been refunded. Payment occurs within 30 days after such written notice from the provider is received.

Line 42a. Number of Claims Involved – Show the number of claims involved in Line 42.

NOTE: Information captured in Lines 43, 44 and 45 reflects time to compute the amount to be paid as well as the effectuation timeframes. Information provided in Lines 43-45 also assumes that contractors must calculate the amounts to be paid. Even though all appropriate timeframes are not reflected here, contractors are still required to follow applicable manual requirements and timeframes with regard to receipt, calculation and effectuation of decisions. CMS anticipates that effectuation of most decisions for which the amount is provided should fall into Line 43.

Line 43. Number Effectuated in 1-30 Days - Show the number of claims from Line 42a where you effectuated the decision within 30 calendar days. Effectuation days include the day of receipt of the reconsideration effectuation notice in your corporate mailroom or electronic transmission, such as fax or secure e-mail through the day the payment is issued. Include written assurance cases in this line, as applicable.

43a. Contractor Computed Amount – Of the number reflected on Line 43, show the number where the contractor was required to compute the amount to be paid.

Line 44. Number Effectuated in 31-60 Days - Show the number of claims from Line 42a where you effectuated the decision within 31-60 calendar days. Effectuation days include the day of receipt of the reconsideration effectuation notice in your corporate mailroom or electronic transmission, such as fax or secure e-mail through the day the payment is issued. Include written assurance cases in this line, as applicable.

44a. Contractor Computed Amount – Of the number reflected on Line 44, show the number where the contractor was required to compute the amount to be paid.

Line 45. Number Effectuated in Over 60 Days - Show the number of claims from Line 42a where you effectuated the decision in more than 60 calendar days. Effectuation days include the day of receipt of the reconsideration effectuation notice in your corporate mailroom or electronic transmission, such as fax or secure e-mail through the day the payment is issued. Include written assurance cases in this line, as applicable.

45a. Contractor Computed Amount – Of the number reflected on Line 45, show the number where the contractor was required to compute the amount to be paid.

Line 46. Medicare Approved Amount Not Applicable - For decisions included in Line 42 show the Medicare approved amount for services at the QIC level where the determination was reversed, either fully or partially. Show the charges prior to application of the deductible and coinsurance.. Round results to the nearest dollar.

It is preferable to report the Medicare Approved Amount at the time that cases are reported on line 42. However, CMS will consider it acceptable for contractors to report the Medicare Approved Amount when adjustment claims tied to cases that are reporting or will report to line42 finalize.

Line 46a. Waiver of Liability Amount Paid Not Applicable – Of the amount recorded on Line 46, show the amount applicable to a waiver of liability payment on the basis that the party did not know that the service wasn't payable under Medicare.

Line 47. Closing Pending Reconsiderations - Show the total number of reconsideration requests that were not effectuated by the end of the reporting month. Consider a case pending from the date of receipt of the request at the contractor, or the date of the request

for the case file from the QIC , until you have received the completed decision from the QIC for all parts of the case. This number shall also reflect those case files not yet forwarded to the QIC by the contractor as well as those decisions that have been received by the contractor from the QIC that still require effectuation on the part of the contractor. For example, if you receive a case from the QIC, and have initiated the adjustment into the system, but have not issued the payment, the case is reported in Line 47 as pending.

Do not include instances where a misrouted file has been sent to the proper QIC in another jurisdiction. Misrouted files that belong to a QIC in another jurisdiction should be considered closed once they have been forwarded to the appropriate QIC. Files that are forwarded to the QIC servicing the same jurisdiction as the contractor should remain open until the effectuation is complete.

460.4 – Section III- Administrative Law Judge (ALJ) Results

(Rev. 130, Issued: 08-31-07, Effective: 01-01-08, Implementation: 01-07-08)

Line 48. Opening Pending - Show the number of ALJ decisions reported on Line 57 as the closing pending on the previous month's report.

Line 49. Number of Appeal Requests for ALJ Hearing Misrouted to Contractor – Report the number of appeal requests for an ALJ hearing that were misrouted to the contractor when they should have been filed with the Office of Medicare Hearings and Appeals instead. These are ALJ requests that were filed with the contractor by mistake.

Line 50. Number of ALJ Decisions Received From Administrative QIC (AdQIC) - Show the number of ALJ hearing decisions returned by the AdQIC to the contractor during the month. Consider the receipt date to be the date the case is received from the AdQIC. Include instances where decisions were received in the previous month, but were not entered into the system until the current month.

Line 51. Number of ALJ Decisions Received that Need Effectuation - Show the number of ALJ decisions from Line 50 which must be effectuated.

Line 51a. **Number of Claims Involved –** Show the number of claims involved in Line 51.

Line 52. Total Effectuations -Show the number of ALJ decisions effectuated during the month. Consider effectuation of a decision to occur when you issue payment based on a fully favorable or partially favorable decision. Include effectuation of affirmations where changes in liability are at issue. Do not include cases for which no effectuation is required.

NOTE: In instances where it is necessary for an intermediary or A MAC to seek written assurance for Part A cases, payment cannot be made until the contractor receives written notice from the provider that payment made by the beneficiary, or on the beneficiary's behalf, has been refunded. Payment occurs within 30 days after such written notice from the provider is received.

Line 52a. Number of Claims Involved – Show the number of claims involved in Line 52.

NOTE: Information captured in Lines 53, 54 and 55 assumes that contractors must calculate the amounts to be paid before effectuation can occur. Contractors are required

to follow other applicable timeframes used when specific amounts to be paid have been provided with the information received from the AdQIC. CMS anticipates that effectuation of most decisions for which the amount is provided should fall into Line 53.

Line 53. Number Effectuated in 1-30 Days - Show the number of claims from Line 52a where you effectuated the decision within 30 calendar days. Effectuation days include day of receipt of the effectuation notice from the AdQIC in your corporate mailroom or electronic transmission, such as fax or secure e-mail, through the day the payment is issued.

Line 54. Number Effectuated in 31-60 Days - Show the number of claims from Line 52a where you effectuated the decision within 31-60 calendar days. Effectuation days include day of receipt of the effectuation notice from the AdQIC in your corporate mailroom or electronic transmission, such as fax or secure e-mail, through the day the payment is issued.

Line 55. Number Effectuated in Over 60 Days - Show the number of claims from Line 52a where you effectuated the decision in more than 60 calendar days. Effectuation days include day of receipt of the effectuation notice from the AdQIC in your corporate mailroom or electronic transmission, such as fax or secure e-mail, through the day the payment is issued.

Line 56. Medicare Approved Amount Not Applicable - For decisions included in Line 52, show the Medicare approved amount for services where the reconsideration determination was reversed at the ALJ level, either fully or partially. Show charges prior to application of the deductible and coinsurance. Round results to the nearest dollar.

It is preferable to report the Medicare approved amount at the time that cases are reported on line 52. However, CMS will consider it acceptable for contractors to report the Amount Paid when adjustment claims tied to cases that are reporting or will report to line 52 finalize.

Line 56a. Waiver of Liability Amount Paid Not Applicable – Of the amount recorded on Line 56, show the amount applicable to a waiver of liability payment on the basis that the party did not know that the service wasn't payable under Medicare.

Line 57. Closing Pending ALJ Decisions - Show the total number of ALJ decisions that were received from the AdQIC, but were not completed by the contractor at the end of the reporting month, and as such, are still pending effectuation. All claims associated with the decision must be received from the AdQIC in order for the decision to be considered complete.

460.5 - Section IV – *Medicare* Appeals *Council* Effectuations

(Rev. 130, Issued: 08-31-07, Effective: 01-01-08, Implementation: 01-07-08)

Line 58. Medicare Appeals Council Effectuations – Show the total number of cases received from the Medicare Appeals Council which require effectuation by the contractor. While it is acknowledged that contractors will not have responsibility for forwarding these cases to the Medicare Appeals Council, information is requested since the contractor will have ultimate responsibility to make payment. For reporting purposes,

the contractor shall consider the date of receipt as the date the Medicare Appeals Council case is received from the AdQIC.

460.6 - Clerical Error Reopenings

(Rev. 130, Issued: 08-31-07, Effective: 01-01-08, Implementation: 01-07-08)

When a determination is made on a claim for services, the beneficiary (and the provider, physician or other supplier of medical services) should be able to rely on the fact that the coverage decision and payment amount are correct. Occasionally, information disclosing an error (on the part of the appellant or the contractor) in the determination comes to light after the payment has been incorrectly processed. Regulations do not permit unrestricted reopening of determinations and decisions, but rather, set specific circumstances under which a determination or decision may be reopened. Refer to 42 Code of Final Regulations (CFR) 405.980-986, Interim Final Rule, dated March 8, 2005.The Clerical Error Reopening section of the 2592 report focuses primarily on those clerical error and minor omission reopenings that occur at the pre and post redetermination level. Data on requests at the QIC level and above are only captured in Lines13 and 14 of the Clerical Error Reopening section of the report. Requests for a clerical error reopening may be received in writing or by telephone. Contractors shall continue to use the appropriate columns and lines of the CMS-2591 and CMS-2590 reports to capture data on reopenings that are not clerical in nature. Do not capture clerical error reopenings data on the 2590/2591.

NOTE: **Clerical Error Reopenings data requested in this section should be reported in claims, not cases.**

Line 1. Total Number of Clerical Error Reopenings Received – Show the total number of clerical error reopening requests received during the month. This number includes any requests originally categorized as a reopening at the pre or post-redetermination level, as well as those requests that were originally categorized as an appeal, but were later determined to be a clerical error reopening.

Line 2. Total Number of Clerical Error Reopenings Processed -- Show the total number of clerical error reopenings processed by the contractor during the month.

Line 3. Total Number Processed – Own Motion – Of the number reflected on Line 2, show the number the contractor reopened the claim on their own motion.

Line 4. Total Number Processed – Claimant Initiated – Of the number reflected on Line 2, show the number of reopenings initiated by the claimant.

Line 5. Total Number of Clerical Error Reopenings Resulting From Contractor Error -- Of the reopenings reflected in Line 2, show the total number of claims that were the result of contractor error, whether discovered by the contractor or the claimant.

Line 6. Total Number of Clerical Error Reopenings Resulting From Provider Error -- Of the reopenings reflected in Line 2, show the total number of claims that were the result of provider error, whether discovered by the contractor or the claimant.

NOTE: Particularly with regard to Lines 3 through 6, it is possible for the same claim to be reflected on more than one line.

.Line 7: Reserved for Future Use

Line 8: Reserved for Future Use

Line 9. Medicare Approved Amount Not Applicable – For cases included on Line 2, show the amount paid for services where the determination was reversed either fully or partially. This is the amount sent after the reopening has been completed – the check amount.. Round results to the nearest dollar.

NOTE: Time frames noted in Lines 10 11 and 11a are for clerical error reopenings initiated by the party only. The time frames do not apply to contractor initiated reopenings or mass adjustments. In addition, no time frames have been established for other types of reopenings.

Line 10. Clerical Error Reopenings Processed in 1-30 Days – Show the number of clerical error reopenings from Line 2 processed in 1-30 calendar days. The processing time frame starts from the date of receipt of the request in the contractor's mailroom.

Line 11. Clerical Error Reopenings Processed in 31-60 Days - Show the number of clerical error reopenings from Line 2 processed in 31-60 calendar days. The processing time frame starts from the date of receipt of the request in the contractor's mailroom.

Line 11a. Clerical Error Reopenings Processed in More than 60 Days – Show the number of clerical error reopenings from Line 2 processed in 61 days or more. The processing time frame starts from the date of receipt of the request in the contractor's mailroom.

Line 12. Total Number of Clerical Error Reopening Requests Pending –Show the number of clerical error reopenings pending at the close of the reporting month.

Line 13. Total Number of Higher Level Reopenings Requiring Adjustment by the Contractor – Show the number of claims that were reopened by the QIC, ALJ or Medicare Appeals Council that require an adjustment by the contractor. These are claims for which the contractor must effectuate the claim as a result of the reopening decision at the higher level.

Line 14. Amount Awarded Not Applicable – Show the amount approved for services from Line 13 where the determination was reversed, either fully or partially. Show amounts that are sent to the provider.. Round results to the nearest dollar.

It is preferable to report the Medicare Approved Amount at the time that cases are reported on line 13. However, CMS will consider it acceptable for contractors to report the Medicare Approved Amount when adjustment claims tied to cases that are reporting or will report to line 13 finalize.

460.7 - Validation of Reports

(Rev. 130, Issued: 08-31-07, Effective: 01-01-08, Implementation: 01-07-08)

The SSM shall automatically produce the CMS 2592 carrier appeals validation report and the carrier performance validation report on a daily and monthly basis without specific carrier maintenance or request or without carrier intervention.

Before sending the reports to CMS, check for completeness and arithmetical accuracy. Note that the information provided below is applicable to each separate column. Use the following checklist for an arithmetical check for each column:

- Line 1 equals Line 21 from previous month's report.
- For each column, Line 1 plus Line 2 equals Line 3.
- Line 3 plus Line 4 minus Line 5 minus Line 6 minus line 12 equals Line 21 for each column.
- The total of Line 6.1a through 6.1i equals Line 6.1.
- The total of 7.1.
- The total of Line 7.1a through 7.1i equals Line 7.1. (Not Applicable)
- The total of Line 8.1a through 8.1i equals Line 8.1.
- The total of Line 9.1a through 9.1i equals Line 9.1.
- The total of Line 10.1a through 10.1i equals Line 10.1.
- The total of Line 11.1a through 11.1i equals Line 11.1.
- Line 6.1 is equal to or greater than Line 6.
- Line 7.1 is equal to or greater than Line 7.
- Line 8.1 is equal to or greater than Line 8.
- Line 10.1 is equal to or greater than Line 10.
- Line 11.1 is equal to or greater than Line 11.

  Note: For contractors handling MSP claims, totals for Lines 6.1 through 11.1 may or may not be equal or greater to Lines 6 through 11, respectively.
- Line 8 plus Line 9 plus Line 10 plus Line 11 must equal Line 6.
- .Line 15 plus Line 16 plus Line 18 plus Line 19 plus Line 20 equals Line 6.
- Line 22 plus Line 23 plus Line 24 plus Line 25 equals Line 21.
- Line 27 plus Line 28 plus Line 29 equals Line 26a.
- Line 30 equals Line 47 of the previous month's report.
- Line 30 plus Line 31 equals Line 32.

- Line 33b must not exceed Line 33a.
- Line 33c must not exceed Line 33a.
- Line 33b plus 33c must equal Line 33a.
- Line 36 plus Line 36a, plus 37 plus Line 37a equals Line 35.
- Line 41a is equal to or greater than Line 41.
- Line 42a is equal to or greater than Line 42.
- Line 43 plus Line 44 plus Line 45 equals Line 42a.
- Line 46a must not exceed Line 46 (Not Applicable)
- Line 48 plus Line 51 minus Line 52 equals Line 57.
- Line 48 equals Line 57 from the previous month's report.
- Line 51a is equal to or greater than Line 51.
- Line 52a is equal to or greater than Line 52.
- Line 56a must not exceed Line 56. (Not Applicable)
- Line 53 plus Line 54 plus Line 55 equals Line 52a.
- Line 3 (Reopenings) plus Line 4 (Reopenings) equals Line 2 (Reopenings).
- Line 5 (Reopenings) must not exceed Line 2 (Reopenings).
- Line 5 (Reopenings) plus Line 6 (Reopenings) equals Line 2 (Reopenings)
- Line 6 (Reopenings) must not exceed Line 2 (Reopenings).
- Line 10 (Reopenings) plus Line 11 (Reopenings) plus Line 11a must not exceed Line 4 (Reopenings).