

for redeterminations within 60 days of receipt of the request. Upon implementation of section 521 of BIPA and section 940 of DIMA, we intend to begin evaluating whether RHHIs are meeting the timeliness and accuracy requirements for processing redeterminations. Because the ability for beneficiaries to request this new first level of appeal will not be initiated until section 521 of BIPA are implemented, RHHIs will not only be processing redeterminations, but will continue to process the reconsideration, review, and hearing workloads that existed prior to the implementation of BIPA. Upon the implementation of section 521 of BIPA and section 940 of DIMA this 60-day requirement and the processing accuracy will be additional functions that may be evaluated.

## VI. Criteria and Standards for Carriers

### A. Claims Processing Criterion

The Claims Processing criterion contains the following six mandated standards:

*Standard 1.* Not less than 95.0 percent of clean electronically submitted claims are processed within statutorily specified time frames. Clean claims are defined as claims that do not require Medicare carriers to investigate or develop them outside of their Medicare operations on a prepayment basis. Specifically, clean electronic claims can be paid as early as the 14th day (13 days after the date of receipt) and must be paid by the 31st day (30 days after the date of receipt). Our expectation is that contractors will meet this percentage on a monthly basis.

*Standard 2.* Not less than 95.0 percent of clean paper claims are processed within specified time frames. Specifically, clean paper claims can be paid as early as the 27th day (26 days after the date of receipt) and must be paid by the 31st day (30 days after the date of receipt). Our expectation is that contractors will meet this percentage on a monthly basis.

*Standard 3.* 98.0 percent of MSNs are properly generated. Our expectation is that MSN messages are accurately reflecting the services provided.

*Standard 4.* 95.0 percent of review determinations are completed within 45 days. Our expectation is that contractors will meet this percentage on a monthly basis.

*Standard 5.* 90.0 percent of carrier hearing decisions are completed within 120 days. Our expectation is that contractors will meet this percentage on a monthly basis.

*Standard 6.* Review determination letters prepared in response to beneficiary initiated appeal requests are written at an appropriate reading level.

Additional functions that may be evaluated under this criterion includes, but are not limited to, the following:

- Claims Processing accuracy.
- Establishment and maintenance of relationship with the CWF Host.
- Accuracy of processing review determination cases.
- Accuracy of processing hearing cases with decision letters that are clear and have an appropriate customer-friendly tone.
- Accuracy and timeliness of processing appeals under BIPA.

**Note:** Section 521 of BIPA and section 940 of DIMA amend section 1869 of the Act by requiring major revisions to the Medicare appeals process. Upon implementation of section 521 of BIPA, the first level in a beneficiary's appeal will be a "redetermination" that will replace the current review for Part B appeals. Carriers will be required to process all requests for redeterminations within 60 days of receipt of the request. Upon implementation of section 521 of BIPA and section 940 of DIMA, we intend to begin evaluating whether carriers are meeting the timeliness and accuracy requirements for processing redeterminations. Because the ability for beneficiaries to request this new first level of appeal will not be initiated until section 521 of BIPA is implemented, there will be a period of time in which carriers will not only be processing redeterminations, but will continue to process the review and hearing workloads that existed prior to the implementation of BIPA. Upon the implementation of section 521 of BIPA and section 940 of DIMA, this 60-day requirement and the processing accuracy will be additional functions that may be evaluated.

### B. Customer Service Criterion

Customer Service criterion contains the following mandated standard:

Standard. Replies to beneficiary correspondence address the beneficiary's concerns, are written with an appropriate customer-friendly tone and clarity, and are at the appropriate reading level.

Contractors must meet our performance expectations that beneficiaries and providers are served by prompt and accurate administration of the program in accordance with all applicable laws, regulations, and our general instructions.

Additional functions that may be evaluated under this criterion include, but are not limited to, the following:

- Providing timely and accurate replies to beneficiary and provider telephone inquiries.
- Quality call monitoring.
- Training of customer service representatives.
- Providing timely and accurate written replies to beneficiary and provider inquiries.
- Ensuring the validity of the call center performance data that are being reported in the Customer Service Assessment and Management System.
- Walk-in inquiry service.
- Conducting beneficiary and provider education, training, and outreach activities.

- Effectively maintaining an Internet Website dedicated to furnishing providers timely, accurate, and useful Medicare program information.

### C. Payment Safeguards Criterion

Carriers may be evaluated on any MIP activities if performed under their contracts. In addition, other carrier functions and activities that may be reviewed under this criterion include, but are not limited to the following:

- Benefit Integrity
  - Referring allegations of potential fraud that are made by beneficiaries, providers, CMS, OIG, and other sources to the Payment Safeguard Contractor.
  - Putting in place effective detection and deterrence programs for potential fraud.
- Medical Review
  - Increasing the effectiveness of medical review activities.
  - Exercising accurate and defensible decision making on medical reviews.
  - Effectively educating and communicating with the provider community.
  - Collaborating with other internal components and external entities to ensure the effectiveness of medical review activities.
- Medicare Secondary Payer
  - Accurately reporting MSP savings.
  - Accurately following MSP claim development/edit procedures.
  - Supporting the Coordination of Benefits Contractor's efforts to identify responsible payers primary to Medicare.
  - Identifying, recovering, and referring mistaken/conditional Medicare payments in accordance with the appropriate Medicare Carriers Manual instructions, and our other pertinent general instructions.
- Overpayments
  - Collecting and referring Medicare debts timely.
  - Accurately reporting and collecting overpayments.
  - Compliance with our instructions for management of Medicare Trust Fund debts.
- Provider Enrollment
  - Complying with assignment of staff to the provider enrollment function and training staff in procedures and verification techniques.
  - Complying with the operational standards relevant to the process for enrolling suppliers.

### D. Fiscal Responsibility Criterion

We may review the carrier's efforts to establish and maintain appropriate financial and budgetary internal controls over benefit payments and administrative costs. Proper internal controls must be in place to ensure that contractors comply with their contracts.

Additional functions that may be reviewed under the Fiscal Responsibility criterion include, but are not limited to, the following:

- Adherence to approved program management and MIP budgets.
- Compliance with the BPRs.
- Compliance with financial reporting requirements.
- Control of administrative cost and benefit payments.