

by the contractor or returned to the hospitals as incomplete within 60 days of receipt.

Intermediaries may also be evaluated on any MIP activities if performed under their Part A agreement. These functions and activities include, but are not limited to the following:

- Audit and Reimbursement
- + Performing the activities specified in our general instructions for conducting audit and settlement of Medicare cost reports.
- + Establishing accurate interim payments.
  - Benefit Integrity
- + Identifying potential fraud cases that exist within the intermediary's service area and taking appropriate actions to resolve these cases.
- + Investigating allegations of potential fraud that are made by beneficiaries, providers, CMS, Office of Inspector General (OIG), and other sources.
- + 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 correct claims payment, and to address situations of fraud, waste, and abuse.
  - Medicare Secondary Payer
- + Accurately reporting MSP savings.
- + Accurately following MSP claim development and edit procedures.
- + Auditing hospital files and claims to determine that claims are being filed to Medicare appropriately.
- + Supporting the Coordination of Benefits Contractor's efforts to identify responsible payers primary to Medicare.
- + Identifying, recovering, and referring mistaken Medicare payments in accordance with appropriate Medicare Intermediary Manual instructions and our other pertinent general instructions, in the specified order of priority.
  - Overpayments
- + Collecting and referring Medicare debts timely.
- + Accurately reporting overpayments to us.
- + Adhering to our instructions for management of Medicare Trust Fund debts.
  - Provider Enrollment
- + Complying with assignment of staff to the provider enrollment function and

training the staff in procedures and verification techniques.

- + Complying with the operational standards relevant to the process for enrolling providers.

#### *D. Fiscal Responsibility Criterion*

We may review the intermediary'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 agreements with us.

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.

#### *E. Administrative Activities Criterion*

We may measure an intermediary's administrative ability to manage the Medicare program. We may evaluate the efficiency and effectiveness of its operations, its system of internal controls, and its compliance with our directives and initiatives.

We may measure an intermediary's efficiency and effectiveness in managing its operations. Proper systems security (general and application controls), ADP maintenance, and disaster recovery plans must be in place. An intermediary must also test system changes to ensure the accurate implementation of our instructions.

Our evaluation of an intermediary under the Administrative Activities criterion may include, but is not limited to, reviews of the following:

- Systems security.
- ADP maintenance (configuration management, testing, change management, security, etc).
- Disaster recovery plan.
- Implementation of our general instructions.
- Data and reporting requirements implementation.
- Internal controls establishment and use, including the degree to which the contractor cooperates with the Secretary in complying with the FMFIA.

#### **V. Criteria and Standards for Regional Home Health Intermediaries (RHHIs)**

The following three standards are mandated for the RHHI criterion:

*Standard 1.* 95.0 percent of clean electronically submitted non-Periodic Interim Payment HHA and hospice

claims are paid within statutorily specified time frames. Clean claims are defined as claims that do not require Medicare intermediaries to investigate or develop them outside of their Medicare operations on a prepayment basis. Specifically, clean, non-Periodic Interim Payment 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.* 95.0 percent of clean paper non-Periodic Interim Payment HHA and hospice claims are paid within specified time frames. Specifically, clean, non-Periodic Interim Payment 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.* 75.0 percent of HHA and hospice reconsiderations are processed within 60 days and 90.0 percent are processed within 90 days. Our expectation is that contractors will meet this percentage on a monthly basis.

*Standard 4.* 95.0 percent of HHA and Hospice Part B 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 HHA and Hospice Part B hearing decisions are completed within 120 days. Our expectation is that contractors will meet this percentage on a monthly basis.

We may use this criterion to review an RHHI's performance with respect to handling the HHA and hospice workload. This includes processing HHA and hospice claims timely and accurately; properly paying and settling HHA cost reports; and timely and accurately processing reconsiderations from beneficiaries, HHAs, and hospices.

#### **VI. Criteria and Standards for Carriers**

##### *A. Claims Processing Criterion*

The Claims Processing criterion contains the following six mandated standards:

*Standard 1.* 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