CMS Manual System

Pub. 100-06 Medicare Financial Management

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

Transmittal 56 **Date: OCTOBER 22, 2004**

CHANGE REQUEST 3486

SUBJECT: Revision to Balancing Requirement on Form 5, Line 10, of the Contractor Reporting of Operational and Workload Data (CROWD)

I. SUMMARY OF CHANGES: The following requirement from Publication 100-06, Medicare Financial Management, chapter 6, §450.3 – Body of Report, (CROWD FORM 5) Line 10, is hereby deleted: The total of the entries on line 10 for columns 1, 2, and 3 must equal the total of all electronic claims processed as reported by intermediaries on page 11, line 38, column 8 of the Monthly Intermediary Workload Report (Form CMS-1566) and by carriers on page 9, line 38, column 6 of the Monthly Carrier Performance Report (Form CMS-1565).

This deletion is necessary as the 1566 and 1565 Workload Reports may not balance to Line 10 of CROWD Form 5.

NEW/REVISED MATERIAL -EFFECTIVE DATE*: November 22, 2004
IMPLEMENTATION DATE: November 22, 2004

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. 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 not updated.*)
(R = REVISED, N = NEW, D = DELETED) – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	6/450.3/Body of Report

III. FUNDING: Medicare contractors shall implement these instructions within their current operating budgets.

IV. ATTACHMENTS:

X	**Business Requirements**
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

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

Attachment - Business Requirements

Pub. 100-06	Transmittal: 56	Date: October 22, 2004	Change Request 3486

SUBJECT: Revision to Balancing Requirement on Form 5, Line 10 of the Contractor Reporting of Operational and Workload Data (CROWD)

I. GENERAL INFORMATION

A. Background: We are deleting the following language from Publication 100-06, Medicare Financial Management, chapter 6, §450.3 – Body of Report, (CROWD FORM 5) Line 10: "The total of the entries on line 10 for columns 1, 2, and 3 must equal the total of all electronic claims processed as reported by intermediaries on page 11, line 38, column 8 of the Monthly Intermediary Workload Report (Form CMS-1566) and by carriers on page 9, line 38, column 6 of the Monthly Carrier Performance Report (Form CMS-1565). (See CMS Pub. 100-06, Chapter 6 – Intermediary and Carrier Financial Reports, §30.3 for intermediaries and §150 for carriers.)"

This deletion is necessary as the 1566 and 1565 Workload Reports may not balance to Line 10 of CROWD Form 5.

B. Policy: Contractors are required to use CROWD FORM 5 to report on EDI transaction use.

C. Provider Education: None.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3486.1	The following requirement from 450.3, Body of Report, Line 10 is hereby deleted: The total of the entries on line 10 for columns 1, 2, and 3 must equal the total of all electronic claims processed as reported by intermediaries on page 11, line 38, column 8 of the Monthly Intermediary Workload Report (Form CMS-1566) and by carriers on page 9, line 38, column 6 of the Monthly Carrier Performance	X	X	X	X	X	X	X		

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	Report (Form CMS-1565).									

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions:

X-Ref Requirement #	Instructions

B. Design Considerations:

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: November 22, 2004 **Implementation Date:** November 22, 2004 **Pre-Implementation Contact(s):** James Krall, jkrall@cms.hhs.gov 410-786-6999 **Post-Implementation Contact(s):** James Krall, jkrall@cms.hhs.gov 410-786-6999	**Medicare Contractors shall implement these instructions within their current operating budgets.**

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

450.3 – Body of Report

(Rev. 56, Issued: 10-22-04, Effective: 11-22-04, Implementation: 11-22-04)

For lines 1-9, the intermediary or carrier completes the report for each column as follows:

- For column 1 data, include data on electronic transactions, batch or online interactive real time, and all formats (e.g., NSF, ASCX12N) and magnetic tape. Do not include Direct Data Entry (DDE) statistics.

- For column 2 data, include statistics on manual processes such as paper, E-mail, fax, diskette, and fax/optical character recognition (except where shaded). Continue with the current requirement for counting and reporting manual inquiry responses as cited in IOM 100-06 Financial Management Manual - Workload Reporting.

For line 10, the intermediary or carrier completes the report for each column as follows:

- *For column 1 data, include data on processed electronic X12 837version 4010.A.1 and NCPDP claims transactions (exclude DDE claims).*

- *For column 2 data, include data on all processed electronic claims submitted via Direct Data Entry (DDE). (DDE claims are considered HIPAA-compliant, but are to be reported separately here from the number of processed 837 version 4010.A.1 and NCPDP claims.)*

- *For column 3 data, include data on processed electronic claims transactions submitted in a non-HIPAA format such as an earlier version of the X12 837,or any version of the National Standard Format (NSF), or the UB-92 flat file.*

Line 1 – Response to Claim Status Inquiry - Report on the number of responses to claims status. Do not report on the number of inquiries. Count each occurrence of the unique trace or reference number as assigned by the provider (e.g., in the 276/277use TRN02).

Line 2 – Response to Eligibility Status Inquiry – Report on the number of responses to inquiries. Do not report on the number of inquiries. Count each unique occurrence of an individual beneficiary HIC number.

Line 3 – Outgoing Coordination of Benefit (COB) Claims Processed (includes Medigap, does not include NCPDP) – Count each unique occurrence of the patient control number as assigned by the provider (e.g., in the 837, use CLM01). Alternately, the intermediary or carrier may count each unique occurrence of the patient's HIC number.

NOTE: Lines 4, 5 and 6 are to be completed by DMERC carriers only.

Line 4 – Prior Authorization Requests (Durable Medical Equipment Regional Carriers or Advance Determination of Medicare Coverage) – Count each unique occurrence of an individual beneficiary HIC number in a valid response.

Line 5 – National Council of Prescription Drug Plans (NCPDP) for Retail Pharmacy Drug Claims Processed – Count each unique occurrence of an individual beneficiary HIC number in the claim.

Line 6 – Outgoing COB NCPDP for Retail Pharmacy Drug Claims Processed (including NCPDP Medigap) – Count each unique occurrence of an individual beneficiary HIC number.

Line 7 – Remittance Advices-Number Sent – For X12 electronic remittance advice, count as "1" each occurrence of the ST through SE segments on the remittance advice for paid and no paid claims. For carrier NSF, count the number of remittance advices sent to each provider. If a provider is sent both an electronic and a paper remittance advice for the same set of claims, count this as two advices, not one.

Line 8 – Number of Payments to Providers or Suppliers – report on the number of electronic fund transfers and paper checks issued to providers' bank accounts, not on the number of claims.

Line 9 – Dollar Amounts Associated with Payments (Dollar Amounts Reflected with Payments) – Report on the dollar amounts associated with those payments reported in line 8.

Line 10 – Claims Processed Data—Report on the number of electronic claims processed to completion for each column as detailed above. (The month in which a claim is considered to be "processed to completion" is defined as the month during which the scheduled payment date falls.)