Medicare
Intermediary Manual
Part 3 - Claims Process

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CHANGE REQUEST 1595

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
3893.3 - 3983.4	9-291 - 9-292 (2 pp.)	9-291 - 9-292 (2 pp.)
3893.4 (Cont.) - 3893.4 (Cont.)	9-295 - 9-296 (2 pp.)	9-295 - 9-296 (2 pp.)
3894.3 (Cont.) - 3894.4	9-298.1 - 9-298.4 (4 pp.)	9-298.1 - 9-298.4 (4 pp.)

NEW/REVISED MATERIAL--*EFFECTIVE DATE: REPORTING OCTOBER 2001 (REPORT DUE NOVEMBER 12, 2001)*
IMPLEMENTATION DATE: OCTOBER 1, 2001

Section 3893.3 - Type of Bill, adds bill types 3-2-2 and 3-3-2, Home Health Prospective Payment System (HH PPS) Requests for Anticipated Payment (RAPs), with dates of service 10/01/2000 and greater, to be reported under Column 5 Home Health Agency (HHA) on page one of Form HCFA-1566.

Section 3893.4 - Body of Report, (Initial Bill Processing Operation), clarifies that claims submitted by HHAs under the HH PPS with three-digit classification 3-2-9 or 3-3-9 are processed as adjustments to a previously submitted RAP record.

Section 3893.4 - Body of Report, (Adjustment Bills), points out that HH PPS RAPs are not to be reported as adjustments.

Section 3894.3 - Body of Report, (Claims Processing Timeliness - All Claims), adds HH PPS RAPs to list of bill types which are excluded from Claims Processing Timeliness reporting requirements.

Section 3894.7 - Body of Report, (Interest Payment Data), excludes from interest payment data those HH PPS RAPs with three-digit classification 3-2-2 or 3-3-2 with dates of service 10/01/2000 and greater.

These instructions should be implemented within your current operating budget.

DISCLAIMER: **The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.**

HCFA-Pub. 13-3

3893.3   Type of Bill.--Include provider bills in the following columns of the report:

Column   (1)   Total--All provider bills.

Column   (2)   Inpatient Hospital--HCFA-1450s submitted by hospitals for inpatient services with the following two-digit classification codes in item 4: 1-1 (inpatient hospital); and 4-1 (Christian Science Hospital- inpatient).

Column   (3)   Outpatient--HCFA-1450s submitted by hospitals or SNFs for outpatient services with the following two-digit classification codes in item 4: 1-3 (Hospital-outpatient); 2-3 (SNF-outpatient); 4-3 (Christian Science Hospital-outpatient); 5-3 (Christian Science-SNF-outpatient); and 8-3 (Hospital-outpatient-surgical procedures-ASC).

Column   (4)   SNF--HCFA-1450s with the following two-digit classification codes in item 4; 1-8 (hospital swing-bed); 2-1 (SNF-inpatient); 2-8 (SNF-swing bed); and 5-1 (Christian Science-SNF-inpatient).

Column   (5)   HHA--HCFA-1450s submitted by HHAs, with the following two-digit classification codes in item 4: 3-2 (HHA-Part B visits and use of DME); 3-3 (HHA-Part A visits and DME); 3-4 (HHA-Other-Part B benefits). Include HH PPS Requests for Anticipated Payment (RAPs) with three-digit classification code 3-2-2 or 3-3-2 with dates of service 10/01/2000 and greater in addition to claims in this column.

Column   (6)   Other--HCFA-1450s with the following two-digit classification codes in item 4:

> 1-2 (hospital inpatient-Part B benefits),
> 1-4 (hospital-Other-Part B benefits),
> 2-2 (SNF-inpatient-Part B benefits),
> 2-4 (SNF-Other-Part B benefits),
> 4-2 (Christian Science-inpatient-Part B benefits),
> 4-4 (Christian Science-inpatient-other),
> 5-2 (Christian Science-SNF inpatient-Part B benefits), 5-4 (Christian Science-SNF inpatient-other),
> 7-1, 7-2, 7-3, 7-4, 7-5 (Clinics-provider and independent RHCs, ESRD hospital-based or independent renal dialysis facilities, FQHCs, CMHCs, ORFs, and
> CORFS), and
> 8-1 and 8-2 (Hospices).

3893.4   Body of Report.--

SECTION A: INITIAL BILL PROCESSING OPERATION

Complete every type of bill column (1 through 6) for each reporting item as described below. Include data on all bills received for initial processing from providers (including all RHCs) directly or indirectly through a RO, another intermediary, etc. Also include data on demand bills and no-pay bills submitted by providers with no charges and/or covered days/visits. Do not include:

   o   Bills received from institutional providers if they are incomplete, incorrect, or inconsistent, and consequently returned for clarification. Individual controls are not required for them;

   o   Adjustment bills;

   o   Misdirected bills transferred to a carrier or another intermediary;

   o   HHA bills where no utilization is chargeable and no payment has been made, but which you have requested only to facilitate recordkeeping processes (There is no HCFA requirement for HHAs to submit no payment non-utilization chargeable bills.); and

   o   Bills paid by an HMO and processed by you.

Claims submitted by HHAs under the HH PPS with three-digit classification 3-2-9 or 3-3-9 are processed as adjustments to a previously submitted RAP record. However, count both HH PPS RAPs and claims as initial bills for this report. Do not exempt HH PPS claims as adjustments.

Opening Pending

Line 1--Pending End of Last Month.--The system will pre-fill the number pending from line 13 on the previous month's report.

Line 2--Adjustments.--If it is necessary to revise the pending figure for the close of the previous month because of inventories, reporting errors, etc., enter the adjustment. Report bills received near the end of the reporting month and placed under computer control sometime after the reporting month as bills received in the reporting month and not as bills received in the following month. In the event that some bills may not have been counted in the proper month's receipts, count them as adjustments to the opening pending in the subsequent month.

Enter on line 2 any necessary adjustments, preceded by a minus sign for negative adjustments, as appropriate.

Line 3--Adjusted Opening Pending.--The system will sum line 1 + line 2 to calculate the adjusted opening pending.

Receipts

Line 4--Received During Month.--Enter the total number of bills received for initial processing during the month.

Count all bills immediately upon receipt regardless of whether or not they are put into the processing operation with the exception of those discussed below.

SECTION B: ADJUSTMENT BILLS

This section includes data on the number of adjustment bills processed and pending for the reporting month, including those generated by providers, PROs, or as a result of MSP or other activity. In reporting adjustment bills, count only the number of original bills requiring adjustment, not both the debit and credit. The total PRO adjustment bills reported as processed on lines 18 and 23 must equal the number reported as processed on CROWD Form Z, Monthly PRO Adjustment Bill Report.

Claims submitted by HHAs under the HH PPS with three digit classification 3-2-9 or 3-3-9 are processed as adjustments to a previously submitted RAP record. However, both HH PPS RAPs and claims are counted as initial bills. Do not report HH PPS claims as adjustments.

Clearances

Line 17--Total CWF Processed (18+19+20+21).-- Report the number of adjustment bills processed through CWF during the month. Count adjustment bills as processed in final only when acceptance from CWF is received. Since §3664 precludes the processing of a utilization adjustment bill until CWF accepts the bill upon which the adjustment action is based, no utilization adjustment billing action may be processed until CWF has accepted the original bill.

Line 18--PRO Generated (CWF).--Report the number of adjustment bills included in line 17 which were generated by PROs.

Line 19--Provider Generated (CWF).--Report the number of adjustment bills included in line 17 which were generated by providers.

Line 20--MSP (CWF).-- Report the number of adjustment bills included in line 17 which were generated as a result of MSP activity.

Line 21--Other (CWF).--Report the number of adjustment bills included in line 17 which were generated by other than PROs, providers, or MSP activity. Include HMO adjustments where the HMO acted as an intermediary and made payment on the initial bill.

Line 22--Total Non-CWF Processed (23+24+25+26).-- Report the number of adjustment bills that you processed outside of CWF during the month. Count such adjustment bills as processed in final only when no further action is required.

If you receive an adjustment bill from a provider when the original bill is still in your possession, take the final adjustment action on the original bill before it is submitted to CWF. Count the adjustment bill as cleared when acceptance of the original bill is received from CWF.

Line 23--PRO Generated (Non-CWF).--Report the number of adjustment bills included in line 22 which were generated by PROs.

Line 24--Provider Generated (Non-CWF).--Report the number of adjustment bills included in line 22 which were generated by providers.

Line 25--MSP (Non-CWF).--Report the number of adjustment bills included in line 22 which were generated as a result of MSP activity.

Line 26--Other (Non-CWF).--Report the number of adjustment bills included in line 22 which were generated by other than PROs, providers, or MSP activity. Include HMO adjustments where the HMO acted as an intermediary and made payment on the initial bill.

Pending

Line 27--Total Pending (28+29+30+31).--Report the number of adjustment bills which were not processed to completion by the end of the reporting month.

Line 28--PRO Generated.--Report the number of adjustment bills included in line 27 which were not processed to completion by the end of the reporting month and which were generated by PROs.

Line 29--Provider Generated.--Report the number of adjustment bills included in line 27 which were not processed to completion by the end of the reporting month and which were generated by providers.

Line 30--MSP.--Report the number of adjustment bills included in line 27 which were not processed to completion by the end of the reporting month and which were generated by MSP activity.

Line 31--Other.--Report the number of adjustment bills included in line 27 which were not processed to completion by the end of the reporting month and which were generated by you or by a source other than PROs, providers, or MSP activity. Include HMO adjustments not processed to completion where the HMO acted as an intermediary and made payment on the initial bill.

SECTION C: MEDICAID CROSSOVER BILLS

This section presents data on the volume of Medicaid crossover bills sent to Medicaid State agencies or their fiscal agents.

Clearances

Line 32--Transmitted to State Agencies.--Enter the total number of Medicaid crossover bills transmitted to State agencies or their fiscal agents in the reporting month.

Line 33--Transmitted Electronically.--Enter the number of bills included in line 32 which were transmitted via electronic media to State agencies or their fiscal agents.

SECTION D: MISCELLANEOUS DATA

INQUIRIES

This section presents data on the volume of provider or beneficiary inquiries which were processed during the reporting month. Include only processed inquiries dealing with Medicare bill processing issues. These issues correspond to the workload budgeted under line 1 of the HCFA-1523 budget form.

Count inquiries as follows:

Beneficiary-Count one per contact (telephone, walk-in, or written), regardless of the number of bills being questioned. For example, if a letter from a beneficiary requests information on the status of one or more bills, count the response (interim or final) as one written beneficiary inquiry. Count each completed reply, terminated telephone conversation, or in-person discussion as processed, regardless of the need for subsequent contact on the same issue. Responses resulting from additional intermediary followup or analysis, or from recontacts by the beneficiary, are separate inquiries. Beneficiary inquiries include those made by anyone on behalf of the beneficiary, except by a provider.

o   Bills received from institutional providers if they are incomplete, incorrect, or inconsistent and consequently returned for clarification. Individual controls are not required for these bills;

o   Adjustment bills;

o   Misdirected bills transferred to a carrier or another intermediary;

o   HHA bills where no utilization is chargeable and no payment has been made, but which you have requested only to facilitate recordkeeping processes. (There is no HCFA requirement for HHAs to submit no payment non-utilization chargeable bills);

o   Bills paid by an HMO and processed by you; and

o   HH PPS RAPs with three-digit classification code 3-2-2 or 3-3-2 with dates of service 10/01/2001 and greater.

Apart from these exceptions, include in the report all bills (including PIP, EMC, provider and independent RHC, as well as HMO bills paid by you) processed to completion (i.e., paid bills, complete denials, and no payment bills) in the reporting month. Report bills in the month the scheduled date of payment falls. See §3600.1 for the definition of scheduled payment date for all bills, including PIP and no payment bills. "Clean" bills are those which do not require investigation or development <u>external</u> to your operation on a prepayment basis. Bills which do not meet the definition of "clean" are "other" bills. See §3600.1 for examples of "clean" and "other." Bills paid are those for which some payment was made (i.e., payment greater than zero). Bills not paid are those for which no payment was made (i.e., bill charges applied completely toward deductible or fully denied).

On each page 2-11 (there is a separate page for each type of bill category listed below), report:

o   In column 1, the total number of bills processed to completion;

o   In column 2, the number of "non-PIP clean" bills paid;

o   In column 3, the number of "non-PIP other" bills paid;

o   In column 4, the number of "PIP clean" bills paid;

o   In column 5, the number of "PIP other" bills paid;

o   In column 6, the number of "clean" bills not paid;

o   In column 7, the number of "other" bills not paid; and

o   In column 8, the number of "clean" and "other" bills processed to completion, which were received via electronic media from providers or their billing agencies and read directly into your claims processing system. Do not count on this line bills that you received in hardcopy and entered using an OCR device. Do not count any bills received in hardcopy and transformed into electronic media by any entity working for you directly or under subcontract.

For each category, show the number processed to completion on the line corresponding to the number of days from receipt by you to the scheduled date of payment or other final action, if a no-pay bill. See §3600.1C for definition of receipt date.

NOTE: For bills received by tape, the date you receive the tape should be used as the receipt date and not the date the tape passes the edits.

To calculate the processing time for a claim, subtract the Julian receipt date from the processed to completion Julian date. When the processed to completion date falls in the year following the year of receipt, add to the Julian date of completion 365 (or 366 if the year of receipt is a leap year). If a claim is processed to completion on the same day it is received, the processing time is one day. This definition applies to all lines of the report, including line 39.

On line 39 report the mean processing time (PT) to one decimal place for each column. To calculate the mean PT, add the processing times for all the bills shown in lines 1-37 of that column and divide by line 38. Do not use the categories on the report to calculate the mean PT. Because of the aggregation of claims in lines 34-37, you must use the processing times for the individual claims as explained below to make this calculation.

Mean Processing Time Calculation for All Claims

o   Subtract the Julian date of receipt from the Julian date of payment (or equivalent action for those not paid) for each claim.

o   Sum the result for each claim into a total number of days for all claims.

o   Divide this result by the total number of claims.

o   Round to one decimal place.

EXAMPLE:

Claim	Julian Date Receipt	Paid	Counter by Days	Counter by Claims
A	91103	91133	30	1
B	91105	91206	101	2
C	91115	91177	62	3
D	91120	91213	93	4
E	91122	91215	93	5
F	91130	91223	93	6

Total Days = 30 + 101 + 62 + 93 + 93 + 93 = 472

Mean = 472/6 = 78.6666 = 78.7

Complete the report for each bill type:

o   Inpatient Hospital--Of the bills reported on the "All Claims" page, show on page 2 data on the number of HCFA-1450s submitted by hospitals for inpatient services with the following two-digit classification codes in item 4: 1-1 (inpatient hospital); and 4-1 (Christian Science Hospital-inpatient),

o   Outpatient--Of the bills reported on the "All Claims" page, show on page 3 data on the number of HCFA-1450s submitted by hospitals and SNFs for outpatient services with the following two-digit classification codes in item 4:   1-3 (hospital-outpatient); 2-3 (SNF-outpatient); 4-3 (Christian Science Hospital-outpatient); 5-3 (Christian Science SNF-outpatient); and 8-3 (hospital-outpatient surgical procedures - ASC),

o   SNF--Of the bills reported on the "All Claims" page, show on page 4 data on the number of HCFA-1450s with the following two-digit classification codes in item 4:   1-8 (hospital swing-bed); 2-1 (SNF-inpatient); 2-8 (SNF-swing-bed); and 5-1 (Christian Science SNF-inpatient),

o   HHA--Of the bills reported on the "All Claims" page, show on page 5 data on the number of HCFA-1450s with the following two-digit classification codes in item 4: 3-2 (HHA-Part B visits and use of DME); 3-3 (HHA-Part A visits and DME); and 3-4 (HHA-other-Part B benefits),

o   Hospice--Of the bills reported on the "All Claims" page, show on page 6 data on the number of HCFA-1450s with the following two-digit classification codes in item 4: 8-1 and 8-2 (Hospice),

o   CORF--Of the bills reported on the "All Claims" page, show on page 7 data on the number of HCFA-1450s with the following two-digit classification codes in item 4: 7-4 (Other Rehabilitation Facility) and 7-5 (Comprehensive Outpatient Rehabilitation Facility),

o   ESRD--Of the bills reported on the "All Claims" page, show on page 8 data on the number of HCFA-1450s with the following two-digit classification codes in item 4: 7-2 (hospital-based or independent renal dialysis facilities),

o   Lab (All referred outpatient diagnostic services)--Of the bills reported on the "All Claims" page, show on page 9 data on the number of HCFA-1450s with the following two-digit classification codes in item 4: 1-4 (Hospital-Other-Part B benefits); and 2-4 (SNF-Other-Part B benefits),

o   Other--Of the bills reported on the "All Claims" page, show on page 10 data on the number of HCFA-1450s not included in the previous eight bill categories, including provider and independent RHC bills, and

o   All Claims--On page 11 include all bills processed to completion during the reporting month.

SECTION E(2): CLAIMS PROCESSING TIMELINESS--EMC CLAIMS AND ADJUSTMENTS FOR CPEP CPT CALCULATIONS

Pages 12-21 of the HCFA-1566 include data on the non-PIP bills paid during the month that were received via electronic media. The basic instructions and definitions that apply to pages 2-11 (see above) also apply to pages 12-21. For each bill type, report the following information:

o   Column 1--Report the number of EMC claims that were included in column 2 (paid non-PIP clean) for the corresponding bill type on pages 2-11.

o   Column 2--Report the number of EMC claims that were included in column 3 (paid non-PIP other) for the corresponding bill type on pages 2-11.

For each bill type on pages 12-21, report the following adjustments for CPEP CPT calculations:

CWF--Claims which were beyond your control due to CWF. (See §3600.1 for definition of claims meeting this criteria.)

    A.   The number of EMC non-PIP clean claims paid beyond the EMC ceiling.
    B.   The number of paper non-PIP clean claims paid beyond the paper ceiling.
    C.   The number of all claims processed beyond 60 days.

WAIVER--Non-PIP claims paid under the claims payment floor for which you had a waiver from HCFA.

    D.   The number of EMC non-PIP clean claims paid under the EMC floor.
    E.   The number of paper non-PIP clean claims paid under the paper floor.
    F.   The number of EMC non-PIP claims (clean and other) paid under the EMC floor plus the number of paper non-PIP claims (clean and other) paid under the paper floor.

3894.4 COMPLETING PAGE 22 OF INTERMEDIARY WORKLOAD REPORT

3894.5   Heading.--This page is referenced as Form W in the CROWD system. Complete the ADD/UPDATE/DELETE DATA criteria screen with the appropriate information to bring the reporting format to your screen.

3894.6   Checking Reports.--Before transmitting page 22 to HCFA, check its completeness and arithmetical accuracy. Use the following checklist:

    o   For each column, line 1 must equal the sum of lines 2-10.

    o   For each column, line 11 must equal the sum of lines 12-20.

    o   For each line, column 1 must equal the sum of columns 2-6.

3894.7   Body of Report.--

SECTION F: INTEREST PAYMENT DATA

Report on Page 22 of the HCFA-1566 data on the bills on which you paid interest because you paid the bills after the required payment date per §9311 of the Omnibus Budget Reconciliation Act of 1986. Counts of bills processed reflect their status as of the last workday of the reporting calendar month. Base data shown on reliable counts of all bill processing activity and not on estimates. Report data on initial bills only. Note that HH PPS RAPs with three-digit classification code 3-2-2 or 3-3-2 with dates of service 10/01/2000 and greater are not subject to interest payment and should be excluded from this section. Include all bills requiring interest payments in the month. Report bills in the month the scheduled date of payment falls. See §3600.1 for a discussion of interest payments and the definition of scheduled payment date.

Complete the report for each column as follows:

    o   Column 1 - Total--Include data for all bills for which interest payments were made in the reporting month.

    o   Column 2 - Hospital--Of the bills reported in column 1, show in column 2 data for HCFA-1450s submitted by hospitals for inpatient or outpatient services with the following two-digit classification codes in item 4: