CMS Manual System

Pub. 100-06 Medicare Financial Management

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

Transmittal 40 **Date: APRIL 30, 2004**

CHANGE REQUEST 3257

I. SUMMARY OF CHANGES: This instruction adds a line to the monthly Medicare Contractor Transaction report submitted to the CMS Contractor Reporting of Operational and Workload Data (CROWD) system by fiscal intermediaries and carriers which will require them to breakout the number of electronic media bills/claims processed each month into three (3) categories: HIPAA EMC, DDE EMC, and non-HIPAA EMC.

NEW/REVISED MATERIAL - EFFECTIVE DATE: 10/01/2004
***IMPLEMENTATION DATE: 10/04/2004**

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
R	6/450.4/Exhibit 1

III. FUNDING:

These instructions shall be implemented within your current operating budget.

IV. ATTACHMENTS:

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

***Medicare contractors only**

Attachment - Business Requirements

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SUBJECT: Modification of CROWD Form 5

I. GENERAL INFORMATION

A. Background:

Fiscal intermediaries (FIs) and carriers are required to submit monthly workload data to the CMS Contractor Reporting of Operational and Workload Data (CROWD) system. One of the data elements reported is a breakout of the number of bills/claims, which are received via electronic media.

The Health Insurance Portability and Accountability Act (HIPAA) requires that claims submitted electronically, effective October 16, 2003, be in a format that complies with the appropriate standards adopted for national use. Currently, it is not possible for CMS to determine how many processed electronic media bills/claims are HIPAA compliant through workload data submitted to the CROWD system. Although bills/claims submitted via direct data entry (DDE) where supported by a intermediary or carrier are considered to be HIPAA-compliant electronic claims, CMS needs to be able to determine the number of such processed bills/claims separately from the number which are HIPAA compliant based on the national standard.

B. Policy:

Summary of Changes*:*

The purpose of this change request is to provide a means to identify the number of electronic media bills/claims processed to completion by FIs and carriers broken out into three (3) separate categories (HIPAA-compliant X12 837 version 4010.A.1 and NCPDP claims transactions, DDE submitted bills/claims, & non-HIPAA compliant claims transactions). This will be achieved by adding a new line to the existing Monthly Medicare Contractor Transaction Report (CMS CROWD Form 5) to capture these breakouts of processed electronic claims.

C. Provider Education: None.

II. BUSINESS REQUIREMENTS

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

Requirement #	Requirements	Responsibility
3257.1	Medicare systems shall revise their data reporting capabilities to allow separate workload counts of the number of electronic media bills/claims, which are processed to completion each month, broken out into: (1) Those claims which were processed as electronic X12 837 version 4010.A.1 and NCPDP bills/claims transactions, (2) Those processed bills/claims submitted via Direct Data Entry (DDE), and (3) Those processed bills/claims which were 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.	All contractors and shared system maintainers
3257.2	CMS shall modify the CROWD system and the Contractor Management Information System (CMIS) monthly Medicare Contractor Transaction Report (CMS Form 5) to allow data collection and extraction of processed electronic Media bills/Claims separated into the above designated categories.	CROWD/CMIS system maintainers

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: Contractor financial reporting will not be affected by this proposed change. Workload reporting will be impacted since the change will be made specifically to the CROWD system.

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date: October 1, 2004 **Implementation Date:** October 4, 2004 **Pre-Implementation Contact(s):** James Krall, jkrall@cms.hhs.gov, or (410) 786-6999, Robert Pruim, rpruim@cms.hhs.gov, or (410) 786-8872 **Post-Implementation Contact(s):** James Krall, *jkrall@cms.hhs.gov*, or (410) 786-6999, Robert Pruim, *rpruim@cms.hhs.gov*, or (410) 786-8872	These instructions shall be implemented within your current operating budget.

450.3 – Body of Report

(Rev. 40, 04-30-04)

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.*

- *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.)*

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.)

450.4 – Exhibit 1

(Rev. 40, 04-30-04)

MEDICARE CONTRACTOR TRANSACTIONS
(CROWD FORM 5)

CONTRACTOR NUMBER_____ REPORT PERIOD_____

TYPE OF TRANSACTION	ELECTRONIC (1)	NON-ELECTRONIC (MANUAL PROCESSES) (2)
1. REPSONSES TO CLAIMS STATUS INQUIRY		
2. RESPONSES TO ELIGIBILITY STATUS INQUIRY		
3. OUTGOING COB CLAIMS PROCESSED (INCLUDE MEDIGAP, NOT NCPDP)		
DMERC ONLY:		
4. PRIOR AUTHORIZATION REQUESTS OR ADVANCED DETERMINATION OF MEDICARE COVERAGE		
5. NCPDP FOR RETAIL PHAR. DRUG CLAIMS PROCESSED		
6. OUTGOING COB NCPDP FOR RETAIL PHARMACY DRUG CLAIMS PROCESSED (INCLUDING NCPDP MEDIGAP)		
7. REMITTANCE ADVICES—NUMBER SENT		
8. # OF PAYMENTS TO PROVIDERS OR SUPPLIERS		
9. DOLLAR AMOUNTS ASSOCIATED W/ PAYMENTS (DOLLAR AMOUNTS REFLECTED W/ PAYMENTS)		

PROCESSED CLAIMS DATA	*HIPAA 837 & NCPDP (1)*	*DDE (2)*	*NON-HIPAA Format EMC (3)*
10. CLAIMS PROCESSED			