Medicare
Carriers Manual
Part 3 - Claims Process

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

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CHANGE REQUEST 2151

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
13302.3 (Cont.) - 13305	13-197 - 13-198 (2 pp.)	13-197 -13-198 (2 pp.)
13311	13-202.1 (1 p.)	13-202.1 (1 p.)

NEW/REVISED MATERIAL--*EFFECTIVE DATE: July 22, 2002*
IMPLEMENTATION DATE: July 22, 2002

Section 13302.4 - Part C--Miscellaneous Claims Data, is revised to add new instructions for reporting data on Medicare Summary Notices (MSNs); Line 31--Total Number of MSNs Mailed.

Section 13311 - Exhibits, Exhibit 1 is revised to reflect the addition of Line 31 as described above.

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.

Count inquiries as follows:

Beneficiary--Count one inquiry per contact (telephone, written, walk-in), regardless of how many claims the beneficiary inquires about. For example, if a beneficiary writes you about the status of two claims, count the response as one beneficiary written inquiry. Count responses to re-contacts made by that beneficiary as an additional inquiry. Count any inquiry made by a beneficiary, or by anyone on behalf of the beneficiary, except a provider.

Provider--Count one inquiry per contact. For example, if a provider calls or writes you regarding the status of 10 claims, count the response as one provider-written or phone inquiry. Count any inquiry made by a provider, or anyone on behalf of the provider, except a beneficiary. Count inquiries regardless of whether they relate to assigned or unassigned claims.

Count beneficiary and provider inquiries as follows:

- Count Medicare inquiries directed to you for a response if they are requests for information from beneficiaries or providers (physicians/suppliers) or their representatives.

- Do not count, as inquiries, professional relations activities and contacts (i.e., your training programs for providers on new requirements).

- Count voice inquiries captured electronically as telephone inquiries, and electronic mail inquiries as written inquiries. Do not count electronic inquiries if the provider can access your system to determine claim status without your involvement.

- Do not count inquiries related specifically to the physician fee freeze or MSP. (This is to achieve comparability with the HCFA-1524 budget form, where all costs related to the fee freeze and MSP are reported on separate lines.)

- Count congressional inquiries in the appropriate category (i.e., as a beneficiary inquiry if made on behalf of a beneficiary, and as a provider inquiry if made on behalf of a provider).

- Count inquiries made by the RO or the SSA DO in the appropriate category if the inquires are on behalf of a beneficiary or a provider and relate to a specific claim. Do not count the inquiries if they are of a general nature (i.e., ongoing liaison necessary during monitoring of day-to-day operations).

- Do not count Part A inquiries if you handle all Part A inquiries for an intermediary on a routine basis. In this case, charge the related costs to the intermediary. Do not include the volume of work on the HCFA-1565.

- Count misdirected telephone inquiries (i.e., those that must be referred to another source for response) as processed telephone inquiries. Do not count misdirected written inquiries.

- Do not count requests for reviews or hearings as inquiries. (See §12010 for definitions of reviews and hearings.) Report reviews and hearings on the HCFA-2590, not on the HCFA-1565.

- Do not count reopenings and revisions. For example, if a claim is denied for lack of information after the appropriate suspense period, and the physician/supplier or beneficiary submits the missing information, do not count any actions taken subsequently. (See §12100 for definitions of reopenings and revisions.)

Report the number of inquiries from beneficiaries (column 2) and providers (column 3) as follows:

Line 24. Total Number Processed During Month.--Enter the total number of inquiries processed during the month. Do not report the number of inquiries received.

Line 25. Telephone.--Report the number of telephone inquiries processed during the month.

Line 26. Walk-in Contact.--Report the number of walk-in inquiries processed during the month.

Line 27. Written.--Report the number of written inquiries responded to during the month.

13302.4 Part C--Miscellaneous Claims Data.--

Medicaid Crossover Claims--This part of the report represents data on the volume of Medicaid crossover claims.

Line 28. Number Transferred to State Agencies.--Enter the total number of Medicaid crossover claims transferred to State agencies or their fiscal agents in the reporting month.

Line 29. Number Transferred Electronically.--Enter the total number of Medicaid crossover claims reported in line 28 which were transferred in the reporting month to State agencies, or their fiscal agents, via electronic media.

Optical Character Recognition Claims

Line 30. Total Claims.--Enter the number of claims that you received in hardcopy and entered using an OCR device. Do not count these claims as EMC claims on line 7, page 1, or in column 6, pages 2-9.

Medicare Summary Notices (MSN)

Line 31. Total MSNs Mailed--Enter the number of MSNs you mailed to beneficiaries during the reporting month.

13305. COMPLETING PAGES TWO THROUGH ELEVEN OF THE CARRIER PERFORMANCE REPORT

13305.1 Heading.--These pages are referenced as Form T (pages 2-9) and Form E (pages 10-11) in the CROWD system. Complete the ADD/UPDATE/DELETE DATA criteria screen with the appropriate information to bring the reporting format to your screen.

13306 Part D(1) - Claims Processing Timeliness--All Claims.--Pages 2-9 of the HCFA-1565 include data on your activity in processing all claims to completion during the reporting period. See functional standard 11 in §5420, Part 2, for definition of completion date for paid claims. For non-paid claims, the date of completion is the date the EOMB or other notice of final action on the claim is mailed. Data shown must be based on reliable counts of all claims (real and replicate) processing activity. Do not estimate claim counts. Report only data relating to initial claims (real and replicate) actions. Do not report data on requests for, or dispositions of, reviews, hearings, or reopenings of initial claim actions.

13311. EXHIBITS

EXHIBIT 1

MEDICARE PROGRAM CARRIER PERFORMANCE REPORT- Page 1

Carrier	**Number**	**Report Period (Month/Yr)**	**Working Days**
	Number and Type of Claim		
Reporting Item	**Total** (1)	**Assigned** (2)	**Unassigned** (3)
A. **Monthly Workload Operations**			
OPENING PENDING			
1. Claims Pndg End of Last Mo.			
2. Adjustments (Show + or -)			
3. Adjusted Opening Pending			
RECEIPTS			
4. Tot. Clms. Rcvd. During Mo.			
5. Transferred to Other Carrier			
6. Net Number of Claims Received			
7. Electronic Media Claims Recvd.			
CLAIMS PROCESSED			
8. Total CWF Claims			
9. Claims Paid			
10. Claims Applied To Deductible			
11. Claims Denied			
12. Total Non-CWF Claims			
13. Claims Approved			
14. Claims Denied			
15. Total Claims Processed			
16. Replicate Claims Processed			
CLOSING PENDING			
17. Claims Pending at End of Month			
DISTRIBUTION OF DAYS ELAPSED SINCE RECEIPT			
18. 1 - 15 Days			
19. 16 - 30 Days			
20. 31 - 60 Days			
21. 61 - 90 Days			
22. Over 90 Days			
CLAIMS INVESTIGATIONS			
23. No. of Clms. Invest. During Mo.			
B. **INQUIRIES**	**TOTAL**	**BENEFICIARY**	**PROVIDER**
24. Tot. No. Processed During Mo.			
25. Telephone			
26. Walk-In Contact			
27. Written			
C. **MISCELLANEOUS CLAIMS DATA**			
MEDICAID CROSSOVER CLAIMS			
28. No. Transferred to St. Agencies		**MSN Data**	
29. No. Transferred Electronically		31. No. Mailed	
OPTICAL CHARACTER			
30. Total Claims			

Form HCFA-1565