Program Memorandum Carriers

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

Transmittal B-02-079 **Date: NOVEMBER 1, 2002**

CHANGE REQUEST 2249

SUBJECT: Contractor Reporting of Operational and Workload Data (CROWD) for Electronic Data Interchange (EDI and Manual Transactions

Beginning April 1, 2003, the CMS operated CROWD system will be ready to accept reporting on the use of several EDI transactions via the attached Form 5. You will access the CROWD system and report into Form 5 on transaction frequency.

Report data into CROWD Form 5 beginning with your April 2003 workload by May 15, 2003. The HCFA Part B Standard System (HPBSS) and its carriers are exempt until the carriers transition to the MCS system. Reporting is required by the 15th day of each month for the prior month's workload. Once in the CROWD system, complete the ADD/UPDATE/DELETE DATA criteria screen with the appropriate information to bring the reporting format to your screen. Complete a Form 5 for each of your offices assigned a separate intermediary or carrier number as you do currently.

Monthly reporting is required for a particular electronic transaction in Column 1, once it is implemented in production. However, reporting for column 2 must begin May 15, 2003.

The *effective date* for this Program Memorandum (PM) is April 1, 2003.

The *implementation date* for this PM is April 1, 2003.

These instructions should be implemented within your current operating budget.

This PM may be discarded after April 1, 2004.

If you have any questions, contact James Krall at (410) 786-6999.

Attachment

Form 5.

MEDICARE CONTRACTOR TRANSACTIONS

MONTHLY REPORT

Type of Transaction	Electronic (1)	Non-Electronic (Manual Processes) (2)
Response to Claim Status Inquiry		
Response to Eligibility Status Inquiry		
Outgoing Coordination of Benefit (COB) Claims Processed (includes Medigap, does not include NCPDP)		
DMERC only--Prior Authorization Requests (Durable Medical Equipment Regional Carriers or Advance Determination of Medicare Coverage (DMERCs only)		
National Council of Prescription Drug Plans (NCPDP) for Retail Pharmacy Drug Claims Processed DMERC only)		
DMERC only--Outgoing COB NCPDP for Retail Pharmacy Drug Claims Processed (including NCPDP Medigap)		
Remittance Advices—Number Sent		
Number of Payments to Providers or Suppliers		
Dollar Amounts Associated with Payments (Dollar Amount Reflected with Payments)		

NOTES:

Do not complete shaded areas.

For column 1, 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).

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 on manual inquiry responses as cited in MCM 13302.2 and 13302.3.

For claims status, 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 276/277, use TRN02).

For eligibility status, 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.

For outgoing COB Claims Processed, count each unique occurrence of the patient control number as assigned by the provider (e.g., in the 837, use CLM01). Alternately, you may count each unique occurrence of the patient's HIC number.

For Prior Authorization Requests or Advance Determination of Medicare Coverage (ADMC), count each unique occurrence of an individual beneficiary HIC number in a valid request.

For NCPDP, count each unique occurrence of an individual beneficiary HIC number in the claim.

For outgoing NCPDP COB, count each unique occurrence of an individual beneficiary HIC number.

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. For paper, 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 remittance advices not one.

For number of payments, report on the number of electronic funds transfers and paper checks issued to providers' bank accounts, not on the number of claims.

Report on the dollar amounts associated with those payments.