Medicare
Intermediary Manual
Part 3 - Claims Process

Department of Health and Human Services (DHHS)
HEALTH CARE FINANCING ADMINISTRATION (HCFA)

Transmittal 1837 **Date: JUNE 21, 2001**

CHANGE REQUEST 1687

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
3898.1 – 3898.9	9-301 – 9-305 (5 pp.)	9-301 – 9-306 (6 pp.)
3898.14 - 3898.14 (Cont.)	9-308.1 – 9-308.2 (2 pp.)	9-308.1 – 9-308.2 (2 pp.)

NEW/REVISED MATERIAL--*EFFECTIVE DATE: Reporting Quarter of October - December 2001 (Report due January 15, 2002)*
IMPLEMENTATION DATE: October 1, 2001

Section 3898.2, Checking Reports, provides revised edits for the quarterly supplement to the Intermediary Workload Report, HCFA-1566A, page 3, to coincide with report changes made in §3898.4.

Section 3898.4, Body of Report, eliminates the breakout reporting of denials by type of denial: Medical Subject to Waiver, Medical-Not Subject to Wavier, and Nonmedical. Reporting of denial data for the sum of these three categories will continue to be required.

Section 3898.14, Quarterly Supplement to the Intermediary Workload Report - HCFA-1566A, Pages 1, 2, and 3, reflects changes made in §3898.4 by crossing out data fields no longer required beginning with the above effective date.

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.

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).

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, FQHCs, ESRD hospital-based or independent renal dialysis facilities, FQHCs, CMHCs, ORFs and CORFs); and 8-1 and 8-2 (Hospices).

3897.4 Body of Report.--

Section A: Bills Processed by State of Provider.--Report in this section the claims workload for each State for which you service one or more providers. Break out by State the number of initial bills (including demand and no-pay bills) reported as processed on line 12 of Form D (see §3893.4) over the 3 months of the reporting quarter.

NOTE: Categorize the information reported by the State of the individual provider, not the home office, if it is part of a chain organization.

Line 1--All.--For each column 1 through 6, the system will sum the number of claims reported on the individual State lines completed below. The numbers so calculated by the system must equal the sum of the numbers reported on line 12 of Form D for the 3 months of the reporting quarter.

State Lines.--In the column just left of column (1), enter the two-digit postal abbreviation of each State (or FO for foreign claims) which includes at least one provider for which you processed claims during the quarter.

Enter opposite each listed State the number of initial bills processed during the reporting quarter for providers located in the State. Report the data in total in column 1, and by type of bill in columns 2 through 6.

3898. COMPLETING QUARTERLY SUPPLEMENT TO THE INTERMEDIARY WORKLOAD REPORT, HCFA-1566A, PAGE 3

3898.1 Heading.--This page is referenced as Form I in the CROWD system. Complete the ADD/UPDATE/DELETE DATA criteria screen with the appropriate information to bring the reporting format to your screen.

3898.2 Checking Reports.--Before submitting Form I to HCFA, check for completeness and arithmetical accuracy. Use the following checklist:

- o For all columns, line 1 + line 7 + line 8 must be equal to or less than line 1 of Form C.
- o For all columns, line 1A + line 1B + line 1C must equal line 1.
- o For all columns, line 1D must be equal to or less than line 1C.
- o For all columns, line 2A must be equal to or less than line 1A.
- o For all columns, line 2A must be equal to or less than line 2.
- o For all columns, line 3A must be equal to or less than line 3.
- o For all columns, line 7A must be equal to or less than line 7.
- o For all columns, line 8B must be equal to or less than line 8.
- o For all columns, lines 3 and 3A must be rounded to whole dollars.

NOTE: This may cause you to force column 1 to equal the sum of columns 2-6.

- o For lines 7 and 7A, and lines 8 and 8B, column 1 must equal the sum of columns 2-6.
- o For columns 4 and 5, line 4 must be equal to or greater than line 1 of Form C.
- o For columns 4 and 5, line 5A + 5B + 5C must equal line 5.
- o For columns 4 and 5, line 6A must be equal to or less than line 5A.
- o For columns 4 and 5, line 6A must be equal to or less than line 6.
- o For columns 4 and 5, line 7B must be equal to or greater than line 7A.
- o For columns 4 and 5, line 8A must be equal to or greater than line 8.
- o For columns 4 and 5, line 5 + line 7B + line 8A must be equal to or less than line 4.

3898.3 Type of Bill.--Report counts in total and by type of bill as outlined in '3897.3 for Form C.

3898.4 Body of Report.--

Section B: Bill Denial Data.--

Line 1: Bills Denied-Total.--Report all full and partial denial determinations that you made during the reporting period. Report only denial determinations resulting in your preparing and sending a notice to the beneficiary. Count a denial when you deny (either in full or in part) bills submitted as covered. Include counts where you made a denial determination but found both the beneficiary and the provider to be without fault under § 213 of Public Law 92-603 and, therefore, made a determination to waive liability in full.

Also, include counts when you found only the provider to be at fault (i.e., you waived the beneficiary's liability). Do not count:

- o Denials of no-pay or demand bills even though you send a denial notice.
- o Denials of future services.
- o Denials made by PROs.

Line 2: Bills Paid Under Waiver-Total.--Report the total number of bills on which you made a determination to waive the liability of both the beneficiary and the provider. Count determinations made at:

- o Initial bill processing,
- o Appeals process, and
- o Any other time such as when you reopen your initial decision.

Do not count waiver determinations made by PROs.

Line 2A: Initial Bills Paid Under Waiver.--Report the number of bills on which you made a decision to waive the liability of both the beneficiary and the provider during the initial adjudication of the bills.

Line 3: Amount Reimbursed Under Waiver.--Report the amounts paid (to the nearest dollar) under the waiver provision for the bills reported on line 2. Do not include coinsurance amounts, charges applied toward the deductible, or reimbursement for services not under consideration with respect to the waiver provision. Where all services on a bill are paid in full (excluding the applicable deductible and coinsurance) as a combination of covered services and noncovered services paid under waiver and the exact dollar amount of the waiver payment is not available without contacting the provider, report an approximation of the waiver payment. In calculating this approximation, apply to total charges the proportion of waiver days to total days included on the bill, and subtract any applicable deductible or coinsurance for the waiver period.

Line 3A: Amount on Initial Bills.--Report the amounts paid (to the nearest dollar) under the waiver provision for the bills reported on line 2A.

Section C: Day/Visit Data.--

Line 4: Days/Visits Processed.--Report under column 4 the total number of days (both covered and noncovered) for SNF bills shown as processed in column 4, line 1 of Form C, for the same reporting period. Report under column 5 the number of billed visits for HHA bills shown as processed in column 5, line 1 of Form C, for the same reporting period.

Line 5: Days/Visits Denied-Total.--Report under column 4 the number of SNF days denied on the bills reported on line 1. Report under column 5 the number of HHA visits denied on the bills reported on line 1. Denied days/visits are those billed as covered which you determine to be noncovered.

Line 6: Days/Visits Paid Under Waiver of Liability.--Report under column 4 the number of SNF days on the bills reported on line 2 that were paid under the waiver provision. Report under column 5 the number of HHA visits on the bills reported on line 2 that were paid under the waiver provision.

Line 6A: Days/Visits Paid Under Waiver on Initial Bills.--Report under column 4 the number of SNF days on the bills reported on line 2A that were paid under the waiver provision. Report under column 5 the number of HHA visits on the bills reported on line 2A that were paid under the waiver provision.

Section D: Demand Bill Data.--

Line 7: Total Demand Bills.--Report under the appropriate column bills which the provider determined to be for noncovered services but which the beneficiary or his representative requested be filed in order to obtain a Medicare decision. Report only bills identified by condition code 20. (See § 3604.) Report the total number of bills processed during the reporting quarter, even if not manually reviewed.

Line 7A: Full/Partial Reversals.--Report the number of demand bills on which you fully or partially reversed the provider's decision that the services were noncovered.

Line 7B: Days/Visits on Reversals.--Report under column 4 the number of SNF days on the demand bills reported on line 7A. Report under column 5 the number of HHA visits on the demand bills reported on line 7A (i.e., report days/visits for which you fully or partially reversed the provider's decision that they were noncovered).

Section E: No-Pay Bill Data.--

Line 8: Total No-Pay Bills.--Report under the appropriate column the total number of no-pay bills (excluding the demand bills reported on line 7 Section D) which are included in the total bills processed reported on line 1, page 1 of the Quarterly Supplement for the same reporting period. No-pay bills are those submitted by providers with no charges and/or covered days/visits. Do not report HHA bills where no utilization is chargeable and no payment has been made, but which you have requested only to facilitate recordkeeping processes.

Line 8A: Days/Visits on No-Pay Bills.--Report under column 4 the number of SNF days on the no-pay bills reported on line 8. Report under column 5 the number of HHA visits on the no-pay bills reported on line 8.

Line 8B: MSP No-Pay Bills.--Report the number of no-pay bills included on line 8 where payment has been made in full by another insurer as primary payer.

3898.5 Completing Medicare Fraud Unit Quarterly Workload Status Report, HCFA-1566B -- General.--Prepare and submit to HCFA each quarter a report on the number of fraud workload items handled by your Medicare fraud unit. This information is required by HCFA to budget for fraud and abuse activities, as well as to monitor the flow of work through the fraud units. Submit this form via the CROWD system no later than the 15th day following the close of the reporting quarter.

3898.6 Heading.--This page is referenced as Form M in the CROWD system. Complete the ADD/UPDATE/DELETE DATA criteria screen with the appropriate information to bring the reporting format to your screen.

3898.7 Checking Reports.--Before submitting Form M to HCFA, check for completeness and arithmetical accuracy. Use the following checklist:

- For all columns, line 1 must equal line 8 of Form M for the previous quarter.
- For all columns, line 1 + line 2 = line 3.
- For all columns, line 6 + line 7 = line 5.
- For all columns, line 3 + line 4 - line 5 = line 8.
- For all lines, column 1 = column 2 + column 3 + column 4.

3898.8 Type of Fraud Workload Item.--Report fraud workload items in the following columns for all lines of Form M:

Column (1) - Total.--All fraud workload items.

Column (2) - Beneficiary Complaints.-- Report the number of complaints received from, or on behalf of, beneficiaries alleging fraud. Do not include complaints filed with the Office of the Inspector General (OIG) Hotline.

Column (3) - OIG Hotline.--Report the number of complaints received via the OIG Hotline.

Column (4) - Referrals and Other.--Report referrals and any other workload received by the fraud unit (e.g., provider complaints, internally generated referrals from medical review, special requests from OIG or HCFA).

3898.9 Body of Report.--

Line 1 - Opening Pending.--The system will pre-fill the number pending from line 8 of the previous quarter's report.

3898.14 Quarterly Supplement to the Intermediary Workload Report - HCFA-1566A, Pages 1,2, and 3.--

QUARTERLY SUPPLEMENT TO INTERMEDIARY WORKLOAD REPORT
HFCA-1566A, PAGES 1 & 2 (CROWD FORM C)

INTERMEDIARY NUMBER_____ REPORT PERIOD_____

	SECTION A: BILLS PROCESSED BY STATE OF PROVIDER	TOTAL 1	INP HOSP 2	OUTPATIENT 3	SNF 4	HHA 5	OTHER 6
1.	TOTAL--ALL						
	STATE CODE	XXXXXXX XXXX	XXXXXX XXX	XXXXXXXXX XXX	XXX X	XXX XX	XXXX XX

QUARTERLY SUPPLEMENT TO INTERMEDIARY WORKLOAD REPORT
HFCA-1566A, PAGE 3 (CROWD FORM I)

INTERMEDIARY NUMBER_____ REPORT PERIOD_____

	TOTAL 1	INPATIENT 2	OUTPATIENT 3	SNF 4	HHA 5	OTHER 6
SECTION B: BILL DENIAL DATA	XXXXXX	XXXXXXXX	XXXXXXXXX	XXX	XXX	XXXX
1. BILLS DENIED - TOTAL						
2. BILLS PAID UNDER WAIVER TOTAL						
2A. INITIAL BILLS PAID UNDER WAIVER						
3. AMOUNT REIMBURSED UNDER WAIVER						
3B. AMOUNT ON INITAL BILLS						
SECTION C: DAY/VISIT DATA	XXXXXX	XXXXXXXX	XXXXXXXXX	XXX	XXX	XXXX
4. DAYS/VISITS PROCESSED	XXXXXX	XXXXXXXX	XXXXXXXXX			XXXX
5. DAYS/VISITS DENIED TOTAL NO-PAY BILLS	XXXXXX	XXXXXXXX	XXXXXXXXX			XXXX
6. DAYS/VISITS PAID UNDER WAIVER - TOTAL	XXXXXX	XXXXXXXX	XXXXXXXXX			XXXX
6A. DAYS/VISITS ON INITIAL BILLS	XXXXXX	XXXXXXXX	XXXXXXXXX			XXXX