CMS Manual System

Pub 100-06 Medicare Financial Management

Transmittal 85

Department of Health & Human Services (DHHS)

Center for Medicare & Medicaid Services (CMS)

Date: NOVEMBER 17, 2005

Change Request 3864

NOTE: Transmittal 82, dated October 31, 2005, is rescinded and replaced with Transmittal 85, dated November 17, 2005. There were changes to the business requirements and manual instructions to correct inconsistencies within, and also to include the correct version of the manual exhibit. All other material remains the same.

SUBJECT: Expansion of Form 5 of the Contractor Reporting of Operational and Workload Data (CROWD)

I. SUMMARY OF CHANGES: Subsections 450.3 and 450.4 are being revised to address changes being made to Form 5 of CROWD. Shared system maintainers, the CWF maintainer, carriers, RHHIs, and FIs will need to begin to collect additional data for inclusion in Form 5. Carriers, RHHIs and FIs will now be required to include monthly statistics in Form 5 for their IVR, DDE, and Internet (when participating in a CMS-approved pilot) eligibility and claim status responses issued each month, as well as COB, remittance advice, paper checks and electronic fund transfers, and prior authorization decisions issued.

Instructions for DMERCs will follow in a separate CR and be implemented in July, 2006.

NEW/REVISED MATERIAL

EFFECTIVE DATE: April 01, 2006

IMPLEMENTATION DATE: April 03, 2006

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. 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 is 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:

Funding for Medicare contractors is available through the regular budget process for costs required for implementation.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment – Business Requirements

Pub. 100-06	Transmittal: 85	Date: November 17, 2005	Change Request 3864

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SUBJECT: Expansion of Form 5 of the Contractor Reporting of Operational and Workload Data (CROWD) Report

I. GENERAL INFORMATION

A. Background:

The Government Performance Reporting Act (GPRA) requires that CMS monitor the rate of usage of individual types of electronic data interchange (EDI) transactions to determine the full benefits attributable to use of EDI. EDI is not the only means of conducting certain types of business. The same types of business may be performed using direct data entry (DDE) screens, interactive voice response (IVR) technology, or in some cases, via the Internet. To most accurately determine the benefits from use of EDI, it is necessary to look at the full picture to the extent possible.

CMS collects statistics in CROWD that establish the number of EDI transactions processed, other than the 270/271 for which statistics will be collected separately, and collects data on the number of non-EDI claims received and remittance advice transactions issued. CMS lacks data at present on transactions other than claim submission that may also be conducted via DDE screens, eligibility queries submitted to data centers by some clearinghouses and processed by CWF hosts, eligibility queries submitted to CWF to obtain information for an IVR or Internet response or a carrier or FI-initiated query, pre-HIPAA electronic legacy formats, IVR claim status responses, and electronic transactions processed via the Internet (when a contractor is in a CMS-approved Internet pilot). CMS now also needs information on these other means of responding to certain queries or performing other activities of the type covered by HIPAA EDI transactions for completion of our annual GPRA report.

In addition to the GPRA needs, in anticipation of implementation of the revised CMS-1500 professional paper claim form effective October 1, 2006 and the UB-04 institutional paper claim form effective March 1, 2007, Business Requirements are also being added in this instruction to enable CMS to evaluate progress in provider transition to the new paper claim forms once the transition periods for those forms begin. CMS will issue separate CRs for implementation of those forms once Office of Management and Budget approval is received for Medicare use of the forms as required by the Paperwork Reduction Act. In anticipation of termination of the Medicare HIPAA ERA contingency plan in coming months, a Business Requirement has also been added for separate reporting of the number of 835 version 4010A1 835s and non-HIPAA ERAs issued.

As result, the following data must be collected, reported monthly, and are listed as Business Requirements:

1. Shared systems must report the following numbers to each carrier or FI they serve by the 5th of the month following the close of each calendar month. If a shared system does not furnish one or more of the listed types of data, the shared system shall report 0 to its carriers or FIs for that type of data for the prior month:
    a. X12 837 version 4010A1 claims adjudicated;
    b. Non-HIPAA electronic claims received before termination of the Medicare HIPAA claim contingency plan but which were adjudicated during the prior month;
    c. Institutional claims adjudicated that were submitted via DDE screen;
    d. Institutional claim adjustments submitted via DDE (even if the initial claim was not submitted via DDE);
    e. CMS-1500 (non-revised) paper claims adjudicated;
    f. CMS-1500 (revised) paper claims adjudicated
    g. UB-92 paper claims adjudicated;
    h. UB-04 paper claims adjudicated;
    i. Non-NCPDP COB transactions;
    j. Claim status responses issued via DDE per carrier and FI each month (count each ICN/CCN for which claim status is reported as a separate response and count responses issued for the same ICN/CCN during separate occasions as a separate response);
    k. X12 277 version 4010A1 flat file records issued (count each ICN/CCN for which a response is issued as a separate response);
    l. Claim status responses issued for IVR delivery (count each ICN/CCN for which a response is issued as a separate response; if a carrier or FI obtains this data from the shared system by having their data center "screen scrape," shared system claim status data, the number of those responses issued via IVR must be tracked by that carrier or FI through the data center if necessary);
    m. Claim status responses issued for Internet pilot delivery (count each ICN/CCN for which a response is issued as a separate response; if a carrier or FI obtains this data from the shared system by having their data center "screen scrape," shared system claim status data, the number of those responses issued via IVR must be tracked by that carrier or FI through the data center if necessary);
    n. Eligibility legacy format EDI flat file records issued (count each HIC for which this data is reported as a separate transaction for counting purposes);
    o. Eligibility responses issued for IVR delivery (count each HIC as a separate response);
    p. Eligibility responses issued for Internet pilot delivery (count each HIC as a separate response);
    q. Electronic Remittance Advice (ERA) flat file records sent for translation to an 835 version 4010A1 (count each GS-GE as a separate ERA);
    r. ERA flat file record sent for translation to a non-HIPAA format ERA, if the Medicare 835 contingency plan has not been terminated by April 2006 (count the equivalent of each GS-GE as a separate ERA);
    s. Standard Paper Remittance (SPR) notice flat file records issued;
    t. Electronic Fund Transfer (EFT) indicators issued to carriers or FIs for provider claim payments;
    u. Paper check indicators issued to carriers or FIs for provider claim payments;
    v. Dollar value of these EFTs; and
    w. Dollar value of these paper checks.

2. CWF must track the number of eligibility responses issued per calendar month per carrier and FI issued via:
    a. HIQA, ELGA, ELGB, or other (except HUQA) eligibility responses delivered as either DDE screens or as HIQA, ELGA, ELGB, or other (except HUQA) eligibility query responses;
    b. HUQA responses delivered to clearinghouses/providers and to carriers and FIs; and
    c. Record this information in the CWF operating report (ORPT) by the 5th of the following month. The HIQA, ELGA and ELGB numbers can be reported as a single total per carrier and FI, but the HUQA total must be reported as a separate figure per carrier and FI.
3. Carriers and FIs:
    a. That obtain IVR or Internet claim status information from a source other than their shared system or obtain the information by "screen scraping" claim status information from the shared system for IVR or Internet delivery must track the number of times they deliver claim status information via IVR or the Internet. Each ICN/CCN for which claim status information is furnished must be counted as a separate claim status response;
    b. That obtain IVR or Internet beneficiary eligibility information without sending a HIQA/ELGA/ELGB/HUQA or other CWF query must also separately track the number of times they issue eligibility information via an IVR or the Internet as part of a CMS-approved Internet pilot. Each HICN for which eligibility data is supplied must be counted as a separate response; and
    c. Must include the totals they collect along with the data furnished by the shared system and CWF maintainers as described above in CROWD Form 5 by no later than the 15th of the month following the month during which the data were collected.

One additional field has been included in the form for which no business requirement has been written. Line 8, column 4 is for reporting of the number of times an Internet Remittance Advice flat file is issued. This has been added in anticipation of release of a separate CR to enable contractors to permit providers to access their remittance advice information via the Internet. When issued, that CR will indicate who is to track that number and when reporting of that total in form 5 must begin.

B. Policy:

Four types of procedures are generally processed via DDE screens: claim submission (institutional providers), claim adjustment (institutional providers), claim status inquiry (institutional and professional providers or their agents) and eligibility inquiry (institutional and professional providers or their agents). Once a provider or an agent (billing service or clearinghouse) has accessed the DDE system, that party may submit or request data for multiple claims and beneficiaries. Once a provider or an agent is redirected to CWF to obtain eligibility data via DDE, that party leaves the shared system maintained DDE system. That party is able to submit multiple eligibility queries to CWF but the shared system cannot track the number of eligibility queries submitted to CWF during that session. In lieu of use of DDE, many

clearinghouses and certain large providers are permitted to submit HUQA eligibility queries for multiple providers and beneficiaries directly to a data center for processing and response by the appropriate CWF host.

Each beneficiary claim, each claim correction, each claim status inquiry, and each beneficiary eligibility inquiry processed via DDE, an electronic legacy format, or CWF must be considered as a separate transaction, separately tracked, and reported to the carriers and FIs each month. For claim status counting, each different ICN/CCN for which a party is given claim status information during the same IVR, DDE or Internet session or connection, or in the same ISA-IEA is a separate claim status response. For eligibility response counting, each different HIC for which a party is given an eligibility response during the same IVR, DDE or Internet session or connection, via an HIQA/ELGA/ELGB/other non-HUQA query response or HUQA not delivered via IVR, DDE or the Internet, or in the same ISA-IEA (or the equivalent involving a proprietary legacy format) is a separate eligibility response. For ERAs, each GS-GE is considered a separate ERA.

For example, if Hospital X enters the FISS DDE system and:

1. Goes to the eligibility screen to check Medicare eligibility for patients Y and W,
2. Is redirected to the CWF HIQA or ELGA screen and then seeing that these beneficiaries have Medicare A and B coverage,
3. Selects the DDE claim screen and separately enters claim data for patients Y and W,
4. Then selects the claim status screen and separately checks on the status of previously submitted claims for patients A, B, and C, and
5. Then opens the claim DDE screen for patient A and submits an adjustment,

the shared system would need to record that two claims receipt transactions, three claim status transactions, and one claim adjustment transaction were processed. CWF would need to record that two DDE/HIQA or ELGA eligibility responses were issued. If one of the claims was not accepted due to insufficient data or for another reason that results in rejection, it would not be considered as a received claim under CROWD rules and may not be considered a received transaction for reporting in form 5 of CROWD. To avoid confusion regarding when to consider a request as received, reporting for transactions other than claims is limited to the number of the outbound query responses, COB, and remittance advices issued.

If clearinghouse M connects to a data center, indicates that beneficiary eligibility data is needed, and is switched to a CWF host, and the clearinghouse then submits 15 beneficiary eligibility requests for provider G, 10 for provider H, and 22 for provider I, which is supplied via HUQA, CWF must attribute those 47 eligibility queries to the appropriate carrier or intermediary that serves those beneficiaries or providers and include that information in the ORPT file HUQA total for that month.

An example of CROWD form 5 is attached. The last 1-2 digits of each Business Requirement have been inserted in each field where the data discussed in that Business Requirement is to be reported by the carrier or FI when completing form 5. Where two numbers and the " + "symbol are shown, it means that the carrier or FI needs to add those numbers if both apply.

II. BUSINESS REQUIREMENTS

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

Where a business requirement indicates that a shared system is to count and report a total to its users for a specific type of data for the prior month, but that shared system did not furnish the type of data mentioned during that month, the shared system is to report zero to its users for that type of data.

Requirement Number	**Requirements**	**Responsibility (“X” indicates the columns that apply)**								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3864.1	Shared systems shall report the number of X12 837 version 4010A1 claims adjudicated during the prior month by each of their carriers or FIs.					X	X	X		
3864.2	Shared systems shall report the number of non-HIPAA format electronic claims received before expiration of the Medicare HIPAA claim contingency plan that completed adjudication during the prior month for each of their carriers or FIs.					X	X	X		
3864.3	FISS shall report the number of claims submitted via DDE that were adjudicated by each FI during the prior month.					X				
3864.4	FISS shall report the number of claim adjustments submitted via DDE screen (even if the initial claim was not submitted via DDE) during the prior month per FI.					X				
3864.5	MCS and VMS shall report the number of CMS-1500 (non-revised) claims adjudicated during the prior month per carrier. (Exclude CMS-1490 claims from this count.)						X	X		
3864.6	MCS and VMS shall report the number of CMS-1500 (revised) claims adjudicated the prior month per carrier. (Exclude CMS-1490 claims from this count.)						X	X		
3864.7	FISS shall report the number of UB-92 paper claims adjudicated during the prior month per FI.					X				
3864.8	FISS shall report the number of UB-04 paper claims adjudicated during the prior month.					X				

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3864.9	Shared systems shall report the number of non-NCPDP COB claim flat file records a carrier or FI obtains to send to a COB trading partner or the COBC during the prior month.					X	X	X		
3864.10	Shared systems shall report the number of claim status responses issued for delivery via DDE screen per carrier or FI the prior month. Each ICN/CCN for which claim status was reported shall be counted as a separate transaction.					X	X	X		
3864.11	Shared systems shall report the number of X12 277 version 4010A1 response flat file records issued per carrier or FI the prior month. Each ICN/CCN for which claim status data is reported in the same 277 shall be counted as a separate response.					X	X	X		
3864.12	Shared systems shall report the number of claim status responses they issued for IVR delivery per carrier or FI during the prior month. Each ICN/CCN for which claim status is reported during the same IVR session shall be counted as a separate response. (Claim status data that a carrier or FI obtains by having the data center "screen scrape" that data from the shared system cannot be counted by the shared system and must be counted by that carrier, FI, or the data center.)					X	X	X		
3864.13	Shared systems shall report the number of claim status responses they issued for Internet pilot delivery per carrier or FI during the prior month. Each ICN/CCN for which claim status is reported during the same Internet session will be counted as a separate response. (Claim status data that a carrier or FI obtains by having the data center "screen scrape" that data from the shared system cannot be counted by the shared system and must be counted by that carrier FI, or the data center.)					X	X	X		

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3864.14	Shared systems shall report the number of eligibility EDI legacy format flat file records issued per carrier or FI during the prior month. Each HIC for which such eligibility data was reported will be counted as a separate response.					X	X	X		
3864.15	Shared systems shall report the number of eligibility responses furnished per carrier or FI for IVR delivery during the prior month. Each HIC for which eligibility data is supplied shall be counted as a separate response. (Eligibility data that a carrier or FI obtains by having the data center "screen scrape" that data from the shared system cannot be counted by the shared system and must be counted by that carrier, FI, or the data center.)					X	X	X		
3864.16	Shared systems shall report the number of eligibility responses furnished per carrier or FI for Internet pilot delivery during the prior month. Each HIC for which eligibility data is supplied shall be counted as a separate response. (Eligibility data that a carrier or FI obtains by having the data center "screen scrape" that data from the shared system cannot be counted by the shared system and must be counted by that carrier, FI, or the data center.)					X	X	X		
3864.17	Shared systems shall report the number of ERA flat file records sent per carrier or FI for translation to an 835 version 4010A1 transaction during the prior month. Each ST-SE is to be counted as a separate 835.					X	X	X		
3864.18	Shared systems shall report the number of ERA flat file records sent per carrier or FI during the prior month for translation into a non-HIPAA format ERA. The equivalent of each ST-SE is to be counted as a separate ERA. If a shared system did not issue any non-HIPAA format ERAs during the prior month, the carrier or FI shall enter zero in form 5.					X	X	X		

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3864.19	Shared systems shall report the number of SPR records issued to each carrier or FI during the prior month to enable them to print and mail SPRs.					X	X	X		
3864.20	Shared systems shall report the number of EFT indicators sent to each carrier or FI for provider claim EFT payments during the prior month. This includes institutional PIP, pass-through, or other payments that would typically be reported in a remittance advice. Each EFT shall be counted separately.					X	X	X		
3864.21	Shared systems shall report the number of paper check indicators that were sent to each carrier or FI during the prior month. Each paper check that was to be printed shall be counted separately.					X	X	X		
3864.22	Shared systems shall report the dollar value of the EFTs (as in BR 3864.20) issued per carrier or FI during the prior month.					X	X	X		
3864.23	Shared systems shall report the dollar value of the paper checks (as in BR 3864.21) that were to be issued per carrier or FI during the prior month.					X	X	X		
3864.24	Shared systems shall issue a report, or make available for carrier or FI electronic access, a record by the 5th of each month that includes all data per carrier or FI for the prior month as included in Business Requirements 3864.1-23.					X	X	X		
3864.25	CWF shall report the number of eligibility responses issued per carrier or FI during the prior month as HIQA, ELGA, ELGB or other non-HUQA eligibility responses delivered either via a DDE screen or as a response to a non-DDE query.								X	
3864.26	CWF shall report the number of HUQA eligibility responses delivered to clearinghouses, providers, carriers or FIs per carrier or FI during the prior month.								X	

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3864.27	CWF shall insert the information described in 3864.25-26 in the CWF ORPT report for access by each carrier and FI by the 5th of each month for the prior calendar month. The HIQA, ELGA, ELGB, other total per carrier and FI shall be listed separately in the ORPT from the HUQA total per carrier and FI.								X	
3864.28	Carriers and FIs that obtain information for any of their claim status IVR responses from a source other than their shared system or that have their data center "screen scrape" that data from the shared system must track the number of IVR claim status responses they issue using that data. Each claim status response issued via IVR for a different ICN/CCN shall be counted as a separate response. The data will be reported in CROWD form 5 following the close of each month.	X	X	X						
3864.29	Carriers and FIs that obtain information for any of their eligibility IVR responses from a source other than CWF via a HIQA, ELGA, ELGB, or other non-HUQA query shall maintain a count of the number of IVR beneficiary eligibility responses issued using that alternate source of information during the prior month. Eligibility data that a carrier or FI obtains by having the data center "screen scrape" that data from the shared system must be counted by that carrier, FI, or the data center. Each HIC for which eligibility information is reported via IVR using this information shall be counted as a separate response. The total must be reported in CROWD form 5 following the close of each month.	X	X	X						
3864.30	Carriers and FIs that supply information for any claim status Internet pilot responses from a source other than their shared system or that obtain that information by having the data	X	X	X						

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	center "screen scrape" that data from the shared system shall maintain a count of the number of Internet claim status responses issued using that data. Each claim status response issued via the Internet for a different ICN/CCN shall be counted as a separate response and reported in CROWD form 5 following the end of each month.									
3864.31	Carriers and FIs that supply information for any eligibility Internet pilot responses from a source other than CWF via a HIQA, ELGA, ELGB, or other non-HUQA query shall maintain a count of the number of Internet beneficiary eligibility responses issued using that alternate source of information during the prior month. Eligibility data that a carrier or FI obtains by having the data center "screen scrape" that data from the shared system must be counted by that carrier FI, or the data center. Each HIC for which eligibility information is reported via the Internet using this information shall be counted as a separate response. The total must be reported in CROWD form 5 following the close of each month.	X	X	X						
3864.32	Carriers and FIs shall accumulate the data required for CROWD form 5 as indicated in Business Requirements 3864.24, 3864. 27, and 3864.28-31, and electronically submit the completed form 5 by the 15th of each month to report the data accumulated by the shared systems, CWF maintainer, and themselves for the prior month.	X	X	X						

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)					
		FI	RH	Ca	DM	Shared System Maintainers	Other

						FISS	MCS	VMS	CWF	
	N/A									

IV. 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: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

G. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: April 1, 2006 **Implementation Date:** April 3, 2006 **Pre-Implementation Contact(s):** Kathleen Simmons, Kathleen.Simmons@cms.hhs.gov, 410-786-6157 **Post-Implementation Contact(s):** Kathleen Simmons, Kathleen.Simmons@cms.hhs.gov, 410-786-6157	**Funding for Medicare contractors is available through the regular budget process for costs required for implementation.**

***Unless otherwise specified, the effective date is the date of service.**

EXHIBIT

(The number in each field of this form corresponds to the Business Requirement number. Business Requirements for line 8 (column 4) and lines 5, 6, 7 and 11 (NCPDP reporting in column 1) will be published in later transmittals.)

MEDICARE CONTRACTOR TRANSACTIONS
CROWD FORM 5

Contractor Number _____ **Report Period_____**

TYPE OF TRANSACTION	ELECTRONIC	NON-ELECTRONIC (MANUAL PROCESSES)	INTERNET
ALL CONTRACTORS			
1. *RESPONSES* TO CLAIMS STATUS INQUIRIES	11		13+30
2. *RESPONSES* TO ELIGIBILITY STATUS INQUIRIES	14		16+31
3. HUQA ELIGIBILITY RESPONSES	26		
4. COB CLAIMS *ISSUED TO TRADING PARTNERS* (INCLUDE MEDIGAP *but* NOT NCPDP)	9		
DMERCs ONLY			
5. PRIOR AUTHORIZATIONS OR ADVANCED DETER-MINATIONS OF MEDICARE COVERAGE *ISSUED*			
6. NCPDP RETAIL PHARMACY DRUG CLAIMS PROCESSED			
7. NCPDP RETAIL PHARM*ACY* DRUG COB CLAIMS *ISSUED* (INCLUDING NCPDP MEDIGAP)			

ALL CONTRACTORS				
8. REMITTANCE ADVICES—NUMBER SENT	*835 v. 4010A1* 17	*SPR* 19	*NonHIPAA ERA* 18	*Internet RA*
9. # OF PAYMENTS TO PROVIDERS OR SUPPLIERS	*# EFT* 20	*# Paper Checks* 21		
10. DOLLAR AMOUNTS ASSOCIATED W/ PAYMENTS	*EFT $* 22	*Paper Checks $* 23		
PROCESSED CLAIMS ACTIONS and DDE/IVR RESPONSES DATA	*HIPAA 837 & NCPDP*	*DDE, HIQA/ ELGA/B/OTH*	*NON-HIPAA Format EMC*	*IVR*
11. ELECTRONIC CLAIMS PROCESSED	*1*	*3*	*2*	
12. DDE CLAIM ADJUSTMENTS REC'D		*4*		
13. DDE/CWF/IVR CLAIM STATUS RESPONSES		*10*		12+28
14. CWF or IVR ELIGIBILITY RESPONSES		*25*		15+29
15. PAPER CLAIMS PROCESSED	*1500* 5	*1500 Rev.* 6	*UB-92* 7	*UB-04* 8

450.3 – Body of Report

(Rev.85, Issued: 11-17-05, Effective: 04-01-06, Implementation: 04-03-06)

A. General Report Content Requirements

The words "adjudicated," "processed to completion" and "processed" are used in some of the instructions for completion of CROWD form 5. A claim is considered to be "adjudicated" or "processed to completion" on the date of its payment (date a check is produced or an EFT authorization is issued), or the date the remittance advice is issued in the event no check/EFT was due. An NCPDP claim is considered "processed" on the date when it has passed all front end edits and is passed to the Core System for processing.

Every column in form 5 does not apply to each type of data, and there are different types of columns in some areas of the report. No data is to be entered into any shaded fields.

All of the data to be reported on form 5 is for the prior calendar month. Form 5 data must be entered by carriers and FIs by the 15th of each month. Data due from a shared system or from CWF must be available for carrier or FI use by the 5th of the month following the month during which the data were collected. Certain types of data must be collected by individual carriers or FIs. When applicable, that data must also be tracked for each calendar month.

B. Line and Column CROWD Form 5 Completion Requirements

CROWD reports must be submitted by carriers and FIs. They cannot be filed by shared system or CWF maintainers.

Line 1 – ***Responses to Claim Status Inquiries*** **–** *Shared systems must track the number of claim status flat file responses sent to each of their carriers and FIs for translation into X12 277 transactions. Each carrier and FI is to report that total in column 1. Shared systems are to c*ount each occurrence of the unique trace *or claim transaction* number as assigned by the provider (e.g., in the 277, use TRN02 *or REF02 of the 2200E loop) as a separate claim status response. Include both positive (able to furnish requested status) as well as negative (unable to furnish requested status for some reason) responses in the count.*

Shared systems are also to track the number of claim status responses they may issue a carrier or FI for delivery via an Internet pilot. In the event a carrier or FI with an Internet pilot uses a source of information other than the shared system for reporting of any claim status information via the Internet, that contractor must track the number of individual claim status responses they issue using that alternate source of information. Carriers and FIs must report the number of electronic claim status responses issued in any format via an Internet pilot. They must report in column 3 the total of all responses that originated from the shared system and all responses that originated from any alternate data source that were delivered via the

Internet. They may not include eligibility responses issued via DDE or an IVR in the total reported in column 3.

Line 2 – Responses to Eligibility Inquiries **–** *Shared systems are to track the number of flat file eligibility responses they send to their carriers and FIs for issuance in electronic legacy formats. Shared systems must exclude from their per carrier and FI totals, the number of these eligibility flat file records produced using CWF HIQA/ELGA/ELGB or HUQA responses. Carriers and FIs are to report the shared system total in column 1. Eligibility responses to be issued via DDE, IVR, or the Internet must also be excluded from these totals. E*ach unique occurrence of an individual beneficiary HIC number *must be counted as a separate eligibility response. A response indicating that no record could be located for a beneficiary is considered a valid response. Include both positive (able to furnish eligibility information) as well as negative (unable to furnish eligibility information) responses in the count.*

In the event a carrier or FI uses a source of data other than the shared system or HIQA/ELGA/ELGB, HUQA or other CWF responses to issue any legacy format electronic eligibility responses, that carrier or FI must track the number of those responses issued. If eligibility data is received both from the shared system, CWF responses, and an alternate source, the carrier and FI must total the numbers from the shared system, CWF, and the alternate source and report that total in column 1.

Shared systems are also to track the number of eligibility responses they may issue a user for delivery via an Internet pilot. In the event a carrier or FI with an Internet pilot uses a source of information other than the shared system or CWF to report any eligibility information via the Internet, that contractor must track the number of individual eligibility responses they issue using that alternate source of information. Carriers and FIs must report the number of electronic eligibility responses issued in any format via an Internet pilot. They must report in column 3 the total of all responses that originated from the shared system, CWF, and from any alternate data source that were delivered via the Internet. They may not include eligibility responses issued via DDE or an IVR in the total reported in column 3.

Line 3 – ***HUQA Eligibility Responses*****--***In lieu of use of DDE, a number of clearinghouses and large providers have been permitted to submit eligibility queries directly to data centers to obtain beneficiary eligibility data from CWF. The incoming query identifies the carrier or FI responsible for processing of claims for the provider requesting the eligibility data, enabling the CWF maintainer to track and notify each carrier and FI of the total number of clearinghouse and provider HUQA eligibility responses processed through CWF.*

Carriers and FIs are to report the number of HUQA eligibility responses issued by CWF for beneficiaries in their service area on line 3. This CWF number must include HUQAs sent to clearinghouses or large providers through the data centers, as well as HUQAs that the contractors might have requested to obtain beneficiary

eligibility data for IVR responses or other purposes. The CWF maintainer must report the number of HUQA responses issued in the CWF operating report (ORPT) file.

> *NOTE: RACF clearance is needed for access to the ORPT file. CWF staff within a carrier's or FI's operation should have access to this file. Staff members in a contractor's EDI department that do not have access to this file should be able to obtain this CWF data through their CWF colleagues or by obtaining RACF clearance through their security office to access this file.*

Line 4--**Coordination of Benefit (COB) Claims *Issued to Trading Partners* (includes Medigap, *but* does not include NCPDP) –** *Shared systems must track the number of 837 COB flat file transactions they send to their users for translation into a COB transaction. E*ach different CLM01 entry in an 837, or alternately, each unique occurrence of the patient's HIC number must be counted *as a separate COB transaction. The carriers and FIs must enter this total in column 1.*

NOTE: Lines 5, 6 *and 7* are to be completed by DMERCs only *(To be implemented in July, 2006).*

Line *5* – Prior Authorization or Advance Determination of Medicare Coverage Requests – *DMERCs are to track and report the number of these decisions issued. (This count should not include telephone discussions about Medicare coverage, but only those cases which result in issuance of specific prior authorization or advance determination decisions.)*

Line *6* – National Council of Prescription Drug Plans (NCPDP) Retail Pharmacy Drug Claims Processed – *VMS must track the number of NCPDP claims processed. VMS is to c*ount each unique occurrence of a *claim control number as a separate* claim. *The DMERCs are to report this number in column 1.*

Line *7* – Outgoing COB NCPDP Claims for Retail Pharmacy Drugs Processed (including NCPDP Medigap) – *VMS must track the number of NCPDP COB transactions sent to DMERCs for translation and issuance to trading partners or the COBC. VMS is to c*ount each unique occurrence of a *claim control number as a separate NCPDP COB claim. DMERCs are to report this total in column 1.*

Line *8* – Remittance Advices-Number Sent – *Shared systems are to track the number of 835 version 4010A1 flat files sent their carriers or FIs. They must report each occurrence of an 835 ST to SE version 4010A1 segment set as a separate electronic remittance advice (ERA) transaction for counting purposes.* If a provider is sent both an electronic and a paper remittance advice for the same group of claims, *they are to count them separately as one electronic and one non-electronic remittance advice. The carriers and FIs must report this total in column 1.*

The shared system must also track the number of standard paper remittance (SPR) flat files sent their users for printing in each calendar month. Carriers and FIs must report this total in column 2.

In column 3, if the Medicare 835 HIPAA contingency plan has not yet been terminated, shared systems must track the number of all non-version 4010A1 electronic remittance advice flat files issued their users for translation. The carriers and FIs must enter this number in column 3.

The total number of remittance advice records furnished via the Internet is to be reported in column 4. A separate CR will be issued concerning reporting of remittance advice information on the Internet for access by the provider for which the record is prepared. In anticipation of this requirement, a field has been added for reporting of the total number of Internet remittance advice flat files records that were issued in the prior month. Information concerning responsibility for tracking of this number and the effective date on which reporting of this number will begin will be included in the implementation instruction for use of the Internet for this purpose.

Line *9* – Number of Payments to Providers – *Shared systems are to track the number of electronic fund transfers (EFT) and paper checks for provider claim payments that the carriers and FIs were to issue. The EFT total must represent the total of all provider claim payments issued via EFTs, regardless if issued in conjunction with an 835 version 4010A1 ERA, an SPR, or a legacy format ERA. The paper check total must be the total of paper checks sent in conjunction with an SPR, an 835 version 4010A1, or a legacy format ERA. In some cases, a remittance advice might not have any payment because all the claims were denied, the entire payment due a provider is being withheld to recoup an overpayment, or payments to a provider are being held in an escrow account pending completion of a fraud and abuse investigation. As result, the number of payments does not always equal the number of SPRs and ERAs issued. Carriers and FIs must report the EFT total in column 1 and the paper check total in column 2.*

Line *10* – Dollar Amounts Associated with Payments – *Shared systems must track the dollar value of the EFTs/checks issued by their carriers and FIs for provider claim payments each month. The carriers and FIs must report the dollar value of the EFTs in column1 and of the paper checks in column 2.*

Line *11* – *Electronic* Claims Processed Data—*Shared systems must track the following information which each* carrier *and FI must enter as indicated in form 5*:

- *In the first* column, *the total of* processed electronic X12 837 version 4010.A.1 claims (exclude DDE claims *sent to FIs; A requirement for DMERCs to include the total of NCPDP claims received in this column will be added in a later transmittal.*).

- *In the second* column, all electronic claims processed that were submitted via DDE screens. (DDE claims are considered HIPAA-compliant, but are to be reported separately here from the number of *received* 837 version 4010.A.1 claims.) *Non-FIs who do not accept claims via DDE must enter zero.*

- *In the third* column, electronic claims transactions *processed to completion that were receive*d in a non-HIPAA format such as an earlier version of the X12 837, *or* any version of the NSF or the UB-92 flat file *prior to termination of the Medicare HIPAA claim contingency plan.*

NOTE: For lines 12-14, shared systems, carriers and FIs must limit reporting to those transactions for which their providers can obtain the type of data noted using DDE (excludes those CWF HUQA eligibility responses reported on line 3) or an IVR. Medicare contractors that do not offer a DDE screen or IVR for the type of information listed on a particular unshaded line must enter zero. CWF uses an HIQA, ELGA or ELGB query screen and response for DDE eligibility requests and must report the monthly total of each of those response types in the ORPT file for carrier and FI access.

Line 12—DDE Claim Adjustments Received—*FISS must track the number of adjustments submitted via DDE for claims (it does not matter for reporting in this line whether the claims themselves were submitted via DDE). If multiple adjustments are made during the same connection session to the same claim, they must be reported as one adjustment. If multiple claims are adjusted during the same session by a provider or clearinghouse, FISS must count each claim separately regardless of the number of fields modified in each of those claims. The FIs must report the total number of adjustments in column 2.*

Line 13—DDE/IVR Claim Status Inquiries—*Shared systems must track the number of claim status responses issued via a DDE screen. Carriers and FIs must report that number in the second column. If a provider can use a single claim status DDE screen to obtain status information for multiple claims during the same session, the shared systems must count each claim for which status information is supplied as a separate query response. The carrier or FI must report that number in the second column*

If a shared system supplies claim status data for reporting via IVR, the shared system must track those responses and the carrier or FI must report that number in the fourth column. If a carrier or FI, or a data center at their direction, "screen scrapes" shared system data to obtain claim status information used to respond via IVR, a shared system would not be able to record the number of responses issued using that data. In that situation, the carrier or FI must count the number of these responses issued via IVR and report that number in the fourth column. Count each ICN/DCN for which status is reported as a separate claim status response.

Line 14—Eligibility Inquiries—*CWF must track the number of DDE (HIQA, ELGA or ELGB) and clearinghouse/provider or other HUQA eligibility responses issued per carrier and FI during the prior month and report those numbers in the CWF ORPT file. Carriers and FIs must report the total of those numbers in the second column. If a provider can use a single eligibility DDE screen to obtain information on more than one beneficiary during the same session, each HIC for which eligibility data is furnished must be counted as a separate response.*

If a carrier or FI obtains eligibility data from their shared system for preparation of responses to any IVR eligibility inquiries, the number of HICs for which eligibility responses are issued must be tracked by the shared system. If a carrier or FI uses any alternate source of eligibility data for some IVR eligibility responses, that carrier or FI must track the number of eligibility responses they issue using the alternate source, and report the total of the shared system and alternate source eligibility responses in the fourth column. If a provider can request beneficiary eligibility data for multiple beneficiaries during the same IVR session, each HIC for which an eligibility data is issued must be counted as a separate response.

Line 15—Paper Claims Processed—*Both the National Uniform Claim Committee (NUCC) and the National Uniform Billing Committee (NUBC) have approved new versions of their paper claim forms to enable reporting of NPIs as well as other provider identifiers. The NUCC has scheduled a transition period, during which providers will be allowed to submit paper claims using either the "old" (non-revised) or the revised CMS-1500 from October 1, 2006 – February 28, 2007. Effective March 1, 2007, "old" CMS-1500 forms should no longer be accepted by health care plans, including Medicare. The NUBC has scheduled a transition period of March 1, 2007-May 22, 2007 for the UB-04 form which will be replacing the UB-92 form.*

In anticipation of these changes, a new line has been added to form 5 to enable CMS to monitor the progress of provider transition from the "old" to the new paper claim forms. Separate CRs will be issued for implementation of the new paper claim forms following Office of Management and Budget approval of the forms as required under the Paperwork Reduction Act. This line is being added to form 5 now, however, to avoid the need for additional modification of form 5 when Medicare begins to accept them for processing. Effective for October 2006 for the carriers and March 2007 for the FIs, their shared systems must track the number of paper claims submitted under the "old" and the "new" version of each paper claim form. The carriers and FIs will then enter those numbers in the appropriate blocks in form 5. No information is to be reported in the fields on line 15 for the revised 1500 and the UB-04 paper forms prior to the start of the transition period for each of those forms. Reporting of data for these fields will terminate three months after the transition periods end for the "old" claim forms.

450.4 – Exhibit 1

(Rev.85, Issued: 11-17-05, Effective: 04-01-06, Implementation: 04-03-06)

MEDICARE CONTRACTOR TRANSACTIONS
CROWD FORM 5

Contractor Number _____ Report Period_____

TYPE OF TRANSACTION	ELECTRONIC	NON-ELECTRONIC (MANUAL PROCESSES)	INTERNET
ALL CONTRACTORS			
1. *RESPONSES* TO CLAIMS STATUS INQUIRIES			
2. *RESPONSES* TO ELIGIBILITY STATUS INQUIRIES			
3. HUQA ELIGIBILITY RESPONSES			
4. COB CLAIMS *ISSUED TO TRADING PARTNERS* (INCLUDE MEDIGAP *but* NOT NCPDP)			
DMERCs ONLY			
5. PRIOR AUTHORIZATIONS OR ADVANCED DETER-MINATIONS OF MEDICARE COVERAGE *ISSUED*			
6. NCPDP RETAIL PHARMACY DRUG CLAIMS PROCESSED			
7. NCPDP RETAIL PHARM*ACY* DRUG COB CLAIMS *ISSUED* (INCLUDING NCPDP MEDIGAP)			

ALL CONTRACTORS				
8. REMITTANCE ADVICES—NUMBER SENT	*835 v. 4010A1*	*SPR*	*NonHIPAA ERA*	*Internet RA*
9. # OF PAYMENTS TO PROVIDERS OR SUPPLIERS	*# EFT*	*# Paper Checks*		
10. DOLLAR AMOUNTS ASSOCIATED W/ PAYMENTS	*EFT $*	*Paper Checks $*		
PROCESSED CLAIMS ACTIONS and DDE/IVR RESPONSES DATA	*HIPAA 837 & NCPDP*	*DDE, HIQA/ ELGA/B/OTH*	*NON-HIPAA Format EMC*	*IVR*
11. ELECTRONIC CLAIMS PROCESSED				
12. DDE CLAIM ADJUSTMENTS REC'D				
13. DDE/CWF/IVR CLAIM STATUS RESPONSES				
14. CWF or IVR ELIGIBILITY RESPONSES				
15. PAPER CLAIMS PROCESSED	*1500*	*1500 Rev.*	*UB-92*	*UB-04*