Medicare
Intermediary Manual
Part 3 - Claims Process

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

Transmittal 1857 **Date: JUNE 21, 2002**

CHANGE REQUEST 2151

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
3893.4 (Cont.) - 3894	9-297 - 9-298 (2 pp.)	9-297 - 9-298 (2 pp.)
3894.8 - 3894.8 (Cont.)	9-299 - 9-299.1 (2 pp.)	9-299 - 9-299.1 (2 pp.)

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

Section 3893.4 - Body of Report, SECTION D: MISCELLANEOUS DATA, is revised to add new instructions for reporting data on the Medicare Summary Notices (MSNs); Line 40--Total Number of MSNs Mailed.

Section 3893.8 - Exhibits, Exhibit 1 is revised to reflect the addition of Line 40 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.

Provider-Count one per contact (telephone, walk-in, or written). For example, if a provider calls or writes to obtain the status of 3, 6, or 10 separate bills, count the response as 1 provider telephone or written inquiry.

Include or exclude beneficiary and provider inquiries as follows:

- o Count as inquiries requests for Medicare information from beneficiaries or providers or their representatives which are directed to you for response.

- o Do not count processed inquiries which are concerned solely with your line of business.

- o Do not count inquiries concerned with professional relations activities.

- o Do not count inquiries related solely to payment issues, MR or utilization review, MSP, audits, etc. These are areas for which you receive separate Medicare funding. This exclusion achieves comparability with the HCFA-1523 budget form.

- o Count voice inquiries captured electronically as telephone inquiries, and electronic mail inquiries as written inquiries. Count electronic inquiries only if the response is provided by telephone or in writing and requires your involvement. Do not count electronic inquiries if the provider can directly access your system to determine bill status.

- o Count Congressional inquiries according to whether they were made on behalf of a beneficiary or provider.

- o Count inquiries made by ROs or SSA district offices only if they concern a Medicare bill and are made on behalf of a beneficiary or provider.

- o Count misdirected telephone inquiries referred to another source for a final response. Do not count misdirected written inquiries.

- o Do not count inquiries which are, in fact, explicit or implicit requests for reconsiderations or hearing. See §§3780ff. for specifics on what is a request for reconsideration or review.

Report the number of inquiries from beneficiaries (column 2) and providers (column 3) processed during the reporting month, as follows:

Line 34--Total.--Report in the appropriate column the total number of inquiries processed.

Line 35--Telephone Inquiries.--Report in the appropriate column the total number of telephone inquiries processed.

Line 36--Walk-in Inquiries.--Report in the appropriate column the total number of walk-in contacts processed.

Line 37--Written Inquiries.--Report in the appropriate column the total number of written inquiries responded to.

OPTICAL CHARACTER RECOGNITION BILLS

Line 38--Total Bills Received.--Enter the total number of bills that you received in hardcopy and entered using an OCR device. Do not count these bills as electronic media bills on line 5, page 1, or in column 8, pages 2-11.

BILLS PAID BY HMOs

Line 39--Total HMO Bills Processed.--Enter the number of bills which were paid by HMOs and processed by you during the reporting month. Report HMO bills paid by you on line 12 but do not report such bills on line 39.

MEDICARE SUMMARY NOTICES

Line 40--Total MSNs Mailed.--Enter the number of MSNs you mailed to beneficiaries during the reporting month.

3894. COMPLETING PAGES 2 THROUGH 21 OF INTERMEDIARY WORKLOAD REPORT

3894.1 Heading.--These pages are referenced as Form U (pages 2-11) and Form E (pages 12-21) in the CROWD system. Complete the ADD/UPDATE/DELETE DATA criteria screen with the appropriate information to bring the reporting format to your screen.

3894.2 Checking Reports.--Before submitting Forms U and E to CMS, check for completeness and arithmetical accuracy. Use the following checklist:

- For each column, line 38 must equal the sum of lines 1-37.
- For lines 1-38 on pages 2-11, column 1 must equal the sum of columns 2-7.
- For each of lines 1-38 on pages 2-11, column 8 must must be less than or equal to column 1.
- For each of lines 1-38 on pages 12-21, column 1 must be less than or equal to column 2 for the corresponding bill type on pages 2-11.
- For each of lines 1-38 on pages 12-21, column 2 must be less than or equal to column 3 for the corresponding bill type on pages 2-11.
- The “Total” pages (pages 11 and 21) must equal the sum of all the bill types (pages 2-10 and 12-20 respectively) for each data element on the page, except line 39.

3894.3 Body of Report.

SECTION E(1): CLAIMS PROCESSING TIMELINESS—ALL CLAIMS

Pages 2-11 of the HCFA-1566 include data on your activity in processing all bills to completion during the reporting period. Count the bill as processed to completion on the "scheduled payment date," which is the date the check you issued is mailed, deposited by you in the provider's account, or transferred electronically. For PIP bills and no payment bills, the "scheduled payment date" is the date for payment bills in the same adjudication batch. Base data shown on reliable counts of all bill processing activity. Do not estimate bill counts. Report data on initial bills only (including demand bills and no-pay bills submitted by providers with no charges and/or covered days/visits). Do not include:

EXHIBIT 1

Form HCFA 1566 - Medicare Program Intermediary Workload Report, Page 1

Intermediary Name:		**Reporting Period:**				
Intermediary Number:		**Number of Working Days:**				
SECTION A: INITIAL BILL PROCESSING	**TOTAL (1)**	**INPATIENT (2)**	**OUTPATIENT (3)**	**SNF (4)**	**HHA (5)**	**OTHER (6)**
Opening Pending						
1. Opening Pending						
2. Adjustments (+ or -)						
3. Adj Opening Pending						
Receipts						
4. Received during Mnth						
5. Electronic Media						
Clearances						
6. Total CWF Bills						
7. Payment Approved						
8. No Payment Approved						
9. Total Non-CWF Bills						
10. Payment Approved						
11. No Payment Approved						
12. Total Processed						
Closing Pending						
13. Pending End of Mnth						
14. Longer than 1 Mnth						
15. Longer than 2 Mnths						
Bill Investigations						
16. Investigations Init						
SECTION B: ADJUSTMENT BILLS						
CWF Clearances						
17. Total CWF Processed						
18. PRO Generated						
19. Provider Generated						
20. MSP						
21. Other						
Non-CWF Clearances						
22. Total Non-CWF Prcsd						
23. PRO Generated						
24. Provider Generated						
25. MSP						
26. Other						
Pending						
27. Total Pending						
28. PRO Generated						
29. Provider Generated						
30. MSP						
31. Other						
SECTION C: MEDICAID CROSSOVER BILLS						
Clearances						
32. Trans to St Agencies						
33. Trans Electronically						
SECTION D:						

MISCELLANEOUS DATA	**TOTAL**	**BENEFICIARY**	**PROVIDER**
Inquiries			
34. Total Inquiries			
35. Telephone			
36. Walk-In			
37. Written			
OCR Bills			
38. Total Received		**MSN Data**	
Bills Paid by HMOs		40. Total Mailed	
39. Total Processed			

EXHIBIT 2

SECTION E(1): CLAIMS PROCESSING TIMELINESS--ALL CLAIMS

Form HCFA 1566 - Medicare Program Intermediary Workload Report, Pages 2-11

Intermediary Number:		**Bill Type:**				**Report Month:**		
		********** PAID **********				*** NOT PAID ***		
		** PIP **		**** I P ****				
DAYS TO PROCESS	**TOTAL (1)**	**CLEAN (2)**	**OTHER (3)**	**CLEAN (4)**	**OTHER (5)**	**CLEAN (6)**	**OTHER (7)**	**EMC (8)**
1. 1								
2. 2								
3. 3								
4. 4								
5. 5								
6. 6								
7. 7								
8. 8								
9. 9								
10. 10								
11. 11								
12. 12								
13. 13								
14. 14								
15. 15								
16. 16								
17. 17								
18. 18								
19. 19								
20. 20								
21. 21								
22. 22								
23. 23								
24. 24								
25. 25								
26. 26								
27. 27								
28. 28								
29. 29								
30. 30								
31. 31								
32. 32								
33. 33								
34. 34-45								
35. 46-60								
36. 61-90								
37. 91+								
38. Total								
39. Mean PT								

HCFA-1566, Page

Page number and bill type to be reported as follows:

Page 2 - Inpatient Hospital (INP)
Page 3 - Outpatient (OUT)
Page 4 - SNF (SNF)
Page 5 - HHA (HHA)
Page 6 - Hospice (HPC)
Page 7 - CORF (COR)
Page 8 - ESRD (ERD)
Page 9 - Lab (LAB)
Page 10 - Other (OTH)
Page 11 - Total (TOT)