CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-06 Medicare Financial Management	Centers for Medicare & Medicaid Services (CMS)
Transmittal 123	**Date: JUNE 8, 2007**
	Change Request 4274

NOTE: Transmittal 121 dated May 2, 2007 is rescinded and replaced with Transmittal 123, dated June 8, 2007. Business Requirements 4274.2, 4274.19, and 4274.21 have been deleted. Changes were made to the manual as a result of the transfer of Medigap responsibility to the COBC. All other information remains the same.

SUBJECT: Contractor CROWD Form 5 Completion Changes

I. SUMMARY OF CHANGES: DME MACs must begin to report additional data in CROWD Form 5. Carriers and fiscal intermediaries (FIs) began to report much of that additional data in April 2006 under CR 3864. As result of the length of time since issuance of CR 3864, some of the reporting requirements in that CR are now obsolete. Reporting of certain data is no longer required by the carriers, A/B MACs, FIs or DME MACs. In addition, further clarification has been added to the requirements for reporting of eligibility information on lines 2, 3 and 14, and check boxes have been added to the beginning of the form to indicate if the data on the form applies to institutional or professional providers.

NEW / REVISED MATERIAL
EFFECTIVE DATE: *October 1, 2007
IMPLEMENTATION DATE: October 1, 2007

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:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2007 operating budgets.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

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

Attachment - Business Requirements

Pub. 100-06	Transmittal: 123	Date: June 8, 2007	Change Request: 4274

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SUBJECT: Contractor CROWD Form 5 Completion Changes

Effective Date: October 1, 2007

Implementation Date: October 1, 2007

I. GENERAL INFORMATION

A. Background:

CMS collects statistics in CROWD that establish the number of EDI transactions processed, other than the X12 270/271 version 4010A1 for which statistics are separately collected. Although CR 3864 expanded reporting requirements for carriers and FIs for many of the lines in Form 5, that CR did not apply to the Durable Medical Equipment (DME) contractors as there were not enough VMS release hours available to make those changes at that time. This CR now requires implementation of the expanded Form 5 reporting requirements by the VMS maintainer and the DME Medicare Administrative Contractors (DME MACs).

CMS needs this information to measure performance for the annual CMS Government Performance Reporting Act (GPRA) report. This CR also: includes five business requirements not included in CR 3864 that affect fiscal intermediaries (FIs), carriers and A/B MACs; deletes the requirement for reporting of information on the UB-92 and CMS-1500 (12/90) forms in CROWD Form 5 since all use of those forms will have been discontinued by the time this CR is implemented; and corrects two titles on the form in response to comments sent to CMS after release of CR 3864.

Due to the termination of the Medicare HIPAA Remittance Advice Contingency Plan and the transition of all Medigap and COB claims transfer responsibilities to the COBC by October 1, 2007, the Form 5 field for non-HIPAA compliant remittance advice transmission has been grayed out, and the names for lines 4 and 7 of the report have been replaced by "Reserved for Future Use".

B. Policy:

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, on paper, or in the case of certain pilots, via the Internet. Many of these alternate means of conducting these activities are more expensive than use of EDI so we also need to determine if increasing use of EDI is resulting in reduction of use of these alternate methods to conduct the same business. To most accurately determine the benefits from use of EDI, it is necessary to look at the full picture to the extent possible.

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement
Use "Should" to denote 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.

The effective date for these business requirements is based upon the date of adjudication or other processing date as specified in each business requirement, and not upon the date of service. Data to be collected by VMS and CWF will first be collected by them for the month of October 2007, and will first be reported by the DME MACs in the CROWD Form 5 report due in November 2007 for October.

Number	Requirement	Responsibility (place an "X" in each applicable column)											
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	EDC	Shared-System Maintainers				OTHER
									FISS	MCS	VMS	CWF	
4274.1	VMS shall report the number of X12 837 version 4010A1 claims adjudicated during the prior month by each DME contractor.										X		
4274.2	Blank but retained to avoid renumbering of the following business requirements.												
4274.3	VMS shall report the number of claim status responses issued for delivery via DDE screen per DME MAC the prior month. Each CCN for which claim status is reported shall be counted as a separate transaction.										X		
4274.4	VMS shall report the number of X12 277 version 4010A1 response flat file records issued per DME MAC the prior month. Each CCN for which claim status data is reported in the same 277 shall be counted as a separate response.										X		
4274.5	VMS shall report the number of claim status responses they issued for IVR delivery per DME MAC the prior month. Each CCN for which claim status is reported during the same IVR session shall be counted as a separate response. (Claim status data that a DME MAC obtains by "screen scraping" that data from the shared system cannot be counted by the shared system and must be counted by that DME MAC.)										X		
4274.6	VMS shall report the number of eligibility EDI legacy format flat file records issued per DME MAC the prior month. Each HIC for which such eligibility data was reported shall be counted as a										X		

Number	Requirement	Responsibility (place an "X" in each applicable column)											
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	EDC	Shared-System Maintainers				OTHER
									FISS	MCS	VMS	CWF	
	separate response.												
4274.7	VMS shall report the number of eligibility responses furnished per DME MAC for IVR delivery the prior month. Each HIC for which eligibility data is supplied shall be counted as a separate response. (Eligibility data that a DME MAC obtains by "screen scraping" that data from the shared system cannot be counted by the shared system and must be counted by that DME MAC.)										X		
4274.8	VMS shall report the number of ERA flat file records sent per DME MAC for translation to an 835 version 4010A1 transaction during the prior month. Each ST-SE is to be counted as a separate 835.										X		
4274.9	VMS shall report the number of flat file records issued to each DME MAC during the prior month to enable them to print and mail SPRs.										X		
4274.10	VMS shall report the number of EFT indicators sent to each DME MAC for provider claim-related EFT payments during the prior month. Each EFT shall be counted separately.										X		
4274.11	VMS shall report the number of paper check indicators that were sent to each DME MAC during the prior month. Each paper check that was to be printed shall be counted separately.										X		
4274.12	VMS shall report the dollar value of the EFTs (as in BR 4274.10) issued per DME MAC during the prior month.										X		
4274.13	VMS shall report the dollar value of the paper checks (as in BR 4274.11) that were to be issued per DME MAC during the prior month.										X		
4274.14	By the 5th of each month, VMS shall issue, or make available for DME MAC electronic access, a record that includes all data per DME MAC for the prior month as included in Business Requirements 4274.1-13.										X		
4274.15	CWF shall report the number of eligibility responses issued per DME MAC the prior month as ELGB or other eligibility responses delivered either via a DDE screen or as a response to a non-DDE query. CWF shall insert this information in											X	

Number	Requirement	Responsibility (place an "X" in each applicable column)											
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	EDC	Shared-System Maintainers				OTHER
									FISS	MCS	VMS	CWF	
	the CWF ORPT report by the 5th of the month for access by each DME MAC.												
4274.16	DME MACs that obtain information for any of their claim status IVR responses from a source other than their shared system or that "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 HIC per date of service shall be counted as a separate response. The data will be reported in CROWD Form 5 following the close of each month.		X										
4274.17	DME MACs that obtain information for any of their eligibility IVR responses from a source other than CWF via an ELGB or other query shall maintain a count of the number of IVR beneficiary eligibility responses issued using that alternate source of information during the prior month, including when a DME contractor obtains eligibility data by "screen scraping" that data for IVR response reporting. 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.		X										
4274.18	DME MACs shall accumulate the data required for CROWD Form 5 as indicated in Business Requirements 4274.14-.17, and electronically submit the completed Form 5 by the 15th of each month with the data reported by VMS and the CWF maintainer.		X										
4274.19	Blank but retained to avoid renumbering of the following business requirements.												
4274.20	MCS and FISS shall discontinue tracking the number of non-HIPAA compliant remittance advice flat files issued. That contingency plan ended October 1, 2006. Carriers, FIs and A/B MACs formerly reported this total in line 8, column 3.								X	X			
4274.21	Blank but retained to avoid renumbering of the following business requirements.												
4274.22	Carriers, FIs and A/B MACs shall check a single	X		X	X		X						

Number	Requirement	Responsibility (place an "X" in each applicable column)											
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	EDC	Shared-System Maintainers				OTHER
									FISS	MCS	VMS	CWF	
	box at the top of Form 5 to indicate whether data being submitted on a form is for institutional or for professional provider transactions.												
4274.23	Carriers, FIs and A/B MACs shall discontinue reporting of totals for the number of CMS-1500 (12/90) and UB-92 paper claim forms processed on line 15. Instead, a single total of paper claims is to be reported on line 15, column 2.	X		X	X		X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)											
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	EDC	Shared-System Maintainers				OTHER
									FISS	MCS	VMS	CWF	
N/A													

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
3864.1-.32	CR 3864

B. For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): Kathleen Simmons, Kathleen.Simmons@cms.hhs.gov, 410-786-6157

Post-Implementation Contact(s): Robert Huffman, Robert.Huffman@cms.hhs.gov, 410-786-6317

VI. FUNDING

A. ***A. For Fiscal Intermediaries and Carriers*:**

No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2008 operating budgets.

B. ***For Medicare Administrative Contractors (MAC)*:**

The contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the Statement of Work (SOW). The contractor is not obligated to incur costs in excess of the amounts specified in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

450.3 – Body of Report

(Rev.123, Issued: 06-08-07, Effective: 10-01-07, Implementation: 10-01-07)

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 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*, DME MACs, A/B MACs* and FIs by the 15th of each month. Data due from a shared system or from CWF must be available for carrier*, DME contractor, A/B MAC* 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*, DME MACs, A/B MACs* or FIs. When applicable, that data must also be tracked for each calendar month.

Institutional and professional blocks have been added to the identification area at the top of the form. A/B MACs process both institutional and professional claims but are expected to separately report their professional and institutional data in CROWD. One CROWD Form 5 must be submitted for professional data and another for institutional data. This corresponds to the separate professional and institutional reporting always done by carriers and FIs. Every CROWD Form 5 submitted must have a check mark next to either institutional or professional. This will enable CMS to compare statistics received from the A/B MACs against historical data separately submitted by carriers and FIs.

B. Line and Column CROWD Form 5 Completion Requirements

CROWD reports must be submitted by carriers*, DME MACs, A/B MACs* and FIs. They cannot *currently* 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*, DME MACs, A/B MACs* and FIs for translation into X12 277 transactions. Each carrier*, DME contractor, A/B MAC* and FI is to report that total in column 1. Shared systems are to count each occurrence of the unique trace or claim transaction number *(ICN/DCN/CCN)* 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, such as unable to locate a claim for that HIC on that day) responses in the count, but do not include queries that were rejected as incomplete or incorrect.

Contractors participating in an Internet pilot that involves claim status data do not obtain their information from a shared system and do not record responses by transaction number (DCN or CCN). They are to track responses by HIC instead. Pilot contractors must report on line 1, column 3, the total of HICs for which they issued claim status responses during the prior month. They are to include both positive (able to furnish requested status) as well as negative (unable to furnish requested status for some reason) responses in the count, but must exclude any claim status responses that may have been issued via *means other than the Internet* in the total reported in column 3. Since it would be very difficult or even impossible for Internet pilot contractors to track responses issued by State, those contractors are permitted to report all Internet responses they issued under the primary contract number that applies to that company, i.e., the contract number under which funding is issued to the contractor by CMS.

Line 2 – Responses to Eligibility Inquiries – Shared systems are to track the number of eligibility responses they *may* send *in a flat file* to *each of* their carriers*, DME MACs, A/B MACs* and FIs for issuance *electronically* in legacy formats. Shared systems must exclude from their per carrier*, DME contractor, A/B MAC* and FI totals, the number of these eligibility flat file records produced using CWF HUQA responses. Carriers*, DME MACs, A/B MACs* 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 *the line 2, column 1* total. *DDE and IVR totals are to be entered on line 14.* Each 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.

Contractors that operate a pilot to allow providers to obtain beneficiary eligibility data via the Internet must track the number of individual Internet eligibility responses they issue. Each unique occurrence of an individual beneficiary HIC number must be counted as a separate eligibility response. Eligibility responses *issued* via non-Internet DDE/PPTN*/PINQ* or an IVR must be excluded from the monthly total reported in column 3. *Since it would be very difficult or even impossible for Internet pilot contractors to track responses issued by State, those contractors are permitted to report all Internet responses they issued under the primary contract number that applies to that company, i.e., the contract number under which funding is issued to the contractor by CMS.*

Line 3 – HUQA Eligibility Responses--In lieu of use of DDE or the 270/271, 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 contractor responsible for processing of

claims for the provider requesting the eligibility data, enabling the CWF maintainer to track and notify each contractor of the total number of clearinghouse and provider HUQA eligibility responses processed through CWF.

Contractors sometimes request HUQAs for local purposes also. Contractors 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 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. Contractor staff members assigned to CWF have access to this file. Staff members in the 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—*Reserved for future reporting needs.*

NOTE: Lines 5, 6 and 7 are to be completed by DME MACs only.

Line 5 – Prior Authorization*s* or Advance Determination of Medicare Coverage Requests – *DME MACs* are to track and report the number of these decisions issued. (This count *must exclude* telephone discussions about Medicare coverage, but *include* those cases which result in issuance of specific prior authorization or advance determination decisions.) *If any of these decisions are issued electronically, that total must be reported in column 1. Manually issued prior authorization decisions are to be reported in column 2.*

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 count each unique occurrence of a claim control number as a separate claim. The DME MACs are to report this number in column 1.*

Line 7 –*Reserved for future reporting needs.*

> *NOTE: Lines 8-11 and 13-15 apply to all carriers, DME MACs, A/B MACs and FIs. Line 12 applies to FIs and A/B MACs only*

Line 8 – Remittance Advices--Number Sent – Shared systems are to track the number of 835 version 4010A1 flat files sent their carriers*, DME MACs, A/B MACs* 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*, DME MACs, A/B MACs* and FIs must report *the total number of ERAs* in column 1.

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

As result of termination of the Medicare electronic remittance HIPAA contingency plan effective October 1, 2006, an entry is no longer required in column 3 by any carriers*, DME MACs, A/B MACs or* FIs.

The total number of remittance advice records furnished via the Internet is to be reported in column 4. A *future CR is expected* concerning *a pilot for* 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 *or Suppliers*– Shared systems are to track the number of electronic fund transfers (EFTs) and paper checks for provider claim payments that the carriers*, DME MACs, A/B MACs* 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 *or* an SPR. The paper check total must be the total of paper checks sent in conjunction with an SPR or an 835 version 4010A1. In some cases, a remittance advice might not have any payment because all the claims were denied, 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 an investigation. As result, the number of payments does not always equal the number of SPRs and ERAs issued. Carriers*, DME MACs, A/B MACs* and FIs must report the EFT total in column 1 and the paper check total in column 2.

Line 10 – Dollar Amounts Associated w/Payments – Shared systems must track the dollar value of the EFTs *and* checks issued by their carriers*, DME MACs, A/B MACs* and FIs for provider claim payments each month. The carriers*, DME MACs, A/B MACs* 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—Shared systems must track the following information which each carrier*, DME contractor, A/B MAC* 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).

- 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.

  NOTE: For lines 12-14, shared systems, carriers*, DME MACs, A/B MACs* and FIs must limit reporting to those transactions for which their providers can obtain the type of data noted using DDE (exclude 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 HIQA, ELGA, ELGB and *ELGH queries to respond to* DDE eligibility requests. *The CWF maintainer* must report the monthly total of each of those response types in the ORPT file for carrier, FI, *DME MAC or A/BMAC* 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 *and A/B MACs* must report the total number of adjustments in column 2.

Line 13—DDE/IVR Claim Status *Responses*—Shared systems must track the number of claim status responses issued via a DDE screen. Carriers*, DME MACs, A/B MACs* 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*, DME contractor, A/B MAC* 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*, DME contractor, A/B MAC* or FI must report that number in the *third* column. If a carrier*, DME contractor, A/B MAC,* FI, or a data center, "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*, DME contractor, A/B MAC* or FI must count the number of these responses issued via IVR and report that number in the *third* column. Count each *HIC/date of service* for which status is reported as a separate claim status response.

Line 14—*CWF or IVR Eligibility Responses*—CWF must track the number of DDE (HIQA, ELGA, ELGB *or ELGH*) *responses* issued per carrier*, DME contractor, A/B MAC* and FI during the prior month *as applicable* and report the numbers in the CWF ORPT file. Carriers*, DME MACs, A/B MACs* and FIs must report the *CWF* total 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 *by CWF*.

If a carrier*, DME MAC, A/B MAC* or FI *obtains eligibility data from their shared system or* an alternate source for IVR eligibility responses, that carrier*, DME MAC, A/B MAC* or FI must track the number of eligibility responses they issue using the *shared system and* alternate source *eligibility data and report that total in the third column of line 14*. *Alternate sources would include CWF, the CMS central office eligibility database under a pilot and any other eligibility data repository not separately listed here that may be available for the contractor's use.* 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—*Shared systems shall track the total number of paper claims processed per contractor and each carrier, A/B MAC, DME MAC and FI shall report their UB-04 or CMS-1500 (08/05) total in column 2.*

450.4 – Exhibit 1

(Rev.123, Issued: 06-08-07, Effective: 10-01-07, Implementation: 10-01-07)

MEDICARE CONTRACTOR TRANSACTIONS
(CROWD FORM 5)

CONTRACTOR NUMBER____________ REPORT PERIOD______________

INSTITUTIONAL ☐ *or PROFESSIONAL* ☐

TYPE OF TRANSACTION	**ELECTRONIC**	**NON-ELECTRONIC** (MANUAL PROCESSES)	**INTERNET**
ALL CONTRACTORS			
1. RESPONSES TO CLAIMS STATUS INQUIRIES			
2. RESPONSES TO ELIGIBILITY INQUIRIES *(Exclude HUQA)*			
3. HUQA ELIGIBILITY RESPONSES			
4. *Reserved for Future Use*			
***DME MACs* ONLY**			
5. PRIOR AUTHORIZATIONS OR ADVANCED DETERMINATIONS OF MEDICARE COVERAGE ISSUED			
6. NCPDP RETAIL PHARMACY DRUG CLAIMS PROCESSED			
7. *Reserved for Future Use*			

ALL CONTRACTORS				
8. REMITTANCE ADVICES—NUMBER SENT	**835 v. 4010A1**	**SPR**		***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**	**DDE, HIQA/ ELGA/ELGB/ *ELGH, CWF***	***IVR***	
11. ELECTRONIC CLAIMS PROCESSED				
12. DDE CLAIM ADJUSTMENTS REC'D				
13. DDE/IVR CLAIM STATUS RESPONSES				
14. CWF or IVR ELIGIBILITY RESPONSES				
15. PAPER CLAIMS PROCESSED				