CMS Manual System

Pub. 100-06 Medicare Financial Management

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

Transmittal 47 **Date: JUNE 25, 2004**

CHANGE REQUEST 3256

NOTE: This transmittal replaces transmittal 43 dated April 30, 2004. This replacement adds addition questions and answer that were received after the initial release, adds an attachment which assigns BSI and updates the tables of contractors.

I. SUMMARY OF CHANGES: The purpose of this change request is to develop a means to identify and track Medicare Fee-for-Service workloads by state level and contract type.

NEW/REVISED MATERIAL - EFFECTIVE DATE: 10/01/04
***IMPLEMENTATION DATE: 10/04/04**

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.

II. CHANGES IN MANUAL INSTRUCTIONS: (*N/A if manual not updated.*)
(R = REVISED, N = NEW, D = DELETED – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	3/180/Table of Contents
R	3/180.1.3/POR System User Manual
N	3/180.1.6/Request Provider Debts from the POR History File
N	3/180.1.7/Request Ad Hoc Reports from (ARMS)
R	10/Table of Contents
R	10/10 General Inforamtion
R	10/20/Structure of the Workload Identifier
R	10/30/Initial Implementation
R	10/40/Basic Requirements and Uses of the Identifier
R	10/50/Maintenance of Contractor Workload Identifiers
R	Exhibit 1 Contractor Workload identifiers

***III. FUNDING:**

These instructions shall be implemented within your current operating budget.

IV. ATTACHMENTS:

X	**Business Requirements**
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

***Medicare contractors only**

Attachment - Business Requirements

Pub. 100-06	Transmittal: 47	Date: June 25, 2004	Change Request 3256

NOTE: This business requirement replaces revision 43 dated April 30, 2004. This replacement adds addition questions and answer that were received after the initial release, adds an attachment, which assigns BSI and updates the tables of contractors.

SUBJECT: Expanded Identification and Workload Reporting for CMS Medicare Systems

I. GENERAL INFORMATION

A. Background:

This change request is a complete replacement for CR 3023. CR 3256 represents the first phase of implementation of the new contractor workload identifier and will address the Shared Systems, CWF, CROWD and POR. CMS intends to fully implement the contractor workload identifier throughout Medicare claims administration systems as was discussed in the early development workgroup. Changes to incorporate the new identifier in other major systems (HIGLAS, REMAS, PECOS, PIMR, CERT, COBC) will be phased in through future change requests.

This change request is necessary for the implementation of Medicare Contracting Reform as required by Section 911 of the Medicare Modernization Act of 2003.

CMS will develop and phase into use a new contractor/workload identification system that is intended to distinguish specific claims administration workloads on a geographic basis. The new system will identify claims administration "business segments". For the near future, this system will be used in conjunction with the Contractor Reporting of Workload Data (CROWD) system of contractor and workload identifiers and CROWD workload reports will be submitted at the business segment level. However, the system is designed to identify key aspects of a claims administration workload and may ultimately replace the CROWD Identifiers.

Additionally, this instruction and the new system of identifiers will address a problem in which specific intermediary and RHHI workloads are not uniquely identified in the current CROWD reporting structure. Eleven of the 27 intermediaries (FIs) currently use a single contractor ID number to process and report two or more individual state-associated workloads. In addition, the four regional home health intermediaries (RHHIs) process and report home health and hospice claims administration under the ID number assigned to the FI for Part A workloads. The resulting CROWD management reports include home health and hospice claims administration workloads along with the inpatient and other Part A workloads.

For example, a fiscal intermediary processes claims for two States and several providers that nominated the contractor and also serves as an RHHI. Currently, all transactions are processed

under one contractor number. If this contractor leaves the Medicare program, its workload cannot be differentiated by FI or RHHI, or at the state level.

All these and other Medicare claims administration workloads need to be distinguished at a more granular level in order to position the Medicare Program for Contracting Reform as required in the Medicare Modernization Act of 2003. The proposed changes will also improve current workload reporting processes and provide better management information.

B. Policy:

Summary of Changes

The purpose of this change request is to develop a means to identify and track Medicare Fee-for-Service (FFS) workloads by state level and contract type (FI, RHHI, Carrier, or DMERC) by creating:

- A unique workload identifier for each intermediary-processed State workload;
- A unique workload identifier for each RHHI-processed State workload;
- A unique workload identifier for each carrier-processed State workload; and
- A unique workload identifier for each DMERC regional workload.

The workload identifier herein is referred to as the Contractor Workload Identifier (ID). It is a nine-digit alphanumeric identifier composed of the following:

1. The first five characters equal the five-digit CROWD reporting number currently used for the CROWD Workload reports (for example, 00308 = Empire Blue Cross and Blue Shield).

2. The last four characters represent the Business Segment, captured as a separate field on each transaction. It consists of the following:

    A. A two-character contract jurisdiction code, which is represented by the official United States Postal Service (USPS) state/territory abbreviation, where applicable (for example, New York = NY). These are the sixth and seventh characters of the contractor ID number. There will be a few exceptions:
        - The business segments for the Railroad Retirement Board carrier, Mutual of Omaha and the DMERCs will represent the aggregated workloads, rather than state level workload.
        - The carrier workloads for Kansas City, currently processed under contractor ID 00651, and the District of Columbia workload, currently processed under contractor ID 00903, will remain intact and do not have to be subdivided by state/political jurisdiction.

    B. A two-character modifier to identify the type of Medicare FFS contract (for example, A_= intermediary, R_= RHHI, B_= carrier, D_ = DMERC). These

are the eighth and ninth characters of the contractor ID number. For now, the ninth character is filled with a space, represented herein by an underscore (_).

Empire Blue Cross Blue Shield has the Medicare Part A contract jurisdiction for the states of New York, Connecticut, and Delaware. Therefore, in this example, the contractor workload IDs for Empire Part A are as follows:

- Empire Part A New York = 00308NYA_;
- Empire Part A Connecticut = 00308CTA_; and
- Empire Part A Delaware = 00308DEA_.

Intermediary systems shall be modified to add the Business Segment to all claim transactions and provider files. Carrier and DMERC systems shall add the Business Segment to the provider file but shall not be required to carry the Business Segment on internal records. All Shared Systems shall add the indicator to outgoing claims transactions to CWF and shall add the indicator to workload and management reports. The indicator may be added as a separate field and the two fields shall be concatenated for reporting purposes when required

This new business segment field is not intended to alter claims processing. Provider submission of electronic media claims will not change. Within the shared systems, the cycles and formats of outputs (check runs, Remittance Advice printing, etc) will not change. The business segment indicator will not be used on transactions in or out of the "system of systems", i.e. it will not be used on external records, so it is not subject to HIPAA requirements and provider education is not required. The functions fulfilled by the current 5-character contractor ID will continue for communications with CWF and the data centers.

The business segment is not intended to change any financial reporting to CMS (e.g. 1521, 1522, 456, 750, 751) or administrative cost reports (e.g. Interim Expenditure Report, NOBA, etc). Contractors should continue to produce these reports using the existing 5-character contractor identifiers. CAFM will extract the composite (contractor summary level) CROWD data to feed the financial reports.

C. Provider Education: None.

II. BUSINESS REQUIREMENTS

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

Requirement #	Requirements	Responsibility
3256.1	Medicare systems shall implement changes necessary to accommodate tracking data at the Contractor Workload Identifier (ID) level. It is a nine-digit	FISS, MCS, and VMS (herein referred to as

	alphanumeric identifier composed of the following: 1. The first five characters equal the five-digit CROWD reporting number currently used for the CROWD Workload reports (for example, 00308 = Empire Blue Cross and Blue Shield). 2. The last four characters represent the Business Segment, captured as a separate field. It consists of the following: A. A two-character contract jurisdiction code, which is represented by the official United States Postal Service (USPS) state/territory abbreviation, where applicable (for example, New York = NY). For DMERCs, these two positions will reflect the DME region, e.g. RA = Region A. These are the sixth and seventh characters of the Contractor ID number. B. A two-character modifier to identify the type of Medicare FFS contract (for example, A_=Intermediary, R_=RHHI, B_=Carrier, D_=DMERC). These are the eighth and ninth characters of the Contractor ID number. For now, the ninth character is filled with a space. Empire Blue Cross Blue Shield has the Medicare Part A contract jurisdiction for the states of New York, Connecticut, and Delaware. Therefore, in this example, the contractor workload IDs for Empire Part A are as follows: • Empire Part A New York = 00308NYA_ • Empire Part A Connecticut = 00308CTA_ • Empire Part A Delaware = 00308DEA_	Shared Systems when all three are impacted) CROWD/CMIS CWF POR
3256.1.1	CMS shall supply a list of contractor and Business	CMS

	Segment Identifiers (BSI). See Attachment A and new manual instructions.	
3256.1.1.1	FISS and MCS shall add the contractor workload identifier field to all provider file records.	FISS MCS
3256.1.1.2	FISS shall add the contractor workload identifier to all provider related transactions.	FISS
3256.1.1.3	Carriers shall add these Contractor Workload IDs to all claims transactions submitted to CWF as delineated in CWF specifications	MCS VMS CWF
3256.1.1.4	FISS shall add these contractor workload IDs to all claims transactions submitted CWF as delineated in CWF specifications as the FI populates the BSI to the provider file,	FISS
3256.1.1.5	CWF shall store and maintain the ID on its history and make it available for review in HIMR.	CWF
3256.1.1.6	These two fields (Contractor ID and Business Segment) shall be concatenated as needed for reporting workloads and for workload transitions.	Shared Systems Contractors CWF
3256.1.2	Intermediaries and regional home health intermediaries shall assign each provider they serve to a specific state-associated workload for workload tracking and reporting according to the state in which the provider is located or the state associated workload to which the nomination or chain relationship applies. Intermediaries shall maintain the business segment on the provider file. FIs shall begin assigning and entering BSIs to the provider file in October, 2004 and shall have completed the entire provider file by December 15, 2004.	FIs RHHIs
3256.1.2.1	FIs shall assign providers not located in the contracted state jurisdiction ("out of area") according to the following rules: 1. If the "out of area" provider or chain of providers is serviced through a nomination of selected contractor, assign the provider to the state-associated workload to which the nomination relates. 2. If the "state" of the nomination cannot be determined, assign the provider to the state represented by the contractor's home office for administrative budget and cost reporting purposes.	FIs RHHIs
3256.1.2.2	The alternate RHHI shall assign the HHAs that are not in their service area to the state in which the provider is located or the chain home office is	Alternate RHHI

	located.	
3256.1.2.3	FIs shall assign the specialty workloads and demonstrations to the state-associated workload represented by the Contractor ID number for the home office for administrative budget and cost reporting purposes. Specialty workloads include: (This is not an all-inclusive list) • Rural health clinics (RHCs) at Anthem ME, Anthem NH, Highmark, Riverbend, TrailBlazer • Federally Qualified Health Centers (FQHCs) at UGS • Graduate Medical Demonstration at Empire • Histocompatibility Labs at Riverbend • Organ Procurement Agencies at Riverbend • Religious Non-Medical Health Care Institutions at Riverbend • Indian Health Services (IHS) at TrailBlazer	FIs
3256.1.2.4	FIs shall assign providers that are serviced only for audit of cost reports to the BSI with which the home office of the chain or the parent corporation is associated.	FIs
3256.1.2.5	RHHIs shall assign hospital based HHAs or hospices that they service for claims processing (as RHHI) and for cost report audit (as the FI) to the BSI that represents the home health/hospice workload.	RHHIs
3256.1.2.6	MCS shall auto-populate the BSI on the provider file.	MCS
3256.1.3	FISS shall prepare a management report for each contractor number on the status of provider BSI assignment. The report shall address the volume of providers assigned in each BSI by the physical location of the provider and the numbers of providers that have not yet been assigned a BSI. Sample formats for the FI and RHHI reports are shown at attachment 2.	FISS
3256.1.3.1	FIs and RHHIs shall submit the management report of BSI assignment for each contractor number to Centers for Medicare Management on a bi-weekly basis beginning Nov 1, 2004 and continuing until all providers are assigned. (See attachment 2.)	FIs RHHIs
3256.1.4	FISS shall add a new Business Segment field for all transactions that might create a pending workload that would be transferred upon contractor transition. Examples of transactions included are claims,	FISS

	adjustments, overpayments, appeals, void checks, cash receipts, settlement transactions, accelerated payments, penalties, PIP/Pass through payments, etc. The BSI shall be populated in these transactions whenever the BSI is coded on the provider file.	
3256.2	POR shall store the BSI on all Part A receivables.	POR
3256.2.1	Intermediaries shall input the BSI with all new receivables into the POR system as of the implementation date.	POR FIs RHHIs
3256.2.2	Intermediaries shall provide the BSI in any requests for re-openings or updates of existing provider debts on POR as of the implementation date.	POR FIs RHHIS
3256.3	FISS shall modify its data collection for CROWD workload reporting to gather data at the BSI level.	FISS
3256.3.1	Shared Systems and contractors shall implement CROWD reporting at the BSI level for the January 2005 reporting period.	Shared Systems Contractors CROWD/CMIS
3256.3.2	Contractors shall test the modifications for CROWD reporting during November – December, 2004. (Additional instructions will follow.)	Contractors CMIS/CROWD
3256.4	Medicare Shared Systems shall provide the capability to update/transfer the records/transactions for a Contractor Workload Identifier from one contractor to another to accommodate contractor transitions.	Shared Systems
3256.5	Contractors shall submit CROWD reports based on the Business Segment: • FIs and Carriers shall submit reports for each business segment, i.e. each line on the attached list, • DMERCs shall submit an aggregate report for the region, • RHHIs shall submit aggregate reports for each CROWD number, (i.e. one each for AHS, Cahaba, Palmetto and two for UGS), but shall collect, retain and have the ability to report at the State level as described in Requirement 3256.3.1 • The testing period will be November – December 2004 with implementation beginning with the January 2005 reporting period.	FIs Carriers RHHIs DMERCs Shared Systems CMS/CROWD

3256.5.1	Shared systems and contractors shall produce monthly and quarterly CROWD workload management reports by the unique Business Segment. The following CROWD forms are required: Monthly 1565 and 1566 all pages Monthly 1563 and 1564 Monthly 2590 and 2591 Quarterly 1565A and 1566A all pages Quarterly 1565C Quarterly 1566C Quarterly 1565D Quarterly 1565E Quarterly 2174 Line items for customer service and MSP savings from the special MSP contractor may be reported at the contractor level. Forms 5, Y and F and the Report of Benefit Savings are not required.	Shared Systems Carriers FIs RHHIs DMERCs CMIS/CROWD
3256.5.2	CMS shall modify CROWD and CMIS to allow data collections and extraction at the Business Segment level. Testing will be Nov – Dec 2004 with implementation beginning with the January 2005 reporting period.	CMS CROWD/CMIS
3256.5.3	CMS shall prepare summary reports (composites) of CROWD data for each contractor reflecting the totals for management and performance statistics of contractor operating sites.	CROWD/CMIS
3256.7.6	FISS shall develop a means to auto-populate the BSI to all open provider receivables once the BSI is assigned at the provider level. The auto-population shall be completed no later than 90 days after implementation of this CR.	FISS FIs
3256.8	Contractors and Shared Systems shall maintain all financial reporting under current procedures and contractor identifiers. Contractors shall continue to submit the 1521, 1522, 456, 750, 751 and all administrative cost reports (e.g. IER, NOBA, etc) under the existing protocols and contractor identification structures.	Shared Systems Contractors
3256.9	Upon implementation of this CR, FIs will have claims in process and pending that do not contain the BSI. Whenever those claims are processed to completion or remain “in process” at the end of the month, the counts for such claims shall default to the “parent” contractor number and BSI. This procedure shall apply to any CROWD report that tracks	FISS FIIs RHHIs

	activities and workload across months.	

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations:

X-Ref Requirement #	Recommendation for Medicare System Requirements
3256.1.1.6	The new Business Segment should be added to the affected records and concatenated for purposes of reporting or transmission to others of the Contractor Workload Identifier.

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact:

Contractor financial reporting will not be affected by this proposed expansion of contractor identification numbers. All contractor administrative budget and CAFM reporting will continue to be submitted under the number assigned to the contractor home office for administrative budget and cost reporting. The composite workload report (prepared by the CROWD system at CMS) will facilitate any necessary crosswalks of workload reporting to financial reporting and will facilitate CMS' review of contractor performance at the operating site level.

E. Dependencies: N/A

F. Testing Considerations:

Testing of CROWD reporting at the BSI level will be conducted in November and December 2004.

CMS will monitor intermediary progress in assigning business segment identifiers on the provider file via a temporary management report identified in requirements 3256.1.3 and 3256.1.3.1.

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date: October 1, 2004 **Implementation Date: October 4, 2004**	**These instructions shall be implemented within your current operating budget.**

Pre-Implementation Contact(s): Jane Herlocker, Jherlocker@cms.hhs.gov or (410)786-7412 **Post-Implementation Contact(s): Jane Herlocker, Jherlocker@cms.hhs.gov or (410)786-7412**	

Attachments

Attachment 1

Contractor Workload Identifiers

State	Contract Type	Contractor	Workload Identifier CROWD Identifier	Workload Identifier Business Segment
Multiple	FI	Mutual of Omaha	52280	NTA_
Multiple	Carrier	Railroad Retirement Board (Palmetto)	00882	RRB_
Alabama	FI	Cahaba	00010	ALA_
	Carrier	Cahaba	00510	ALB_
	RHHI	Palmetto	00380	ALR_
	DMERC	Palmetto	00885	RCD_
Alaska	FI	Noridian	00322	AKA_
	Carrier	Noridian	00831	AKB_
	RHHI	UGS	00454	AKR_
	DMERC	CIGNA	05655	RDD_
Arizona	FI	BCBS Arizona	00030	AZA_
	Carrier	Noridian	00832	AZB_
	RHHI	UGS	00454	AZR_
	DMERC	CIGNA	05655	RDD_
Arkansas	FI	BCBS Arkansas	00020	ARA_
	Carrier	BCBS Arkansas	00520	ARB_
	RHHI	Palmetto	00380	ARR_
	DMERC	Palmetto	00885	RCD_
California	FI	UGS	00454	CAA_
	Carrier	NHIC- Northern CA	31140	CAB_
	Carrier	NHIC- Southern CA	31146	CAB_

	RHHI	UGS	00454	CAR_
	DMERC	CIGNA	05655	RDD_
Colorado	FI	TrailBlazer	00400	COA_
	Carrier	Noridian	00824	COB_
	RHHI	Cahaba	00011	COR_
	DMERC	Palmetto	00885	RCD_
Connecticut	FI	Empire	00308	CTA_
	Carrier	First Coast	00591	CTB_
	RHHI	AHS Maine	00180	CTR_
	DMERC	HealthNow	00811	RAD_
Delaware	FI	Empire	00308	DEA_
	Carrier	TrailBlazer	00902	DEB_
	RHHI	Cahaba	00011	DER_
	DMERC	HealthNow	00811	RAD_
District of Columbia	FI	Carefirst of MD	00190	DCA_
	Carrier*	TrailBlazer	00903	DCB_
*Includes parts of MD and VA				
	RHHI	Cahaba	00011	DCR_
	DMERC	AdminaStar	00635	RBD_
Florida	FI	First Coast	00090	FLA_
	Carrier	First Coast	00590	FLB_
	RHHI	Palmetto	00380	FLR_
	DMERC	Palmetto	00885	RCD_
Georgia	FI	BCBS Georgia	00101	GAA_
	Carrier	Cahaba	00511	GAB_
	RHHI	Palmetto	00380	GAR_
	DMERC	Palmetto	00885	RCD_
Hawaii *	FI	UGS	00454	HIA_
	Carrier	Noridian	00833	HIB_
	RHHI	UGS	00454	HIR_
	DMERC	CIGNA	05655	RDD_
* Includes Guam and American Samoa				
Idaho	FI	Regence	00350	IDA_
	Carrier	CIGNA	05130	IDB_
	RHHI	UGS	00454	IDR_
	DMERC	CIGNA`	05655	RDD_

Illinois	FI	AdminaStar	00131	ILA_
	Carrier	Wisconsin Physicians Svc	00952	ILB_
	RHHI	Palmetto	00380	ILR_
	DMERC	AdminaStar	00635	RBD_
Indiana	FI	AdminaStar	00130	INA_
	Carrier	AdminaStar	00630	INB_
	RHHI	Palmetto	00380	INR_
	DMERC	AdminaStar	00635	RBD_
Iowa	FI	Cahaba	00011	IAA_
	Carrier	Noridian	00826	IAB_
	RHHI	Cahaba	00011	IAR_
	DMERC	CIGNA	05655	RDD_
Kansas	FI	BCBS Kansas	00150	KSA_
	Carrier	BCBS Kansas	00650	KSB_
	RHHI	Cahaba	00011	KSR_
	DMERC	CIGNA	05655	RDD_
Kentucky	FI	AdminaStar	00160	KYA_
	Carrier	AdminaStar	00660	KYB_
	RHHI	Palmetto	00380	KYR_
	DMERC	Palmetto	00885	RCD_
Louisiana	FI	Trispan	00230	LAA_
	Carrier	BCBS Arkansas	00528	LAB_
	RHHI	Palmetto	00380	LAR_
	DMERC	Palmetto	00885	RCD_
Maine	FI	Associated Hospital of ME	00180	MEA_
	Carrier	NHIC	31142	MEB_
	RHHI	Associated Hospital of ME	00180	MER_
	DMERC	HealthNow	00811	RAD_
Maryland	FI	Carefirst of Maryland	00190	MDA_
	Carrier *	TrailBlazer	00901	MDB_
	RHHI	Cahaba	00011	MDR_
	DMERC	AdminaStar	00635	RBD_
*See also District of Columbia				
Massachusetts	FI	Associated Hospital of ME	00181	MAA_
	Carrier	NHIC	31143	MAB_
	RHHI	Associated Hospital of ME	00180	MAR_
	DMERC	HealthNow	00811	RAD_
Michigan	FI	UGS	00452	MIA_

	Carrier	Wisconsin Physicians Svc	00953	MIB_
	RHHI	UGS	00450	MIR_
	DMERC	AdminaStar	00635	RBD_
Minnesota	FI	Noridian	00320	MNA_
	Carrier	Wisconsin Physician Svc	00954	MNB_
	RHHI	UGS	00450	MNR_
	DMERC	AdminaStar	00635	RBD_
Mississippi	FI	Trispan	00230	MSA_
	Carrier	Cahaba	00512	MSB_
	RHHI	Palmetto	00380	MSR_
	DMERC	Palmetto	00885	RCD_
Missouri	FI	Trispan	00230	MOA_
	Carrier	Arkansas BCBS – East MO	00523	MOB_
	Carrier	BCBSKS – West MO	00651	MOB_
	RHHI	Cahaba	00011	MOR_
	DMERC	CIGNA	05655	RDD_
Montana	FI	BCBS Montana	00250	MTA_
	Carrier	BCBS Montana	00751	MTB_
	RHHI	Cahaba	00011	MTR_
	DMERC	CIGNA	05655	RDD_
Nebraska	FI	BCBS Nebraska	00260	NEA_
	Carrier	BCBS Kansas	00655	NEB_
	RHHI	Cahaba	00011	NER_
	DMERC	CIGNA	05655	RDD_
Nevada	FI	UGS	00454	NVA_
	Carrier	Noridian	00834	NVB_
	RHHI	UGS	00454	NVR_
	DMERC	CIGNA	05655	RDD_
New Hampshire	FI	BCBS NH/VT	00270	NHA_
	Carrier	NHIC	31144	NHB_
	RHHI	Associated Hospital Svc	00180	NHR_
	DMERC	HealthNow	00811	RAD_
New Jersey	FI	Riverbend	00390	NJA_
	Carrier	Empire	00805	NJB_
	RHHI	UGS	00450	NJR_
	DMERC	HealthNow	00811	RAD_
New Mexico	FI	TrailBlazer	00400	NMA_

	Carrier	Arkansas BCBS	00521	NMB_
	RHHI	Palmetto	00380	NMR_
	DMERC	Palmetto	00885	RCD_
New York	FI	Empire	00308	NYA_
	Carrier	Empire	00803	NYB_
	Carrier	Group Health Inc.	14330	NYB_
	Carrier	HealthNow	00801	NYB_
	RHHI	UGS	00450	NYR_
	DMERC	HealthNow	00811	RAD_
North Carolina	FI	Palmetto	00382	NCA_
	Carrier	CIGNA	05535	NCB_
	RHHI	Palmetto	00380	NCR_
	DMERC	Palmetto	00885	RCD_
North Dakota	FI	Noridian	00320	NDA_
	Carrier	Noridian	00820	NDB_
	RHHI	Cahaba	00011	NDR_
	DMERC	CIGNA	05655	RDD_
Ohio	FI	AdminaStar	00332	OHA_
	Carrier	Palmetto	00883	OHB_
	RHHI	Palmetto	00380	OHR_
	DMERC	AdminaStar	00635	RBD_
Oklahoma	FI	BCBS Oklahoma	00340	OKA_
	Carrier	Arkansas BCBS	00522	OKB_
	RHHI	Palmetto	00380`	OKR_
	DMERC	Palmetto	00885	RCD_
Oregon	FI	Regence	00350	ORA_
	Carrier	Noridian	00835	ORB_
	RHHI	UGS	00454	ORR_
	DMERC	CIGNA	05655	RDD_
Pennsyl-vannia	FI	Veritus	00363	PAA_
	Carrier	Highmark	00865	PAB_
	RHHI	Cahaba	00011	PAR_
	DMERC	HealthNow `	00811	RAD_

Puerto Rico	FI*	Cooperativa	57400	PRA_
	Carrier (PR)	Triple-S	00973	PRB_
	Carrier (VI)	Triple-S	00974	VIB_
	RHHI*	UGS	00450	PRR_
	DMERC*	Palmetto	00885	RCD_

*Includes Virgin Islands

Rhode Island	FI	Arkansas BCBS	00021	RIA_
	Carrier	Arkansas BCBS	00524	RIB_
	RHHI	Associated Hospital of ME	00180	RIR_
	DMERC	HealthNow	00811	RAD_
South Carolina	FI	Palmetto	00380	SCA_
	Carrier	Palmetto	00880	SCB_
	RHHI	Palmetto	00380	SCR_
	DMERC	Palmetto	00885	RCD_
South Dakota	FI	Cahaba	00011	SDA_
	Carrier	Noridian	00889	SDB_
	RHHI	Cahaba	00011	SDR_
	DMERC	CIGNA	05655	RDD_
Tennessee	FI	Riverbend	00390	TNA_
	Carrier	CIGNA	05440	TNB_
	RHHI	Palmetto	00380	TNR_
	DMERC	Palmetto	00885	RCD_
Texas	FI	TrailBlazer	00400	TXA_
	Carrier	TrailBlazer	00900	TXB_
	RHHI	Palmetto	00380	TXR_
	DMERC	Palmetto	00885	RCD_
Utah	FI	Regence	00350	UTA_
	Carrier	Regence	00910	UTB_
	RHHI	Cahaba	00011	UTR_
	DMERC	CIGNA	05655	RDD_
Vermont	FI	BCBS NH/VT	00270	VTA_
	Carrier	NHIC	31145	VTB_
	RHHI	Associated Hospital of ME	00180	VTR_
	DMERC	HealthNow	00811	RAD_
Virginia	FI	UGS	00453	VAA_

	Carrier *	TrailBlazer	00904	VAB_
	RHHI	Cahaba	00011	VAR_
	DMERC	AdminaStar	00635	RBD_

*See also District of Columbia

Washington	FI	Noridian	00322	WAA_
	Carrier	Noridian	00836	WAB_
	RHHI	UGS	00454	WAR_
	DMERC	CIGNA	05655	RDD_
West Virginia	FI	UGS	00453	WVA_
	Carrier	Palmetto	00884	WVB_
	RHHI	Cahaba	00011	WVR_
	DMERC	AdminaStar	00635	RBD_
Wisconsin	FI	UGS	00450	WIA_
	Carrier	WPS	00951	WIB_
	RHHI	UGS	00450	WIR_
	DMERC	AdminaStar	00635	RBD_
Wyoming	FI	BCBS Wyoming	00460	WYA_
	Carrier	Noridian	00825	WYB_
	RHHI	Cahaba	00011	WYR_
	DMERC	CIGNA	05655	RDD_

Attachment 2

Fiscal Intermediary
Business Segment Identifier Assignment
Progress Report

The following report must be submitted by every fiscal intermediary to report the contractor's progress in assigning and encoding the business segment identifier (BSI) to every provider on the provider file. The intermediary shall submit a separate report for each contractor number. Reports are due 10 work days after the close of the reporting period.

Period:	_____October 1 – October 31, 2004	Due November 12, 2004
	_____November 1 – November 15, 2004	Due November 29, 2004
	_____November 16 – November 30, 2004	Due December 14, 2004
	_____December 1 – December 15, 2004	Due December 29, 2004
	_____Other _____	

Intermediary _____Contractor Number_____

Cumulative numbers of Part A providers that have been assigned BSIs:

Location of Provider	State BSI	State BSI	State BSI
State	*999*	*999*	*999*
State	*999*	*999*	*999*
State	*999*	*999*	*999*
!	*!*	*!*	*!*
!	*!*	*!*	*!*
!	*!*	*!*	*!*
!	*!*	*!*	*!*
State	*999*	*999*	*999*

Part A Providers not yet assigned BSIs for the above contractor number:_____

Signed_____ Date_____

Submit to: Medicare Contractor Management Group/CMS
Mail Stop S1-14-17
7500 Security Blvd
Baltimore, MD
Attention: Sandra Clarke
FAX: 410-786-1978
e-mail: sclarke2@cms.hhs.gov

Home Health/Hospice
Business Segment Identifier Assignment
Progress Report

The following report must be submitted by every RHHI to report the contractor's progress in assigning and encoding the business segment identifier (BSI) to every provider on the provider file. The RHHI shall submit a separate report for each contractor number. Reports are due 10 work days after the close of the reporting period.

Period:	_____October 1 – October 31, 2004	Due November 12, 2004
	_____November 1 – November 15, 2004	Due November 29, 2004
	_____November 16 – November 30, 2004	Due December 14, 2004
	_____December 1 – December 15, 2004	Due December 29, 2004
	_____Other _____	

RHHI _____Contractor Number_____

Cumulative number of home health agencies and hospices that have been assigned BSIs:

Location of Provider-BSI	Number of HHAs
State - xxR	*999*
!	*!*
!	*!*
!	*!*
State – xxR	*999*

Home health agencies and hospices not yet assigned BSIs for the above contractor number:_____

Signed_____ Date_____

Submit to: Medicare Contractor Management Group/CMS
Mail Stop S1-14-17
7500 Security Blvd

Baltimore, MD
Attention: Sandra Clarke
FAX: 410-786-1978
e-mail: sclarke2@cms.hhs.gov

Medicare Financial Management Manual
Chapter 3 - Overpayments

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180.1.3 - POR System User Manual

(Rev. 47, 06-25-04)

SIGNING ONTO THE POR SYSTEM

This User Manual begins upon entry into the CMS Data Center. The following instructions for access onto the system are very brief. Any questions concerning access should be directed to your servicing regional office for assistance.

1. Upon entering the CMS Data Center press enter. You will then be taken to an Application Menu.
2. At the Application Menu enter #3 for the CICS41 System.
3. You will then be prompted to enter your Userid and Password. If you do not have a UserId or Password contact your servicing regional office to obtain instructions for access.
4. After entering your userid and password you will be required to choose the system you wish to enter.
5. Choose #1 for Provider Overpayment Recovery; Then hit Enter.
6. You should now be at the Request Screen.
7. *A new Business Segment Identifier (BSI) field has been added to the POR Master Screen.*

THE REQUEST SCREEN

Below is an example of what the request screen will look like upon entering into the POR System. Following the example, detailed instructions are given as to what to input in each field.

HCFA - PROVIDER OVERPAYMENT REPORTING SYSTEM - REQUEST SCREEN

REGION # xx INTERMEDIARY # xxxxx *BSI xxxx*

PROVIDER # xxxxxx PROV TYPE xx

COST REPORT DATE MMDDYYYY DETERMINATION DATE MMDDYYYY
O/P TYPE x

FUNCTION: I = ADD NEW OVERPAYMENT RECORD

U = UPDATE AN EXISTING OVERPAYMENT RECORD

B = BROWSE OVERPAYMENT TRANSACTIONS

PRESS F3 TO END SESSION...
PRESS ENTER KEY TO CONTINUE

A. Positioning of the Cursor

Where the cursor is initially positioned when this screen is displayed depends upon the level of security found in the system security table for the User-identification code entered.

1. CMS Central Office Personnel - Security Level One (1)

The cursor is positioned at the Region Number field. There will be a default Region Number, Region Name, Intermediary Number and Intermediary Name placed in the appropriate fields by the security program. CMS Central Office personnel can key in all characters of the record key, starting with the default region number field if they wish.

2. Regional Office Personnel - Security Level Two (2)

For this level of security, the cursor is positioned at the Intermediary Number field. There will be a default Intermediary Number and Name displayed. The Region Number and Name fields, however, will be filled in with the appropriate values and are locked to the User. The Regional Office personnel may key in any valid intermediary WITHIN their region and then continue with the rest of the key fields.

3. Intermediary Personnel - Security Level Three (3)

For this level of security, the cursor is positioned at the Provider Number field. The Region Number, Region Name, Intermediary Number and Intermediary Name fields are filled in with the appropriate data and are locked to the User. The Intermediary personnel may key in any valid provider number WITHIN their area of responsibility and then continue with the rest of the key fields.

B. The following are field by field instructions for the Request Screen.

1. REGION NUMBER

Again, only CMS CO personnel can key in this field. If it is keyed, the value MUST BE 01 through 10. The Region Name is supplied to the screen by the System Tables File.

2. INTERMEDIARY NUMBER

Only CO and RO personnel may key in the five position numeric field. If it is keyed, it must be numeric, it must be a valid Intermediary Number and it must be valid for the Region Number associated with it on this screen. The Intermediary Name is supplied from the System Tables File.

Intermediaries are required to input the new Business Segment Identifer (BSI) effective October 1, 2004, for all new provider overpayments that are entered on the POR system. This BSI will e a four alpha field. Once the BSI has been input, then it will appear automatically on the POR Master Screen. (See CR 3023 for a complete list of the intermediaries' BSI.)

3. PROVIDER NUMBER

The Provider Number field must be keyed by all Users, must be numeric and must be contained on a Provider Extract File which was created especially for the PORS system. Additionally, when the Provider Extract File is checked for validity, the "servicing intermediary number" contained in that record is compared to the intermediary number on the screen. If they do not match, a security violation has occurred and the User is notified of that fact on the screen.

Note: The current six-digit provider number provides useful information to CMS. The first two digits identify the state in which the provider is located. The last four digits identify the type of facility. For a detailed listing see §2779 in the State Operations Manual.

4. PROVIDER TYPE

This two position numeric field is a key field. It must be entered, must be numeric and must be one of the following:

10 = Primary Hospital Number
20 = Psychiatric Unit S
30 = Hospital Rehabilitation Unit T
40 = Swing Bed U
50 = Alcohol/Drug Unit V
60 = Organ Procurement
70 = HIST Laboratory

If the third digit of the Provider Number is not = to zero (i.e., the provider is not a general hospital), the Provider Type field MUST BE A l0.

If the provider is a general hospital (i.e., the third digit of the provider number is equal to zero) the provider may have an overpayment determined for the primary facility

(Provider Type = l0) or any of the six sub units described above (Provider Type = 20, 30, 40, 50, 60 or 70).

For the sub units above, the third position of the provider number has been replaced with the letters S, T, U, or V. These are shown above next to their corresponding Provider Types.

For purposes of the PORS system, an overpayment determined for one of the general hospital sub units described above, will be entered into the system using the provider's primary provider number (i.e., zero in the third position) and the applicable Provider Type (20, 30, 40, or 50). If the overpayment is for the primary facility, a Provider Type of l0 will be used.

Examples

a. If an overpayment has been determined for a hospital rehabilitation unit with a provider number of 05T0l2. This would be entered as:

0500l2 = Provider Number
30 = Provider Type

b. An overpayment has been determined for a general hospital with a provider number of 0500l2. This would be entered as:

0500l2 = Provider Number
l0 = Provider Type

5. COST REPORT DATE

This eight position numeric date is part of the overpayment record key and must be entered in the format of MMDDYYYY.
The Cost Report Date can never be later than the Recoupment Initiated Date, Recoupment Completed Date or Closed Date.

EXCEPT
If the overpayment type is equal to "D" or "J." In this case, the Cost Report Date may be later than any or all of the above dates.

6. DETERMINATION DATE

This eight position numeric date is also part of the record key and must be entered in the MMDDYYYY format. As explained in 5. above, the Determination Date may be equal to or later than the Cost Report Date but it never can be later than the Recoupment Initiated, Recoupment Completed or Closed Dates.

7. OVERPAYMENT TYPE (O/P TYPE)

The Overpayment Type is a one (1) position alphabetic field which must be entered since it is part of the record key. The values for this field, which are maintained in the System's Table File, are:
A = Audited Cost Report
B = Desk Review (Tentative Settlement)
C = Current Financing
D = Accelerated Payment
E = Cost Report Overpayment
F = Cost Report Reopening
G =Desk Review (Final Settlement)
H = Technically Recoverable Amounts - Unfiled Cost Reports
I = Others - Not Included Above
J = Interim Rate Adjustment
K = Hospice
L = Currently Not in Use
M = Unfiled Cost Report- Balance Recouped
X = Interest

8. FUNCTION CODE

This is a one position alphabetic code field which allows the User to select which system function is to be performed. It must be present and must be I, U or B.

I = Add a new overpayment record
U = Update an existing overpayment record or INQUIRE only
B = Browse the Online Transactions File

C. General information about the PORS Request Screen.

1. Explanation of the inter-relationship between the Function Code field and the Record Key fields

If the Function Code is "I" or "U", the entire 28 position key must be present and correct.

If the Function Code is "B" any number of key fields may be requested (after the Region Number). This is referred to as a 'generic key' and is usually executed to display related groups of data.

There are two points to remember about the "generic keys". One, you will still have your security defaults in the fields and two, the requested key (from major field to minor) must be contiguous - No Blanks.

2. If the Function Code of "I" or "U" was keyed in, the Provider Overpayment Reporting System Master Screen will be displayed - after the enter key is TAPPED.

3. If the Function Code of "B" was keyed in, the Provider Overpayment Reporting System Transaction History Screen will be displayed - after the enter key is TAPPED.

4. Fields 10 through 14 will contain all underlines initially but will contain the actual dollar values after that information has been supplied to the system.

ADD/UPDATE MASTER SCREEN

Below is an example of what the Add/Update Screen looks like in the Provider Overpayment Reporting System. Following this example are detailed instructions for entering the appropriate data into each section.

HCFA - PROVIDER OVERPAYMENT REPORTING SYSTEM - MASTER SCREEN UPDATE

REGION # xx INTERMEDIARY # xxxxx *BSI # xxxx*

PROVIDER # xxxxxx PROV TYPE xx PROV NAME xxxxxxxxxxxxxxxxxxxxxxxxxxx

COST RPT DTE xxxxxxxx DETERM DTE xxxxxxxx O/P TYPE x O/P $ xxxxxxxx

RECOUPED T/D	OPEN BAL	RECOUPED T/Q	ADJUST T/Q	END BAL
$ xxxxxxxxx	$ xxxxxxxxx	$ xxxxxxxxx	$ xxxxxxxxx	$ xxxxxxxxx
01 CAUSES x $ xxxxxxxxx	$ xxxxxxxxx	$ xxxxxxxxx	$ xxxxxxxxx	$ xxxxxxxxx

(F7=ROLL)

INTERMED CHANGE(Y/N) x OWNER CHANGE OWNER TYPE x ORG CHAIN(Y/N) x

TERMINATED(Y/N) x PIP(Y/N) x HHA/PPS x PPS DATE xxxxxxxx
NUMBER BEDS xxxx

INIT RECOUP DATE xxxxxxxx COMP RECOUP DATE xxxxxxxx METH xx
TOT REIM xxxxxxxxx

STATUS CODE xx LOCATION xxx STATUTE DATE xxxxxxxx
CLOSED DATE xxxxxxxx

CNC DATE xxxxxxxx STATUS CHG DATE .....

TRANSACTIONS .. $ .... $ .... $ .... $ .....

PRESS ENTER KEY TO APPLY TRANSACTIONS, PRESS F3 KEY TO RETURN TO REQUEST SCREEN

PRESS F1 KEY FOR HELP; PRESS F4 KEY FOR TRANSACTIONS BROWSE

A. General Information Concerning the Screen - For both the ADD and UPDATE Functions.

1. Field numbers 1 through 7 are the key fields which were keyed into the Request Screen and carried forward to this screen automatically. *In addition to field number 2 (intermediary number), you will have to key the Business Segment Identifer (BSI) field UU into the Request Screen.*

2. Field 37 (top right hand corner) will display the word 'ADD' if an 'I' was the Function Code selected on the Request Screen or the word 'UPDATE' will appear if the 'U' Function Code was selected.

3. Field 8, fields 18 through 23 and field 26 are filled in initially by accessing the Provider Extract File created for the PORS system.

B. The following are field by field instructions for the ADD/UPDATE Master Screen.

1. Fields 1 through 7, again are key fields passed from the Request Screen. These fields are not keyable on the screen.

Immediately after this screen is displayed to the operator, for an ADD or UPDATE, review the key fields very carefully.

If the key is incorrect: TAP the F3 key to return to the Request Screen

2. Field 8 - PROVIDER NAME

This field will be displayed from the Provider Extract File.
IT IS NOT KEYABLE.

3. Field 9 - OVERPAYMENT AMOUNT (O/P $)

This field will contain the total overpayment amount.
For an ADD - This field will initially contain the underlines
For an UPDATE - This field will display the total overpayment amount.
IT IS NOT KEYABLE.

4. Field 10 - TOTAL RECOUPED TO DATE AMOUNT (RECOUPED T/D)

For the life of the overpayment, the field will reflect the current total of all recouped monies.
IT IS NOT KEYABLE.

For an ADD - This field will initially contain the underlines.

For an UPDATE - This field will display the total from the PORS Master File. If a regular recoupment transaction is entered on the Transaction Line (see fields 35 and 36), this field and the RECOUPED T/Q (Recouped T/D = Recouped-to-quarter) field (field 12) are changed instantly.

5. Field 11 - OPENING BALANCE (for the current quarter) (OPEN BAL)

This field was added to the screen and to the master file to assist in quarter to quarter comparisons. This field is calculated by a batch quarter end program and is not changed for the duration of the quarter.
THIS FIELD IS NOT KEYABLE.

For an ADD - This field contains the underlines.

For an UPDATE - This field is not affected. The value that is displayed is the last quarter end calculated amount.

6. Field 12 - RECOUPED THIS QUARTER AMOUNT (RECOUPED T/Q)

This field will contain the total of all regular recoupment monies entered this quarter (i.e., transaction code RO). At the end of each quarter a batch program moves zeros to this field to begin the next quarter.
THIS FIELD IS NOT KEYABLE.

For an ADD - This field initially displays underlines.
For an UPDATE - This field will initially display the amount from the master file. If the appropriate transaction code is entered with an amount, this field and the RECOUPED *T/D field (field 10) are updated instantly to reflect the change.*

7. Field 13 - RECOUPMENT ADJUSTMENT AMOUNT ENTERED THIS QUARTER (ADJUST T/Q)

This field will contain the total of all recoupment adjustment transactions entered within the current quarter. This field is also initialized to zeros at the end of each quarter by a batch program.

The current recoupment adjustment transactions are 'RA', 'RB', 'RC', 'RD', 'RI' and *'RZ'*.
THIS FIELD IS NOT KEYABLE.

For an ADD - This field initially contains the underlines.

For an UPDATE - This field will initially contain the data value from the Master File. If a recoupment adjustment transaction is entered, this field and the RECOUPED T/D field (field 10) are updated instantly to reflect the change.

8. Field 14 - ENDING BALANCE (END BAL)

This field reflects the current balance of the overpayment case. It is recalculated after every financial transaction is added to the case.

The calculation required to arrive at this figure is the ORIGINAL-OVERPAYMENT-AMOUNT (Field 9) minus RECOUPMENT-TO-DATE (Field 10) minus ADJUSTMENT-TO-DATE (this field is on the master file but was not requested for the screen display.
THIS FIELD IS NOT KEYABLE.

For an ADD - This field initially contains the underlines.

For an UPDATE - This field is recalculated and redisplayed after each financial transaction has been entered into the system and the enter key TAPPED.

9. Field 15 - TOTAL NUMBER OF CAUSES (CAUSES)

This field will display the current number of causes that have been added to the Master File for this overpayment. Its primary purpose is to alert the User to what the total is, especially if that figure is more than five (5). If there are more than five causes, the User can use the 'F7=Roll' feature to display the Cause Code and Cause Amount of each of the causes.
THIS FIELD IS NOT KEYABLE.

For an ADD - This field contains the underlines.

For an UPDATE - This field will contain the number of causes that have been added to the master file.

ROLLING THE CAUSE LINE

During the ADD and UPDATE functions, when the Master Screen is initially displayed, you will be viewing the last five (5) cause codes and amounts that were entered.

Each time you TAP the F7 key, five more sets of codes and amounts will be displayed - until you reach the first cause entered.

If you wish to view all of the sets again, you must first TAP the Enter Key. (This will reset the screen display back to the last five causes entered.) Then you may TAP the F7 key as many times as necessary to 'Roll' the causes.

10. Field 16 - CAUSE CODE (There are 5 occurrences of this field)

Each of these five fields will contain a valid cause code which has been added to the file. There may be up to 26 cause codes used for one overpayment master record. The screen

will show the User five of these at a time, and by using the 'F7=Roll' feature, may review all 26 if necessary.
THIS FIELD IS NOT KEYABLE.

For an ADD - These fields contain the underlines.

For an UPDATE - As many of these fields that are required will contain a one position valid cause code. As with all other transactions, the causes were entered on the transaction line as a two position 'TRANSACTION CODE', of which the rightmost position of the transaction code is the actual Cause Code. This rightmost position is moved to the five (5) field 16's.

A. Initial Retroactive Adjustment
B. Non Allowable Excessive Provider Expense
C. Chain Home Office Expense
D. Cost to Related Organization
E. Cost Finding
F. Return on Equity Capital
G. Reimbursement Statistics
H. Excessive Interim Rate
I. Excessive Cost Estimates
J. Excessive Census Days/Visits and/or Charges
K. Excess Cost Limit
L. Excessive Estimates of DRG Discharge
M. Erroneous DRG Designations
N.
O.
P.
Q.
R.
S.
T.
U.
V. Accelerated Payment (Type D)
W. Interim Rate Adjustment (Type J)
X. Unfiled Cost Report (Type H)
Y. Interest (Type X)
Z. Other
NOTE: Cause Codes N through U are reserved for future use.

NOTE: Cause Code CN shall be used with the M overpayment type M. When CN is used a closed date is required.

11. Field 17 - CAUSE AMOUNTS (There are 5 occurrences of this field.)

These five amount fields correspond directly to the five cause code fields explained in 9 above. Again, there may be up to 26 cause codes and amounts of which the User can see five (5) at a time.
THESE FIELDS ARE NOT KEYABLE.

For an ADD - These fields contain the underlines.

For an UPDATE - Each of these fields may contain an amount that corresponds to a specific cause code (up to 26 of them).

If the Master Record exists, the codes and amounts are displayed from the Master File initially on an update. New cause codes and amounts may be added or existing ones modified by using the Transaction Line (see fields 35 and 36). The User currently may key in a cause code with no amount on the Transaction Line and initialize to zeros, the corresponding amount field on the screen and in the Master Record but will maintain the Cause Code in both places.

12. Field 18 - INTERMEDIARY CHANGE (Y/N)

This field indicates whether there was a change in intermediaries by the provider during the cost report year in which the overpayment occurred.

This field, on and ADD and UPDATE, will display a "Y" or "N". This data value came from the Provider Extract File.

THIS FIELD, HOWEVER, MAY BE CHANGED.
If the User wishes to change the value of this field, the cursor should be positioned properly, the new data value entered (Y=Yes, N=No) and the enter key TAPPED.

13. Field 19 - OWNER CHANGE

The data values for this field are 'A through F' and blank, and indicate the number of times during the cost report year of the overpayment, the provider changed ownership. If there was no change, the field should be left blank; if there was one (1) change the value should be an "A" and so on.

This field, on an ADD and UPDATE , will display a blank or 'A' through 'F' which came from the Provider Extract File.
THIS FIELD MAY BE KEYED.
The User may update this field with a valid ownership change code. The update will be edited, as defined above.
14. Field 20 - OWNER TYPE

This field most closely describes the provider's ownership situation.

For an ADD and UPDATE, this field will be displayed with a valid Owner type which came from the Provider Extract File.
THIS FIELD MAY BE KEYED.

The User may update this field with a valid TYPE OF OWNER CODE. The valid list is as follows:

Hospitals and SNFs

1 = Church
2 = Other Non-Profit
3 = Proprietary
4 = State
5 = County
6 = City
7 = City - County
8 = Hospital District
9 = Other (SNFs Only)

HHAs

1 = Non-Profit other than Church
2 = Non-Profit Church
3 = State Health Department
4 = State Welfare Department
5 = Other State Departments
6 = City or County Health Department
7 = City or County Welfare Department
8 = Other City or County Departments
9 = Combination Government or Voluntary

15. Field 21 - ORGANIZATION CHAIN (Y/N)

This field indicates whether the provider, during the cost report year for which the overpayment is being reported, was part of a chain organization.

The valid data values are 'Y' and 'N'.

This field, for an ADD and UPDATE, is displayed with data received from the Provider Extract File.
THIS FIELD MAY BE KEYED.

This field can also be updated by the User by keying directly over the existing data.

16. Field 22 - TERMINATED (Y/N)

This field indicates whether the provider, for which the overpayment is being reported, has left the Medicare program.

The valid data values are 'Y' and 'N'.

This field for an Add and UPDATE, is displayed with data received from the Provider Extract File.

FI'S SHALL UPDATE THIS FIELD WITHIN 10 CALENDAR DAYS OF LEARNING OF THE TERMINATION FROM THE MEDICARE PROGRAM. (Notification should come from CMS RO/CO. If the FI learns of a termination from the Medicare Program from another source, the FI should contact the appropriate RO to determine further collection efforts.)

This field shall be updated by the User by keying directly over the existing data.

17. Field 23 - PIP (Y/N)

This field indicates whether the provider was participating in the PIP program during the cost report year for which the overpayment is being reported.

For an ADD function, this field is Mandatory.

For an UPDATE function, the User may change the value by keying directly over the existing data.
The valid data values are 'Y' and 'N'.

18. Field 24 - HHA/PPS

This one position, alphabetic code has a double purpose in the PORS system.

For an ADD function, this field is mandatory.

For an UPDATE function, the User may change the value by keying directly over the existing data.

For an ADD or UPDATE, the data values must be 'C,' 'D,' or 'X' where:

C = HHA which has Medicare utilization of no less than 85 percent
D = Indicates a PPS Provider
X = If neither of the above codes applies

Additionally, if the data value entered is equal to 'D,' the following edit checks are also performed.

The PPS DATE (field 25) MUST BE entered and MUST BE equal to or later than l0/0l/83.
If the data value entered is equal to 'C,' the following comparison is also made.

The third digit of the PROVIDER NUMBER (field 3) MUST BE equal to a '7'.

For an UPDATE function, this field is optional.

19. Field 25 - PPS DATE

This field is a six position date in the format of MMDDYY. The data value entered corresponds to the date the provider began PPS (Prospective Payment System). This date cannot be earlier than 10/01/83.

For an ADD this field is optional, but if entered, it must be a valid date.

For an UPDATE, the User will key the modification directly over the existing data. Again, the system will check this for validity.

20. Field 26 - NUMBER BEDS

This field displays the number of beds maintained by the provider during the Cost Report Year for which the overpayment is being reported. The data displayed on the screen has been received from the Provider Extract File. THIS FIELD IS OPTIONAL.

If entered, or modified in either an ADD or UPDATE function, the data values entered must be numeric or the program will issue an appropriate error message. When making these updates, the User keys directly over the existing data.

21. Field 27 - INIT RECOUP DATE

This field is an eight position date in the format of MMDDYYYY. This represents the date the intermediary first took positive action to recover the overpayment.

For an ADD, this field is optional until there is a recoupment transaction entered.

When there is recoupment to the overpayment, this field becomes MANDATORY.

For an UPDATE, the User may change the date by keying directly over the existing date.

The following edits are performed on this date.

Must be a valid date
Cannot be earlier than the Determination Date.
Cannot be later than the Recoupment Completed or Closed Dates.
Cannot be earlier than the Cost Report Data EXCEPT if the overpayment type is equal to a 'D' or 'J'.

22. Field 28 - COMP RECOUP DATE

This field is also an eight position date in the format of MMDDYYYY. This represents the date the intermediary EXPECTS the overpayment to be completely recovered.

For an ADD, this field is OPTIONAL.

For an UPDATE, the User may key the modifications directly over the existing data.

For both functions, the following edits are in effect.

The Completed Recoupment Date cannot be earlier than the Determination or Recoupment Initiated Dates.

It also may not be earlier than the Cost Report Data EXCEPT if the overpayment type is equal to 'D' or 'J'.

23. Field 29 - METHOD

The two position numeric field represents which best explains the actual method by which the overpayment will be recovered.

For an ADD, this field is MANDATORY.

For an UPDATE, the User may key directly over the existing data.

For either function, the data which is entered will be verified against the following table which has been included in the System Tables File.

01 Lump Sum Payment
02 Current Interim Payments
03 Combination of 01 and 02
04 Periodic Lump Sum Installments
05 Combination of 01 and 04
06 Combination of 02 and 04
07 Combination of 01, 02 and 04
08 Offset
09 Combination of 01 and 08
10 Combination of 02 and 08
11 Combination of 01, 02 and 08
12 Combination of 04 and 08
13 Combination of 01, 04 and 08
14 Combination of 02, 04 and 08
15 Combination of 01, 02, 04 and 08

24. Field 30 - TOTAL REIMBURSEMENT

This field represents the total reimbursement amount (benefits paid) to a given provider for the Cost Report Year for which the overpayment is being reported.

For an ADD and the Overpayment Type (field 7) is equal to 'D', 'J' or 'X', this field is OPTIONAL.

If supplied, however, the amount field must be numeric and must be greater than the Overpayment Amount (field 9).

For an ADD and the Overpayment Type is not equal to 'D', 'J' or 'X', this field is MANDATORY AND the amount must be greater than the Overpayment Amount (field 9). The only exception is an unfiled cost report. The amount of the overpayment and the total reimbursement will normally be equal for an unfiled cost report.

For an UPDATE, this field may be changed by the User by keying directly over the existing data.

25. Field 31 - STATUS CODE

This field represents the current status of the overpayment. The status shall change as the overpayment record proceeds through the recovery process.

This field is mandatory for an ADD function and shall be updated when a status change occurs.

The data values are two position alphabetic codes or spaces. These codes are supplied for your review in §180.1.4.

26. Field 32 - LOCATION

This field identifies the current work station of the overpayment case.

For an ADD, this field is mandatory and must be equal to the value 'INT'.

For an UPDATE, the User may change the location field by keying directly over the field. The valid location codes that shall be used are as follows:

INT = Intermediary

IDC = Intermediary- Referred to Treasury
INT# = Intermediary- Bankruptcy; the number represents the number of the lead regional office (example IN1 would mean that Region 1 is the lead regional office on the bankruptcy case)
ROA = Regional Office
COA = Central Office
DCC = Central Office- Referred to Treasury
DC# = Regional Office- Referred to Treasury (example DC1, DC2…DC0)
GAA = General Accounting Office
DJA = Department of Justice

For an ADD function, the online program will automatically move 'INT' into the location field.

27. Field 33 - STATUTE DATE

This field is an eight-position date in the format of MMDDYYYY. It is used to identify the date on which the 'statute of limitations' expires on this overpayment case. It is generally six years from the Determination Date.

For an ADD, this field is MANDATORY but the computer program will calculate a date of six years from the Determination Date and move that result to the screen and to the Master File.

For an UPDATE, the User may modify this field by keying directly over the existing data. Any update value must be a valid, six position date in the format MMDDYY.

28. Field 34 - CLOSED DATE

This field is an eight-position date in the format of MMDDYYYY. It is used to identify the date on which the overpayment was completely recovered.

This field is fully Keyable and for an ADD or UPDATE function, the date must be a valid six position date in MMDDYY format and must also pass the following inter-relationship edits.

1. If the outstanding balance (field 14) is equal to zero, you must supply a closed date.
2. If the outstanding balance is not equal to zero AND the location (field 32) is equal to 'INT' you cannot enter a closed date.
3. If the outstanding balance is not equal to zero you may enter a valid closed date ONLY if any of the following combinations of the location (field 32) and status (field 31) are true.

Location = ROA AND Status = DT
Location = COA AND Status = GK
Location = GAA AND Status = LF or LG
Location = DJA AND Status = PI or PJ
Location = ICC AND Status = UJ

29. Fields 35 and 36 - TRANSACTION CODES AND TRANSACTION AMOUNTS

These eight fields, four transaction code fields and four transaction amount fields, are the heart of the ADD/UPDATE MASTER SCREEN and will be discussed together. They are contained on the Transaction Line.

The primary Users have developed a group of two position transaction codes,, which they feel, will accommodate all possible FINANCIAL information to be entered into the system.

These forty codes, of which 26 are for CAUSE information, are located in and maintained by the System Table File.

A. When considering the functionality of the overall process, there are some general comments and/or instructions which should be conveyed first.

1. All four sets of fields can be used for any transaction, in any order. There is no expressed rule about starting in the left most set. Some users prefer to right align all transaction amounts to prevent the possibility of the system/user creating an error by adding additional zeros to the end of the transaction amount.

2. Except for the Overpayment Full Delete transactions, these sets of fields must be used in pairs, transaction code and transaction amount.

3. The 'OO' transaction (the original overpayment) must always be the first transaction entered on an ADD.

4. The total of all cause amounts must equal the overpayment amount at all times. If either total changes, the other must change accordingly.

5. When entering multiple transactions, you may enter one and TAP the enter key or you may use all four sets of fields and amounts before you TAP the enter key.

6. The error message line is the last line on the screen. Currently, only one error message at a time is displayed (in bright characters) and the cursor is positioned at the field in error. If you have more than one error, the second and subsequent ones will be displayed as their predecessors are being corrected.

7. If you have displayed the ADD/UPDATE Master Screen for either function, and you do not wish to continue - For Any Reason - simply TAP the F3 key and the program will return you to the PORS REQUEST SCREEN.

NOTE: IN DOING THIS YOU WILL LOSE CHANGES YOU HAVE MADE TO THE ADD/UPDATE SCREEN. IF YOU WERE IN AN ADD FUNCTION, THAT OVERPAYMENT CASE MUST BE ADDED ONCE AGAIN STARTING WITH THE REQUEST SCREEN.

8. If you are keying in a transaction code and you need assistance with what code should be used, or what codes are available, simply TAP the F1 key for HELP. This action will display the HELP SCREEN which shows all transaction codes available for use with their twenty two character descriptions.
After you have found the necessary information on the HELP screen, simply TAP the F3 key and the program will return you to the ADD/UPDATE Screen.

9. If you are working with the ADD/UPDATE screen and, for any reason, you wish to view the detail transactions for this overpayment case, simply TAP the F4 key. The program will then display the TRANSACTION HISTORY BROWSE SCREEN. This screen will show you every financial transaction that was entered for the case since it was added to the file.

When you are finished reviewing the transaction History Screen, you can TAP the F3 key to return to the ADD/UPDATE Screen.

ENTERING TRANSACTIONS

All financial transactions entered into the PORS System by the terminal USERS can be divided into three major categories; OVERPAYMENTS, CAUSES and RECOUPMENTS. The following are specific instructions for entering each kind of transaction into the PORS System using the Transaction Line.

A. OVERPAYMENT TRANSACTIONS

This category includes three types of overpayment transactions: ORIGINAL OVERPAYMENT, OVERPAYMENT ADJUSTMENT and OVERPAYMENT FULL DELETES.

1. ORIGINAL OVERPAYMENT

a. Valid transaction code is 'OO' only.
b. Must be the first financial transaction entered when adding a new overpayment.
c. The amount field must be numeric.
d. The amount field must be less than the TOTAL REIMBURSEMENT FIELD unless the overpayment type is an unfiled cost report (field 30).
e. This code, 'OO' is the only valid Overpayment transaction code for use in the ADD function.
f. The amount will be moved to field nine (9) on the ADD/UPDATE Screen and into the appropriate master record field when the ADD function is complete.
g. Only one (1) 'OO' transaction may be entered for an ADD.
h. An original overpayment transaction (OO) is invalid for an update.
i. When the ADD function is complete, the transaction code and amount are written to the Open Transaction History File.

2. OVERPAYMENT ADJUSTMENTS

a. Valid transaction codes are 'OA' through 'OD', 'OI' and 'OZ".
b. The functionality of all of the above codes is exactly the same. There are multiple codes for recording and reporting purposes.
c. The function of these transactions is to adjust the original overpayment amount.
d. The adjustment is accomplished by overlaying (replacing) the original overpayment amount in the master file with the amount on the overpayment adjustment transaction.
e. Although the adjustment amount is 'moved' to the Master File, the following must take place for the Transaction

File update:
1. The original amount (OO transaction) is still on the transaction file and can't be deleted.
2. To maintain fiscal integrity, the program will subtract the original overpayment amount in the master file from the overpayment adjustment amount.
3. This amount, positive or negative will be written to the transaction file along with the transaction code.
f. All overpayment adjustment amounts must be numeric.
g. Overpayment adjustments are invalid during the ADD process.
h. If the overpayment adjustment transaction code is equal to 'OI' the overpayment type must be a 'J'.

REMINDER:

When an overpayment adjustment is used to 'adjust' the original overpayment amount this action will probably establish an out of balance condition between the original overpayment amount and the SUM of the Causes. This condition must be resolved before the update will be accepted. You will have to update the Cause information that currently exists for this overpayment.

3. OVERPAYMENT FULL DELETES

These transaction codes are extremely powerful tools within the PORS System which must be handled with care. There are four codes which, functionally are identical, that will logically zero balance an overpayment case and allow that case to be closed.

a. Valid codes are 'OE', 'OF', 'OG', 'OH', and 'OI'.
b. The functionality of the codes above is exactly the same. There are multiple codes for recording and reporting purposes.
c. The major function of these transactions is to Logically zero balance the case. In doing so, a Closed Date will be Mandatory and the case will be officially closed.
d. All 'FULL DELETED' cases will be bypassed by all quarter and batch reporting programs, therefore the dollar amounts on all fully deleted cases will not be reflected in any report.

e. An OVERPAYMENT FULL DELETE is processed as follows:

1. A valid overpayment full delete transaction code is entered in any one of four transaction code fields on the transaction line.
2. NO AMOUNT IS REQUIRED IN THE TRANSACTION AMOUNT FIELD FOR A FULL DELETE TO PROCESS.
3. The User TAPS the enter key.
4. The PORS program then perform the following:

(a) The program issues an applicable warning message asking the User if they are absolutely sure they want to process a full delete.
(b) If the User wants the full delete to take place, an overpayment full delete transaction code must be re-entered and the enter key TAPPED.
(c) Calculates the current balance of the overpayment case.
(d) Writes a record to the transaction file using the overpayment full delete transaction code and an amount field equal to zeros.
(e) Generates and writes a Recoupment Adjustment record to the transaction file. This record will contain an amount equal to the ending balance calculated in (3) above. The transaction code will have an 'R' in the leftmost position and the rightmost position will correspond to the rightmost position of the overpayment full delete transaction code.
(f) At this time, the outstanding balance is zero and the program is looking for a valid close date by issuing another warning message and positioning the CURSOR at the CLOSED DATE FIELD.
(g) NOTE:
The User can still back out of the entire full delete procedure by TAPPING the F3 key. This action will abort all updates that have just been discussed and return control to the REQUEST SCREEN.
(h) The User should key in the proper closed date and TAP the enter key.
(i) If the above Close Date is valid, another warning message is issued to the User, stating the case is about to be closed.
(j) If the User is absolutely sure the full delete is correct, the enter key should be TAPPED.
(k) At this point, the full delete transaction has been processed and the case is closed.

B. CAUSE CODE TRANSACTIONS

1. For each determined overpayment case, the CAUSES(s) for that overpayment will be identified and entered into the system using the transaction line on the ADD/UPDATE SCREEN.
2. There are twenty six (26) CAUSE TRANSACTION CODES defined in the PORS System of which 18 are currently active. These codes, ranging from CA through CZ were explained earlier in the instructions for FIELD 16 (five of them).
3. Cause transactions are entered on the transaction line (fields 35 and 36), and after verification, are moved to fields 16 and 17.
4. As an enhancement, we have designed the Master File so we may retain all 26 Cause Codes and Cause Amounts for a given overpayment case.

5. Another enhancement we feel will help maintain the system's integrity, is to balance the sum of all entered Cause Amounts with the Overpayment Amount (field 9). This balancing MUST TAKE PLACE before a case is ADDED to the Master File. We understand that some overpayment cases will be very difficult to 'BALANCE' because of missing information. To allow this kind of overpayment into the system for tracking and recoupment efforts, we have added a Suspense Cause Transaction Code of 'CZ' to the list of valid cause codes.
This suspense cause code is intended for specialized, limited use, and it use will be monitored. The total amount that may be entered using this Cause Code is $10,000.

Note: If the original overpayment amount is adjusted, the appropriate cause codes should also be adjusted so that the original overpayment amount and the cause code amounts are the same.

6. Out of the possible 26 codes, only four Causes have special edit criteria.

a. CAUSE CODE V (Accelerated Payment) must only be used with TYPE D overpayments.
b. CAUSE CODE W (Interim Rate Adjustment) is only valid with TYPE J overpayments.
c. CAUSE CODE X (Unfiled Cost Report) must only be used with TYPE H overpayments.
d. CAUSE CODE Y (Interest) is only valid with TYPE X overpayments.

7. The two position Cause Code and Amount are keyed into the transaction line. Again, you may use any one of the four sets or all four at the same time.

8. When the enter key is TAPPED, the program moves the rightmost character of the Cause Transaction Code (which is the actual cause code) and the Cause Amount to an available set of fields on the 'Cause Line' (fields 16 and 17). It also moves the number of causes entered into the Cause Count Field (field 15). It then adds up all Cause Amounts and compares that SUM to the Overpayment Amount.
9. If the case is in balance, and no more input is required, the case is added to the Master File.
10. If the case is out of balance, the User will see an appropriate message in the message area. The User must balance the case either by keying in an Overpayment Adjustment or by modifying the just entered Cause Transactions.

C. RECOUPMENT TRANSACTIONS

This category includes three types of recoupment transactions; REGULAR RECOUPMENT, RECOUPMENT ADJUSTMENTS AND RECOUPMENT -FULL DELETES.

1. Regular Recoupment
a. Valid transaction code is 'RO' only.

b. Must be the first 'recoupment' transaction entered for an overpayment case.
c. The amount must be numeric and positive.
d. The transaction code of 'RO' and the amount may be keyed into any one of the 'sets' on the transaction line.
e. When the enter key is TAPPED, the transaction, after being thoroughly edited, is added to the RECOUPED-TO-DATE (field 10) and the RECOUPED-TO-QUARTER (field 12) fields on the screen and also to the appropriate Master File fields.
f. A record including the transaction code and amount is also written to the transaction file.

2. Recoupment Adjustments

a. Valid transaction codes are 'RA' through 'RD', 'RI' and 'RZ'.
b. All of the above codes have the exact same functionality. There are multiple codes for reporting purposes.
c. The function of these transactions is to adjust previously applied 'Regular Recoupment' dollars. To maintain fiscal integrity, previously applied dollars will stay on the Master and Transaction Files, but we will use the appropriate 'Recoupment Adjustment Transaction' to affect the required monetary change.
d. To be as flexible as possible, these transactions may be entered as positive OR negative values. To make the field negative, the operator must key in the 'dash/hyphen' after the amount. For a positive value, there is no additional effort involved.
e. The User, after keying in the appropriate Recoupment Adjustment Transaction Code and amount, should TAP the enter key.
f. The amount, after thorough editing, is added to the 'ADJUST-T/Q' field (field 13) on the screen and to the same field in the Master File. It is also to the 'ADJUSTMENT TO DATE' field in the Master File.
g. After the Master File is updated, a record is written to the transaction file with the recoupment adjustment transaction code and amount fields included.

3. Recoupment - Full Deletes
a. Valid codes are 'RE', 'RF' 'RG' and 'RH' and 'RI'.
b. These four transaction codes are 'GENERATED ONLY' by their corresponding 'OVERPAYMENT FULL DELETE' transaction - 'OE', 'OF', 'OG', 'OH' and 'OI'.
c. The Recoupment - Full Delete transactions ARE NOT KEYABLE BY THE USER.
d. They are generated with appropriate amount fields and written to the transaction file to maintain fiscal integrity.
e. The amounts are also added to the Master File recoupment fields but, as explained earlier, these Master Records are bypassed for all PORS reporting.

30. Field 37 - CNC Date

This field is an 8-position date in MMDDYYY format. Enter the Currently Not Collectible date within 10 days of receiving written approval for CNC Classification from the Regional Office.

31. Field 38 – CNC Code

This field is a 2- position code. Enter the appropriate CNC Status Code from the Status Code Listing in 180.1.4 within 10 days of receiving written approval for CNC Classification from the Regional Office.

TRANSACTION HISTORY BROWSE SCREEN

A. General information concerning this Screen.
1. This Screen will be used for inquiry purposes only.
2. This Screen may be displayed only from the PORS REQUEST and PORS ADD/UPDATE Screens.
3. The displaying of information on this screen is governed by the same security hierarchy explained for the Request Screen.
4. There are two primary objectives of this Screen.

a. To provide an audit trail of all financial transactions that were entered for the life of an active, open case. This audit trail will provide the various levels of responsible Users with instant information about a specific case or groups of cases. It will identify which User entered the data, when it was entered and how that action affected the balance of that case.

b. The second objective is to have the physical protection of the Transaction File in case something should ever happen to the Master File. We could use the Transaction File to 'rebuild' the financial portion of our online PORS Master File.

5. The screen is divided into two distinct parts; the screen header line and the screen body.

a. The header line is represented by the line of dashes on the second line from the top of the screen.
This line will contain the entire record key that was requested for the screen to be displayed.

1. If this screen display was 'requested' from the ADD/UPDATE processing, this header line 'record key' will be a specific 28 position key.
2. If, however. this screen was requested from the PORS REQUEST SCREEN using the 'B' function, the header line 'record key' may have from 2 to 28 positions filled in. This is the generic key search that was described earlier in these instructions.

EXAMPLES:
1. A regional office User may key in just the region number and 'B' function on the PORS REQUEST SCREEN and TAP the enter key. This action will display the Transaction History Browse Screen showing the User ALL open overpayment cases for that region.

2. A contractor User may do the same function, but, because of the security table, they must also key in their own intermediary number on the PORS REQUEST SCREEN.

b. The screen body consists of sixteen (16) detail lines showing the 13 individual fields on each line.

If there are more than 16 lines of detail to be displayed, the User may TAP the F8 key to page forward or F7 to page backward.

B. Specific information concerning the fields displayed on the screen.

1. Field 1 through 7

These fields constitute the overpayment record key. They will be printed according to the instructions contained in A.5 above.

2. Field 8 - SEQUENCE NUMBER

This field was added to ensure uniqueness when writing records to the transaction file.

3. Field 9 - OPERATOR ID

This is primary security code used throughout the system. It is shown on the Browse Screen for obvious reasons.

4. Field 10 - TRANSACTION ENTRY DATE
This is the date, in MMDDYYYY format; the User entered this particular transaction.

5. Field 11 - TRANSACTION CODE (TR CD)
This is one of the forty (40) valid codes used to enter financial information into the system.

6. Field 12 - TRANSACTION AMOUNT
This field displays the edited dollar amount which was keyed by the User on the ADD/UPDATE MASTER SCREEN.

7. Field 13 - BALANCE
This is a 'Running Balance' for the overpayment case. It is re-calculated after each successful financial update to the PORS Master File. It will provide the User with a display of the current balance of the case.

HELP SCREEN

A. General information concerning the Screen.

1. The screen contains all of the current, valid transaction codes in the system along with their descriptions.

2. The design function for this screen is to provide the terminal User with online assistance at the time of data entry. This will happen during transaction code selection and entry on the ADD/UPDATE MASTER SCREEN.

3. If the User forgets the transaction code to use or does not remember which ones are even available merely:

TAP the F3 key for HELP

This will display the HELP SCREEN. When the User finishes reviewing the HELP SCREEN, simply:

TAP the F3 key to return to the same position on the ADD/UPDATE SCREEN.

B. Specific information concerning the HELP SCREEN.

1. There are three columns displaying eighteen transaction codes each.

2. If there should be more than 54 transaction codes in the future, the User may TAP the ENTER KEY to view the remaining codes.

180.1.4 List of Status Codes

(Rev. 22, 10-03-03)

POR SYSTEM STATUS CODES- INTERMEDIARY LEVEL

Category	Status Codes	Description/When to Use
Accelerated Payments	CA	Accelerated Payment (Less than 90 days old)
	CB	Accelerated Payment (Over 90 days old)
Advanced Payments	AP	Advanced Payment
	CP	Advance Payment (Claims processing problem has not been corrected)
Demand Letters	AL	First Demand Letter
	BL	Second Demand Letter
	CL	Third Demand Letter
Recoupment	AC	Interim Payments Suspended
	BV	Congressional Intervention- repayment delayed
ERS	AE	Negotiating Repayment Schedule
	AF	Established Repayment Schedule (up to 12 months)
	AG	Defaulted Repayment Schedule
	BG	Established Repayment Schedule (over 12 months)
	BJ	Court Established Repayment Schedule
Appeals/ Hearing	AB	Intermediary Appeal Pending
	BP	PRRB Hearing
Fraud	BA	Active Fraud and Abuse Investigation- on Suspension by contractor Fraud department, RO, CO, or OIG
Bankruptcy	BH	Provider Filed Bankruptcy Petition
Litigation/	BN	RO Approved delay in Recovering Overpayments

DOJ Involved	AW	Collections stopped by Court Decision- Litigation
	BE	DJA Case Returned to Intermediary for further Collection action
	BQ	Returned to INT for preparation of CCLR and Referral to DJ
Debt Referral INT)	AQ	Pending Referral to Cross Servicing/TOP
	CM	Debt returned from DCC (waiting further action by
CNC	01	Reclass to CNC
	03	CNC- DCIA Letter Sent
	04	Reactivate CNC- Bankruptcy
	05	Reactivate CNC- Payment Received
	06	Reactivate CNC- Appeal/Litigation/Fraud
	07	Reactivate CNC- Compromise
	08	Reactivate CNC- Extended Repayment Plan Approved
	09	CNC Debt Written Off Closed
	00	Reactivate CNC- Other (Deceased, etc)

Effective 10/01/03 the CNC Status Codes should be used in the CNC Code field not in the Status Code Field. When inputting a CNC Status Code a CNC Date should also be entered. The existing status code shall remain and shall be accurate as to the status of the debt. (For example bankruptcy, debt referral, appeal, fraud) The CNC Status Code field and the CNC Date field should only be used after written approval for CNC Classification is received from the Regional Office. Refer to the Financial Management Manual, Chapter 5, §400.20 for additional information concerning CNC Classification.

Write-off	BY	Pending Write-Off Authority
	CC	Closed- compromise negotiation by OGC/DOJ, Balance written off
	CD	Closed with a balance- CMS CFO approved compromise
	CE	Closed with a balance due to bankruptcy (Authority to close must be received from lead RO)
	CF	Closed with a balance- ARA DFM approved
Liability	*AH*	*New Owner Assumed Liability*
	AI	*Assumption of Liability in Question*
	AU	New Owner did not Assume Liability
Referred to RO	AK	Referred to Regional Office
Medicaid	AS	Title XIX Suspension in Effect

Cost Reports	AA	Cost Report Filed but Subsequently found to be Unacceptable
	AD	Final Settlement pending current or subsequent cost reports
	AM	Cost Report Filed- Overpayment Recouped
	AY	Cost Report Filed- Pending Acceptance
	BX	Cost Report not Filed- Provider Paid back all interim payments
Other	AN	Medicare Adjustment Bills
	AV	Waiver agreement obtained for Statute of Limitations
	AX	Terminated Provider re-entered Medicare program with New provider number
	BF	Financial Record of Provider in Hands of State- Exact Amount of OP
Undetermined or Unknown		
	BI	Incoming Intermediary recovering overpayment for Outgoing intermediary
	BW	Waiver State of Demonstration Project
	BZ	Outpatient Non-Physician Services

When determining the most accurate status code intermediaries must remember that certain status codes/categories take precedence over others:

Bankruptcy supercedes all other status codes
Appeal supercedes all other status codes except for bankruptcy and litigation
Litigation supercedes all other status codes except for bankruptcy
ERP supercedes all other status codes except bankruptcy, appeal, active fraud investigation, and litigation
Debt Referral supercedes all other status codes except bankruptcy, appeal, active fraud investigation, and litigation.

If you are not sure of the appropriate status code the servicing regional office should be contacted.

180.1.6 – Requesting Provider Overpayment Debts from the Provider Overpaymet Reporting System (PORS)

(Rev. 47, 06-25-04)

Intermediaries are required to indicate the appropriate Business Segment Identifier (BSI) on all written requests, to open closed debts on the POR system. The request should include: regional office code, intermediary number, BSI code, provider number, proivder type, cost report date, determination date, overpayment type, original amount, desired

reopening amount and explanation for the reopening. (See CR 3023 for complete BSI codes.)

EXAMPLE of the Business Segment Identifier (BSI)

00380ARR – Intermediary Number (00380), State Code (AR) and Regional Home Health Agency (R).

00382NCA – Intermediary Number (00382), State Code (NC) and Intermediary (A)

180.1.7 – Requesting Report from the AD Hoc Reports Management System (ARMS) (Rev.)

When intermediaries are retrieving reports from the AD Hoc Report Management System (ARMS), they should use field code UU, which identifies the Business Segment Identifiers (BSI.) This ia a new field that has been added to the POR system and it is associated with the intermediary numbers.

EXAMPLE:

FIELDS: 01,02, UU (New BSI field), 03,04,05,06,07,27,31,32,35,QQ

PARAMETER: 02 (Intermediary Number) # E (Equal) # 00380

Medicare Financial Management Manual

Chapter 10- Fee-for-Service Claims Administration Contractor and Workload Identification

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(Rev. 47, 06-25-04)

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Chapter 10 - Fee-for-service Claims Administration Contractor and Workload Identification

10 - General Information

(Rev. 47, 06-25-04)

CMS will assign to every claims administration contractor a contractor workload identifier for each geographic workload area that is included in the contractor's jurisdiction. These contractor workload identifiers shall be the officially recognized identifier for the contractor.

The contractor workload identifier will provide a unique identifier for each type of claim processed (Intermediary, Regional Home Health Intermediary, Carrier, and Durable Medical Equipment Carrier), the geographic jurisdiction associated with that claim, and the contractor that processed the claim or other transaction.

The contractor workload identifier will be used by contractors in claims processing operations and to track the flow of transactions among the contractor and CMS claims administration systems. The identifier will also be used for general management and workload reporting.

CMS will assign a single contractor number that contractors will use for financial management and reporting of administrative costs and program benefits.

The Center for Medicare Management in CMS will have the authority and responsibility for assigning all contractor workload identifiers and for maintenance of the identifiers as contractor or workload configurations change.

Exhibit 1 shows the master list of all officially recognized identifiers.

20 - Structure of the Workload Identifier

(Rev. 47, 06-25-04)

CMS will assign the contractor workload identifier. It will consist of a combination of data to comprise a nine-digit alpha-numeric contractor workload identifier:

- *The first five characters will be a five-digit contractor number.*
- *The next four characters represent the Business Segment Identifier (BSI) and consist of the following:*
    - *A two character contract jurisdiction code:*

        - *For fiscal intermediary, carrier and regional home health intermediary workloads, the code will be the official United States Postal Service (USPS) state abbreviation for the state jurisdiction.*
        - *For Durable Medical Equipment Regional Carriers, these two positions will identify the DME region, for example Region A will be RA.*
    - *A one-character modifier to identify the type of Medicare FFS contract:*
        - *Fiscal Intermediary = A*
        - *Carrier = B*
        - *Regional Home Health Intermediary = R*
        - *Durable Medical Equipment Regional Carrier = D.*
    - *The final digit will be filled with a space.*

This structure recognizes that CMS considers there to be four different "types" of contractors, based on the types of claims they process for beneficiaries and providers in every state. The BSI distinguishes the customers in the geographic areas served and the type of claims administered:

- *For Fiscal Intermediaries – Providers in the state served plus any providers in other locations that nominated the FI to process its claims, and any chains (of providers) assigned to the FI.*
- *For carriers and regional home health intermediaries – Providers in the state served.*
- *For DMERCS – Suppliers serving beneficiaries that reside in the DMERC's jurisdiction.*

30 - Initial Implementation

(Rev. 47, 06-25-04)

While CMS will assign the contractor number, the initial implementation of the BSI will require the claims administration contractors to assign the state codes (positions 6 and 7 of the contractor workload identifier) to their providers according to the master list on exhibit 1.

Contractors shall assign the BSI as follows:

- *Fiscal Intermediaries shall assign each provider they service to a specific state associated workload based on the state in which the provider is located. Intermediaries shall assign providers not located in the contracted state jurisdiction (i.e. providers that are "out of area" through nominations and/or chains of providers that elect the FI) according to the following rules:*
    - *If the "out of area" provider or chain of providers is serviced through a nomination of selected contractor or a chain relationship, assign the provider to the state-associated workload to which the nomination relates.*

- *If the "state" of the nomination cannot be determined, assign the provider to the state represented by the contractor's home office for administrative budget and cost reporting purposes.*

  Example: A Fiscal Intermediary services Part A providers in States XX, YY and ZZ, as well as providers in several other states that nominated the FI or previous intermediaries, the workloads of which are now awarded to the current FI. Providers serviced by this FI should be assigned to either XX, YY or ZZ and would be coded XXA_, YYA_, or ZZA_ respectively.

- *Carriers shall assign the state code based on where the physician or supplier is located.*

  Example: A carrier services Part B providers in States XX and YY and will utilize XXB_ and YYB_ respectively.

- *RHHIs shall assign a state code based on where the home health agency or hospice is located or, if a chain of providers, where the home office is located.*

- *DMERCs shall assign codes as follows:*

  *DMERC Region A = RAD_*
  *DMERC Region B = RBD_*
  *DMERC Region C = RCD_*
  DMERC Region D = RDD_.

40 - Basic Requirements and Uses of the Identifier

(Rev. 47, 06-25-04)

The contractor workload identifier will be required for interface among the basic claims processing systems including FISS, MCS, CWF, HIGLAS, REMAS, and PECOS.

All claims administration systems shall be capable of tracking claims activity and identifying claims administration databases by the new BSI.

Claims administration contractors shall produce management and workload reports by the unique contractor workload identifier.

Claims administration contractors shall track financial management activities and produce financial reports for both administrative costs and program benefits by the corporate contractor number assigned by CMS.

50 - Maintenance of Contractor Workload Identifiers

(Rev. 47, 06-25-04)

There are several major circumstances that may require changes or updates to the contractor workload identifiers. Maintenance of the identifiers, including the contractor number and the BSI, will be the responsibility of the Center for Medicare Management, which will notify the affected claims processing contractor of any changes.

- *Contractor Transitions - The new or incoming contractor will be instructed by the CMS transition manager about any changes in the contractor workload identifier, both the contractor number and the BSI.*

- *Provider Change of Intermediary - The BSI of a Part A provider (e.g. hospital, skilled nursing facility, home health agency, etc) may change when CMS approves a provider's request for change of intermediary or the provider's request to submit all bills to a single intermediary because of a chain relationship. CMS will advise the new intermediary, as well as the former intermediary, of the required change in the BSI through the tie-in notices which are necessary to coordinate the change of intermediary process.*

- *Generally, the BSI of carriers and DMERCs will not change, but CMS will advise of any changes during any contractor transition.*

- *New Systems Implementations - As contractors are implemented on HIGLAS and REMAS, transactions that are converted into the HIGLAS and REMAS databases shall be converted with their appropriate BSI(s) to distinguish different workloads. CMS will advise for any HIGLAS implementation.*

Exhibit 1

(Rev. 47, 06-25-04)

Contractor Workload Identifiers

State	*Contract Type*	*Contractor*	*Workload Identifier*	
			CROWD Identifier	*Business Segment*
Multiple	*FI*	*Mutual of Omaha*	*52280*	*NTA_*
Multiple	*Carrier*	*Railroad Retirement Board (Palmetto)*	*00882*	*RRB_*
Alabama	*FI*	*Cahaba*	*00010*	*ALA_*
	Carrier	*Cahaba*	*00510*	*ALB_*
	RHHI	*Palmetto*	*00380*	*ALR_*
	DMERC	*Palmetto*	*00885*	*RCD_*
Alaska	*FI*	*Noridian*	*00322*	*AKA_*
	Carrier	*Noridian*	*00831*	*AKB_*
	RHHI	*UGS*	*00454*	*AKR_*
	DMERC	*CIGNA*	*05655*	*RDD_*
Arizona	*FI*	*BCBS Arizona*	*00030*	*AZA_*
	Carrier	*Noridian*	*00832*	*AZB_*
	RHHI	*UGS*	*00454*	*AZR_*
	DMERC	*CIGNA*	*05655*	*RDD_*
Arkansas	*FI*	*BCBS Arkansas*	*00020*	*ARA_*
	Carrier	*BCBS Arkansas*	*00520*	*ARB_*
	RHHI	*Palmetto*	*00380*	*ARR_*
	DMERC	*Palmetto*	*00885*	*RCD_*
California	*FI*	*UGS*	*00454*	*CAA_*
	Carrier	*NHIC- Northern CA*	*31140*	*CAB_*
	Carrier	*NHIC- Southern CA*	*31146*	*CAB_*

	RHHI	*UGS*	*00454*	*CAR_*
	DMERC	*CIGNA*	*05655*	*RDD_*
Colorado	*FI*	*TrailBlazer*	*00400*	*COA_*
	Carrier	*Noridian*	*00824*	*COB_*
	RHHI	*Cahaba*	*00011*	*COR_*
	DMERC	*Palmetto*	*00885*	*RCD_*
Connecticut	*FI*	*Empire*	*00308*	*CTA_*
	Carrier	*First Coast*	*00591*	*CTB_*
	RHHI	*AHS Maine*	*00180*	*CTR_*
	DMERC	*HealthNow*	*00811*	*RAD_*
Delaware	*FI*	*Empire*	*00308*	*DEA_*
	Carrier	*TrailBlazer*	*00902*	*DEB_*
	RHHI	*Cahaba*	*00011*	*DER_*
	DMERC	*HealthNow*	*00811*	*RAD_*
District of Columbia	*FI*	*Carefirst of MD*	*00190*	*DCA_*
	*Carrier**	*TrailBlazer*	*00903*	*DCB_*
	RHHI	*Cahaba*	*00011*	*DCR_*
	DMERC	*AdminaStar*	*00635*	*RBD_*
Florida	*FI*	*First Coast*	*00090*	*FLA_*
	Carrier	*First Coast*	*00590*	*FLB_*
	RHHI	*Palmetto*	*00380*	*FLR_*
	DMERC	*Palmetto*	*00885*	*RCD_*
Georgia	*FI*	*BCBS Georgia*	*00101*	*GAA_*
	Carrier	*Cahaba*	*00511*	*GAB_*
	RHHI	*Palmetto*	*00380*	*GAR_*
	DMERC	*Palmetto*	*00885*	*RCD_*
*Hawaii**	*FI*	*UGS*	*00454*	*HIA_*
	Carrier	*Noridian*	*00833*	*HIB_*
	RHHI	*UGS*	*00454*	*HIR_*
	DMERC	*CIGNA*	*05655*	*RDD_*

**Includes parts of MD and VA*

** Includes Guam and American Samoa*

Idaho	*FI*	*Regence*	*00350*	*IDA_*
	Carrier	*CIGNA*	*05130*	*IDB_*
	RHHI	*UGS*	*00454*	*IDR_*
	DMERC	*CIGNA`*	*05655*	*RDD_*

Illinois	*FI*	*AdminaStar*	*00131*	*ILA_*
	Carrier	*Wisconsin Physicians Svc*	*00952*	*ILB_*
	RHHI	*Palmetto*	*00380*	*ILR_*
	DMERC	*AdminaStar*	*00635*	*RBD_*
Indiana	*FI*	*AdminaStar*	*00130*	*INA_*
	Carrier	*AdminaStar*	*00630*	*INB_*
	RHHI	*Palmetto*	*00380*	*INR_*
	DMERC	*AdminaStar*	*00635*	*RBD_*
Iowa	*FI*	*Cahaba*	*00011*	*IAA_*
	Carrier	*Noridian*	*00826*	*IAB_*
	RHHI	*Cahaba*	*00011*	*IAR_*
	DMERC	*CIGNA*	*05655*	*RDD_*
Kansas	*FI*	*BCBS Kansas*	*00150*	*KSA_*
	Carrier	*BCBS Kansas*	*00650*	*KSB_*
	RHHI	*Cahaba*	*00011*	*KSR_*
	DMERC	*CIGNA*	*05655*	*RDD_*
Kentucky	*FI*	*AdminaStar*	*00160*	*KYA_*
	Carrier	*AdminaStar*	*00660*	*KYB_*
	RHHI	*Palmetto*	*00380*	*KYR_*
	DMERC	*Palmetto*	*00885*	*RCD_*
Louisiana	*FI*	*Trispan*	*00230*	*LAA_*
	Carrier	*BCBS Arkansas*	*00528*	*LAB_*
	RHHI	*Palmetto*	*00380*	*LAR_*
	DMERC	*Palmetto*	*00885*	*RCD_*
Maine	*FI*	*Associated Hospital of ME*	*00180*	*MEA_*
	Carrier	*NHIC*	*31142*	*MEB_*
	RHHI	*Associated Hospital of ME*	*00180*	*MER_*
	DMERC	*HealthNow*	*00811*	*RAD_*
Maryland	*FI*	*Carefirst of Maryland*	*00190*	*MDA_*
	*Carrier**	*TrailBlazer*	*00901*	*MDB_*
	RHHI	*Cahaba*	*00011*	*MDR_*
	DMERC	*AdminaStar*	*00635*	*RBD_*
Massachusetts	*FI*	*Associated Hospital of ME*	*00181*	*MAA_*
	Carrier	*NHIC*	*31143*	*MAB_*
	RHHI	*Associated Hospital of ME*	*00180*	*MAR_*
	DMERC	*HealthNow*	*00811*	*RAD_*

* *See also District of Columbia*

Michigan	*FI*	*UGS*	*00452*	*MIA_*
	Carrier	*Wisconsin Physicians Svc*	*00953*	*MIB_*
	RHHI	*UGS*	*00450*	*MIR_*
	DMERC	*AdminaStar*	*00635*	*RBD_*
Minnesota	*FI*	*Noridian*	*00320*	*MNA_*
	Carrier	*Wisconsin Physician Svc*	*00954*	*MNB_*
	RHHI	*UGS*	*00450*	*MNR_*
	DMERC	*AdminaStar*	*00635*	*RBD_*
Mississippi	*FI*	*Trispan*	*00230*	*MSA_*
	Carrier	*Cahaba*	*00512*	*MSB_*
	RHHI	*Palmetto*	*00380*	*MSR_*
	DMERC	*Palmetto*	*00885*	*RCD_*
Missouri	*FI*	*Trispan*	*00230*	*MOA_*
	Carrier	*Arkansas BCBS – East MO*	*00523*	*MOB_*
	Carrier	*BCBS Kansas - West MO*	*00651*	*MOB_*
	RHHI	*Cahaba*	*00011*	*MOR_*
	DMERC	*CIGNA*	*05655*	*RDD_*
Montana	*FI*	*BCBS Montana*	*00250*	*MTA_*
	Carrier	*BCBS Montana*	*00751*	*MTB_*
	RHHI	*Cahaba*	*00011*	*MTR_*
	DMERC	*CIGNA*	*05655*	*RDD_*
Nebraska	*FI*	*BCBS Nebraska*	*00260*	*NEA_*
	Carrier	*BCBS Kansas*	*00655*	*NEB_*
	RHHI	*Cahaba*	*00011*	*NER_*
	DMERC	*CIGNA*	*05655*	*RDD_*
Nevada	*FI*	*UGS*	*00454*	*NVA_*
	Carrier	*Noridian*	*00834*	*NVB_*
	RHHI	*UGS*	*00454*	*NVR_*
	DMERC	*CIGNA*	*05655*	*RDD_*
New Hampshire	*FI*	*BCBS NH/VT*	*00270*	*NHA_*
	Carrier	*NHIC*	*31144*	*NHB_*
	RHHI	*Associated Hospital Svc*	*00180*	*NHR_*
	DMERC	*HealthNow*	*00811*	*RAD_*
New Jersey	*FI*	*Riverbend*	*00390*	*NJA_*
	Carrier	*Empire*	*00805*	*NJB_*
	RHHI	*UGS*	*00450*	*NJR_*
	DMERC	*HealthNow*	*00811*	*RAD_*

New Mexico	*FI*	*TrailBlazer*	*00400*	*NMA_*
	Carrier	*Arkansas BCBS*	*00521*	*NMB_*
	RHHI	*Palmetto*	*00380*	*NMR_*
	DMERC	*Palmetto*	*00885*	*RCD_*
New York	*FI*	*Empire*	*00308*	*NYA_*
	Carrier	*Empire*	*00803*	*NYB_*
	Carrier	*Group Health Inc.*	*14330*	*NYB_*
	Carrier	*HealthNow*	*00801*	*NYB_*
	RHHI	*UGS*	*00450*	*NYR_*
	DMERC	*HealthNow*	*00811*	*RAD_*
North Carolina	*FI*	*Palmetto*	*00382*	*NCA_*
	Carrier	*CIGNA*	*05535*	*NCB_*
	RHHI	*Palmetto*	*00380*	*NCR_*
	DMERC	*Palmetto*	*00885*	*RCD_*
North Dakota	*FI*	*Noridian*	*00320*	*NDA_*
	Carrier	*Noridian*	*00820*	*NDB_*
	RHHI	*Cahaba*	*00011*	*NDR_*
	DMERC	*CIGNA*	*05655*	*RDD_*
Ohio	*FI*	*AdminaStar*	*00332*	*OHA_*
	Carrier	*Palmetto*	*00883*	*OHB_*
	RHHI	*Palmetto*	*00380*	*OHR_*
	DMERC	*AdminaStar*	*00635*	*RBD_*
Oklahoma	*FI*	*BCBS Oklahoma*	*00340*	*OKA_*
	Carrier	*Arkansas BCBS*	*00522*	*OKB_*
	RHHI	*Palmetto*	*00380`*	*OKR_*
	DMERC	*Palmetto*	*00885*	*RCD_*
Oregon	*FI*	*Regence*	*00350*	*ORA_*
	Carrier	*Noridian*	*00835*	*ORB_*
	RHHI	*UGS*	*00454*	*ORR_*
	DMERC	*CIGNA*	*05655*	*RDD_*
Pennsyl-vannia	*FI*	*Veritus*	*00363*	*PAA_*
	Carrier	*Highmark*	*00865*	*PAB_*
	RHHI	*Cahaba*	*00011*	*PAR_*
	DMERC	*HealthNow* `	*00811*	*RAD_*

Puerto Rico	*FI**	*Cooperativa*	*57400*	*PRA_*
	Carrier(PR)	*Triple-S*	*00973*	*PRB_*
	Carrier(VI)	*Triple-S*	*00974*	*VIB_*
	*RHHI**	*UGS*	*00450*	*PRR_*
	*DMERC**	*Palmetto*	*00885*	*RCD_*

**Includes Virgin Islands*

Rhode Island	*FI*	*Arkansas BCBS*	*00021*	*RIA_*
	Carrier	*Arkansas BCBS*	*00524*	*RIB_*
	RHHI	*Associated Hospital of ME*	*00180*	*RIR_*
	DMERC	*HealthNow*	*00811*	*RAD_*
South Carolina	*FI*	*Palmetto*	*00380*	*SCA_*
	Carrier	*Palmetto*	*00880*	*SCB_*
	RHHI	*Palmetto*	*00380*	*SCR_*
	DMERC	*Palmetto*	*00885*	*RCD_*
South Dakota	*FI*	*Cahaba*	*00011*	*SDA_*
	Carrier	*Noridian*	*00889*	*SDB_*
	RHHI	*Cahaba*	*00011*	*SDR_*
	DMERC	*CIGNA*	*05655*	*RDD_*
Tennessee	*FI*	*Riverbend*	*00390*	*TNA_*
	Carrier	*CIGNA*	*05440*	*TNB_*
	RHHI	*Palmetto*	*00380*	*TNR_*
	DMERC	*Palmetto*	*00885*	*RCD_*
Texas	*FI*	*TrailBlazer*	*00400*	*TXA_*
	Carrier	*TrailBlazer*	*00900*	*TXB_*
	RHHI	*Palmetto*	*00380*	*TXR_*
	DMERC	*Palmetto*	*00885*	*RCD_*
Utah	*FI*	*Regence*	*00350*	*UTA_*
	Carrier	*Regence*	*00910*	*UTB_*
	RHHI	*Cahaba*	*00011*	*UTR_*
	DMERC	*CIGNA*	*05655*	*RDD_*
Vermont	*FI*	*BCBS NH/VT*	*00270*	*VTA_*
	Carrier	*NHIC*	*31145*	*VTB_*
	RHHI	*Associated Hospital of ME*	*00180*	*VTR_*
	DMERC	*HealthNow*	*00811*	*RAD_*
Virginia	*FI*	*UGS*	*00453*	*VAA_*

	*Carrier**	*TrailBlazer*	*00904*	*VAB_*
	RHHI	*Cahaba*	*00011*	*VAR_*
	DMERC	*AdminaStar*	*00635*	*RBD_*

* *See also District of Columbia*

Washington	*FI*	*Noridian*	*00322*	*WAA_*
	Carrier	*Noridian*	*00836*	*WAB_*
	RHHI	*UGS*	*00454*	*WAR_*
	DMERC	*CIGNA*	*05655*	*RDD_*
West Virginia	*FI*	*UGS*	*00453*	*WVA_*
	Carrier	*Palmetto*	*00884*	*WVB_*
	RHHI	*Cahaba*	*00011*	*WVR_*
	DMERC	*AdminaStar*	*00635*	*RBD_*
Wisconsin	*FI*	*UGS*	*00450*	*WIA_*
	Carrier	*WPS*	*00951*	*WIB_*
	RHHI	*UGS*	*00450*	*WIR_*
	DMERC	*AdminaStar*	*00635*	*RBD_*
Wyoming	*FI*	*BCBS Wyoming*	*00460*	*WYA_*
	Carrier	*Noridian*	*00825*	*WYB_*
	RHHI	*Cahaba*	*00011*	*WYR_*
	DMERC	*CIGNA*	*05655*	*RDD_*

Aid to Contractors

In Determining the Business Segment Identifiers

June 14, 2004

This package is intended as an aid to fiscal intermediaries and regional home health intermediaries in determining the business segment identifier (BSI) to be assigned to each provider as required by CR 3256. Pages 2 and 3 list all the FI and RHHI contractor numbers and the associated authorized BSIs. Where a contractor number has more than one BSI, the contractor may refer to page 4 which provides a structured, step by step, approach to determining the BSI for each category of provider. Pages 5 and 6 provide examples.

Authorized Business Segment Identifiers for Intermediaries and RHHIs:

Contractor	Contractor Number	Type of Workload	State(s)	Authorized BSIs - If there is a choice, see the following table/chart.
Assoc'd Hospital Srvc of ME -ME	00180	FI	ME	MEA_
Assoc'd Hospital Srvc of ME	00180	RHHI	Multiple	Any state code within the jurisdiction plus R_
Assoc'd Hospital Srvc of ME -MA	00181	FI	MA	MAA_
Anthem – NH/VT	00270	FI	NH, VT	NHA_ or VTA_
Empire – NY/CT/DE	00308	FI	NY, CT, DE	NYA_, CTA, or DEA_
Cooperativa	57400	FI	PR	PRA_
CareFirst of MD – MD/DC	00190	FI	MD, DC	MDA_ or DCA_
Veritus	00363	FI	PA	PAA_
Palmetto - SC	00380	FI	SC	SCA_
Palmetto	00380	RHHI	Multiple	Any state code within the jurisdiction plus R_
Palmetto - NC	00382	FI	NC	NCA_
Cahaba - AL	00010	FI	AL	ALA_
Cahaba – IA/SD	00011	FI	IA, SD	IAA_ or SDA_
Cahaba	00011	RHHI	Multiple	Any state code within the jurisdiction plus R_
First Coast	00090	FI	FL	FLA_
Georgia BC	00101	FI	GA	GAA_
Trispan – MS/LA/MO	00230	FI	MS, LA, MO	MSA_, LAA, or MOA_
Riverbend – TN/NJ	00390	FI	TN, NJ	TNA_ or NJA_
AdminaStar - KY	00160	FI	KY	KYA_
AdminaStar – IL	00131	FI	IL	ILA_
AdminaStar – IN	00130	FI	IN	INA_
AdminaStar – OH	00332	FI	OH	OHA_

UGS - MI	00452	FI	MI	MIA_
UGS - WI	00450	FI	WI	WIA_
UGS	00450	RHHI	Multiple	Any state code within the jurisdiction plus R_
UGS - VA/WV	00453	FI	VA, WV	VAA_ or WVA_
UGS – CA/HI/NV	00454	FI	CA, HI, NV	CAA_, HIA_ or NVA_
UGS	00454	RHHI	Multiple	Any state code within the jurisdiction plus R_
Arkansas – AR	00020	FI	AR	ARA_
Arkansas – RI	00021	FI	RI	RIA_
Oklahoma	00340	FI	OK	OKA_
Kansas BC	00150	FI	KS	KSA_
Nebraska BC	00260	FI	NE	NEA_
Mutual	52280	FI	Multiple	NTA_
TrailBlazer – TX/CO/NM	00400	FI	TX, CO, NM	TXA_, COA_ or NMA_
Noridian – ND/MN	00320	FI	ND, MN	NDA_ or MNA_
Montana	00250	FI	MT	MTA_
Wyoming	00460	FI	WY	WYA_
Arizona	00030	FI	AZ	AZA_
Regence – OR/ID/UT	00350	FI	OR, ID, UT	ORA_, IDA_ or UTA_
Premera – WA/AL	00430	FI	WA, AL	WAA_ or ALA

Assigning BSIs Within a Single Contractor Number

Fiscal Intermediary	Regional Home Health Intermediary
1. Assign specialty providers (FQHC, demos) to the corporate contractor number and BSI.	1. Assign demonstration project providers to the corporate contractor number and BSI.
2. Assign chains to the BSI for the chain home office or the state nominated.	2. Assign chains of home health agencies/hospices to the BSI for the state of the provider's home office.
3. For providers that are "out of area" (e.g. Empire providers in other than NY/CT/DE), assign the provider to the BSI of the state they originally nominated (which should be either NY,CT or DE). This may be identified by determining if the provider was part of a workload assumed from another contractor. If the original nomination cannot be determined, assign the provider to the BSI of the corporate contractor.	
4. COST REPORT SETTLEMENT : For UGS – 00450, UGS – 00454, Cahaba –00011, AHS Maine – 00180, or Palmetto – 00380, if a hospital based home health agency/hospice is on the provider file for cost report settlement, and the home health agency/hospice is part of a hospital serviced under the above contractor numbers, it will be assigned to a BSI for the RHHI.	3. For UGS –00450, UGS –00454, Cahaba –00011, AHS Maine – 00180, or Palmetto – 00380, if a hospital based home health agency/hospice is serviced in the same contractor number as the hospital, assign it to a BSI for the RHHI for claims processing purposes.
5. COST REPORT SETTLEMENT: If a hospital-based provider is on the provider file for cost report settlement only, assign it to the BSI of the hospital.	
6. The remainder should be only providers in the contractor's jurisdiction (e.g. Empire=NY/CT/DE). Assign BSI based on the first two digits of provider number.	4. The remainder should be only individual, free-standing home health agencies/hospices. Assign BSI based on the first two digits of the provider number.

Fiscal Intermediary Examples:

Step 1	TrailBlazer processes Indian Health Service claims for the nation under 00400. The BSI would be TXA_.
Step 2	Cahaba has a SNF chain headquartered in South Dakota that has providers in several states. Claims processing is conducted under the IO/SD contractor number 00011**. All the providers in the chain should be assigned a BSI of SDA_ as part of the South Dakota workload.**
	Cahaba serves a large chain of hospitals many of which are located in states other than Alabama. The home office of the chain is located in Birmingham. **The BSI for all the providers in the chain will be 00010ALA_. Also, since 00010 represents only one state, every provider served under 00010 will be ALA_.**
	UGS serves a large chain of skilled nursing facilities out of its California office. The home office of the chain is in Ohio. The chain was assumed from Aetna. **The BSI for all providers in the chain will be 00454CAA_ because UGS assumed workload from the previously nominated contractor.**
	Cahaba has one hospital in Illinois that is part of a chain the home office of which is in Iowa and claims processing is handled under contractor number 00011. **All providers in the chain should be assigned to 00011IAA_.**
Step 3	Empire has providers located in Massachusetts that were acquired from two separate and distinct transitions: Aetna (MA) and Anthem (CT). **The MA providers acquired from Anthem should be assigned CTA_ on the assumption that they were part of the CT workload of Anthem. The MA providers acquired from Aetna should be assigned NYA_ because in 1997 when Aetna left the Medicare program Empire only had the New York workload.**
Step 4	AHS-Maine services hospitals in Maine that have HHAs and hospices as subunits, under contractor number 00180. Should these HHAs and hospices be coded as Part A or RHHI workload? **The contractor workload identifier for the hospital will be 00180MEA_ and the identifier for the home health agency will be 00180MER_. Cost report settlement transactions for the HHA will show as MER_ even though the cost report work is done by the FI.**
Step 5	Empire provides claims processing for a hospital in New York. UGS provides claims processing for the hospice that is associated with the hospital. Empire does both cost reports. **Empire will code an identifier of 00380NYA_ for the hospital and 00380NYA_ for the hospice that is on the Empire file for cost report settlement only. UGS will code the hospice as 00450NYR_.**

RHHI Examples:

Step 1	
Step 2	Cahaba services a large chain of HHAs that have a home office in Kansas. **All the providers should be coded 00011KSR_.**
Step 3	Associated Hospital Service of Maine has two contractor numbers: 00180 for Maine Part A and Regional 1 RHHI and 00181 for Massachusetts Part A workload. What BSI is appropriate for Massachusetts hospital-based HHAs and Hospices? **The Massachusetts HHAs and Hospices should be coded as RHHI workload from Massachusetts, i.e. 00180MAR_.**
Step 4	Associated Hospital Service of Maine services hospitals in Maine that have HHAs and Hospices as subunits. Should these hospital-based HHAs and Hospices be coded as Part A or RHHI workload? **The Maine HHAs and Hospices that are subunits of Maine hospitals should be coded as RHHI workload from Maine, i.e. 00180MER_. Cost report settlement transactions for the HHA will show as MER_ even though the cost report work is done by the FI.**

Revised and Re-released June, 2004

Following are the Questions and Answers on CR 3256 – Expanded Identification and Workload Reporting for CMS Medicare Systems

HGSA

1. Draft CMS CR 3256 appears to be for one small piece of CMS CR 3023 (Issued in final on February 6, 2004). However, there is no notation anywhere in this new CR that it replaces CMS CR 3023. Therefore we must assume both CRs are still active, with CR 3023 scheduled for July 1 implementation, and CR 3256 scheduled for October 1 implementation. Answer**: CR 3023 was for analysis only. CR 3256 is a complete replacement for CR 3023. CR 3256 includes major portions of the original concept for the contractor workload identifier for all of the shared systems. However, it does not include any changes to accommodate PECOS, HIGLAS, REMAS, COBC or other MSP systems; CMS will address changes for these systems to incorporate the contractor workload identifier in future CRs.**
2. There are also two Transmittal cover sheets on this CR, which differ. One deals with developing a means to identify and track Medicare fee-for-Service workloads by state level, and one instructing intermediaries to add the BSI to the POR report. Which is correct? Answer**: Both Transmittal cover sheets are correct and both apply to the changes in this CR. They change two chapters of the Financial Management Manual. One transmittal addresses the changes to POR operations, which apply only to intermediaries and RHHIs, and the other provides a general overview of the new contractor workload identifier.**
3. The Business Requirements in CMS CR 3256 are identical to those in CMS CR 3023. Yet CR 3256 appears to be only for Part A to make changes to add BSI to their POR report. The Business requirements in the CR however, list work that needs to be done by MCS, VMS, RHHIs, CWF, Contractors, Carriers, and others which appear not to be involved in the Part A changes listed in the "Summary of Changes" section of the Transmittal. We are confused as the Business Requirements list everything that needs to be done, not just the Part A changes to the POR report. This must be clarified and corrected. Answer: **As explained above, CR 3256 is a replacement for CR 3023 for the October release and the two transmittals apply to two different chapters in the manual. The changes for the contractor workload identifier will be handled in FISS differently than in the carrier systems, necessitating different business requirement statements. All shared systems will include the BSI on the provider file, on the submission file to CWF and on CROWD reports. But FISS will also carry the BSI on detail records within FISS. We'll try to clarify the background statement and any business requirements that are not clear.**

TrailBlazer

4. CR 3256 (Section 5.1) has the Quarterly 2174 report listed as a workload report. This report is for beneficiary financial reporting and will no longer be produced out of the shared system with HIGLAS. Since HIGLAS will identify contractor workload, I suggest this report be deleted from the listing in section 5.1. Answer: **We understand that the 2174 will be replaced by a report from HIGLAS, but since HIGLAS will not be implemented at all contractors for quite some time, we believe that the 2174 should include the business segment identifier for this CR.**

Empire

5. CR 3256 appears nearly identical to the 3/29 Draft of 3023 we reviewed in our last Work Group Call on 3/31. The changes/differences reflect the comments made during the call. Does CR 3256 replace CR 3023? Answer: **Yes, CR 3256 replaces CR 3023 and reflects the discussion of the early involvement call on March 31.**
6. Under Summary of changes, it "instructs all intermediaries to add a new BSI when entering a new Part A provider overpayment debt." However, the Business Requirements still reflect VMS, MCS, Carriers and DMERCs. Is this CR FI only or should it be considered A/B? Answer: **This CR applies to carriers and intermediaries and all shared systems – FISS, VMS, MCS and CWF. The summary of changes on the transmittal page for the POR manual instructions calls for intermediaries to add the BSI to Part A provider overpayments, which applies only to intermediaries. The business requirements for this new activity (3256.2, 3256.2.1 and 3256.2.2) make the intermediaries responsible.**

Associated Hospital Service

7. Associated Hospital Service (AHS) is a Regional Home Health Intermediary. How should RHHI contractors assign the Business Segment Indicator (BSI) for the HHAs & Hospices that the Contractor serves as both the Audit Intermediary, as well as the Claims Processing Intermediary? For example, we service hospitals in Maine that have HHAs and Hospices as subunits. Should these hospital-based HHAs and Hospices be coded as Part A or RHHI workload? Answer: **The Maine HHAs and hospices that are subunits of Maine hospitals should be coded as RHHI workload, i.e. 00180MER_. We will consider a clarification to the business requirements for this situation.**

8. AHS currently has two base contractor #s: 00180 and 00181. #00180 generally relates to Maine Part A and Region I RHHI workloads. #00181 generally relates to Massachusetts Part A Workload. Question: what BSI is appropriate for Massachusetts hospital-based HHAs and Hospices? Are these subunits to be considered Part A or RHHI Workload? Answer: **The Massachusetts HHAs and hospices should be coded as RHHI workload, i.e. 00180MAR_.**

9. AHS services a Federally Qualified Health Center (FQHC) that is a subunit of a Massachusetts HHA. Is this FQHC workload deemed Part A or RHHI? Answer: **We understand that there are some circumstances in which an FQHC can function as an HHA. However FQHCs more commonly bill as Part A providers. Therefore, the subject FQHC should be coded as 00181MAA_.**

New York Regional Office

10. Which state(s) should you assign if the Part B provider has locations in multiple states under the jurisdiction of a single carrier? If the provider has locations in multiple states under the jurisdiction of multiple carriers? Answer: **All claims processed by a given carrier under a physician number assigned by that carrier should show the BSI of that carrier.**

11. Which state should you assign for services rendered in foreign countries or shipboard? Answer**: All claims processed by the carrier should show the BSI of that carrier.**

12. If a provider makes a home visit to a beneficiary in a neighboring state under the jurisdiction of a separate contractor, where should the data be included? (Contractor home office or the location of the beneficiary?) Answer: **All claims processed by the carrier should show the BSI of that carrier.**

FISS

13. The FISS Maintainer is requesting clarification from CMS on regarding this CR estimation. CR3023 was the requirements and analysis phase. It was my understanding that this was to be the coding and unit testing phase. Is this statement correct or is CR3256 a replacement of CR3023. The reason we ask is that this has requirements not in the original. If it is a replacement, it should be stated as such in the CR, thus as a replacement, it would be to re-estimate the entire project. Answer: **Yes, 3256 is a complete replacement for 3023 and we will explain this in the final version of the CR. Yes, we are expecting a full re-estimation based on the requirements in this CR.**

Cahaba

14. Cahaba serves a large chain of hospitals many of which are located in states other than Alabama. The home office of the chain is located in Birmingham and the chain submits all claims to Cahaba. How should be BSI be assigned for these providers? Answer: **Business Requirement 3256.1.2.1 addresses this situation. Where a chain of providers has selected the FI as the servicing intermediary for all of its providers, the BSI for all the providers will be the BSI of the nominated FI. In this instance, the BSI for all the providers in the chain will be 00010ALA_.**

VIPS

15. Requirement 3256.1.1.1 - 'SSM shall add contractor workload identifier field to all provider file records." VMS response: Our understanding was that VMS was not required to add this to the provider records. Would CMS please clarify if this applies to VMS? Additional hours would be needed in order to meet this requirement. Answer: **Only FISS and MCS will be required to maintain the BSI on the provider file. We have revised requirement 1.1.1 to exclude VMS. Thanks for catching this problem.**

16. Requirement 3256.1.2.5- 'MCS and VMS shall autopopulate the BSI on the provider file.' VMS response: Our understanding was that VMS was not

required to add this to the provider records within VMS. Would CMS please clarify if this applies to VMS? Additional hours would be needed in order to meet this requirement. Answer: **Please see the answer to question 15.**

17. Requirement 3256.4 - 'SSM shall provide the capability to update/transfer the records/transactions for a Contractor Workload Identifier from one contractor to another to accommodate contractor transitions.' VMS response: We are not planning any system changes for this requirement. We believe this requirement would be fulfilled when conversions are written for a given contractor when their workload is transitioned to another contractor. The work associated with that conversion would be billed at the time of the transition. Would CMS please confirm that this approach is acceptable? If our proposed approach is not following what CMS was expecting, would CMS please clarify what outcome is expected from this requirement? By adding the BSI to the carrier / DMERC record (requirement 3256.1), conversions will be able to utilize this information within VMS to populate the BSI on a given file. This is contingent upon which records would need to be converted and would need to be addressed at the time of the carrier/DMERC's transition. Would CMS please review our Assumptions and confirm that our proposed approach meets the requirements of this CR Answer: **The VMS proposed approach is in accord with CMS concepts for contractor transitions and is acceptable.**

18. We need updated copies of the HUBC/HUDC and HUCM copybooks. The versions we received for the CR3190 changes did not include the BSI. Answer: **CWF has included the changes for 3256 with the changes needed for 3190. OIS sent copybooks to the SSM on the 14th of April. The following are the changes CWF made to the Part B copybook. The provider number has been expanded and I have copied the portion of the copybook that shows the additional 4 bytes.**

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The following copybooks incorporate changes adding header and Line Item Override Edit Code tables, expanding the Contractor Number from five to nine bytes, removing filler created as a byproduct of Y2K changes, and regrouping the Part B and DME HCPCS Code Modifiers so all four may be populated for either Part B or DME claims.

****

```
15  HUBC-PROC-CARRIER.
C23???          20  HUBC-PROC-CARR  PIC  X(05).
C23???             88  SPECIAL-CARRIER       VALUE '13311'
C23???                                              '26211'
C23???                                              '88880'
C23???                                              '88888'
C23???                                              '81818'.
C23???          20  HUBC-PROC-CARR-EXP   PIC  X(04).
```

19. Willl CWF add the BSI to the HIMR screen? This would assist contractors when reviewing claims that were transitioned and it would also assist with system

testing this change with CWF. Answer: **The changes for the provider number should be in HIMR. We will check with CSC to ensure that the changes to HIMR will be made.**

Empire

20. Summary of changes does not include or mention CROWD. Answer: **We will add a reference to the expanded CROWD reporting.**

21. Business Requirements 3256.1.2 – Where will the BSI be populated on the provider file? Answer**: FISS will determine the record layout**.

22. How do we determine the BSI for startup and how will the provider file be populated? Answer: **By "startup" we understand that the question refers to the initial process of assigning the BSI to the providers. The series of requirements beginning at 3256.1.2 are the responsibility of the FIs and RHHIs because we don't believe the assignment of BSIs can be programmed; it will be a manual process. Please refer to the attached package which outlines the process for determining the BSIs.**

23. Empire Part A has providers located in Massachusetts that were acquired from two separate and distinct transitions; Aetna (MA) and Anthem (CT). We have a BSI for CT but not for MA. Where would we report these MA providers since they were transitioned to us from two different contractors? Would the MA providers acquired from Anthem go to CT and the MA providers acquired from Aetna go to NY? Answer: **Yes, the MA providers acquired from Anthem go to CT and the MA providers acquired from Aetna go to NY**. **This assumes that none of the subject providers are part of a chain, the home office of which is in another state serviced by Empire.**

24. Bus. Req. 3256.1.2.2 - Where and how do we identify the specialty providers? Answer: **Specialty providers are to be assigned the BSI of the corporate contractor, as described in step 1 of the attached package.**

25. Bus. Req. 3256.1.2.2 - What will the maintainers look at to determine the contract jurisdiction code? Answer: **We understand that "contract jurisdiction code" means the business segment identifier. The business requirements that detail the assignment of BSIs are the responsibility of the intermediaries, not FISS. We believe that intermediaries will have to determine the BSIs manually.**

26. Bus. Req. 3256.2 - Will the POR reports from FISS be updated to show the BSI? Answer: **Please see questions 30, 31 and 32 below**.

27. Bus. Req.3256.2 - How do we identify providers that are not in one of our 3 areas, i.e. providers that are part of a chain that are located in a state not in the workload identifiers? Answer: **Business Requirement 3256.1.2.1 addresses chain providers: "FIs shall assign providers not located in the contracted state jurisdiction ("out of area") according to the following rules: 1. If the "out of area" provider or chain of providers is serviced through a nomination of selected contractor, assign the provider to the state-associated workload to which the nomination relates." The nominated contractor is usually the one serving the location of the home office of the chain. Please refer to the attached package.**

28. Bus. Req. 3256.5.1 - Would CMS explain why the Business Segment is needed for the 1563 report? We have the following questions on this process: Answer: **CMS needs an accounting of overall savings attributed to each contractor and/or workload. For those contractors with one contractor number covering many states, it is imperative to know by savings/workload who is doing what work**. (1) Much of the savings are attributed to the special contractor. We have been advised that savings do not need to be broken out to the business segment for the special contractor. Answer: **The Business Segment Identifier will not interfere with the accounting of savings attributed to the special contractor. We have augmented requirement 5.1 with the statement "Line items for customer service and MSP savings from the special MSP contractor may be reported at the contractor level." Also, we have shared your comment with Tom Bouchat, coordinator for CR 3181**. (2) This would leave savings for the data center (e.g., 00308), which would be broken out by state. However, even though the claim was processed by the data center, the MSP record could have been initiated by any non-special contractor (e.g., 00801, 00902. etc). Answer: TBD (3) Because the 1563 report is being expanded, breaking it out by the business segment adds considerably to the number of reports required. Answer: **We understand that there will be additional reports, but have been advised that it will not be a significant increase**. **The author of CR 3181 encourages contractors to comment on this issue with specifics of any additional workload**. (4) Since it is unlikely that contractors would change mid-month, what is the purpose of having the savings report broken out to the business segment? Answer: TBD

TrailBlazer

29. With the implementation to POR being earlier than the Shared Systems (FISS), there is a risk the BSI utilized for updating POR may be inconsistent with the one populated in the Shared System(FISS). The difference might be due to special workload assignments that would carry a different BSI other than the state where the provider resides. Answer: **We recognize that this is a task that the FI will have to coordinate, but believe it is a manageable risk. Also if the FI enters an incorrect BSI on the POR they will be able to change it.**

30. Br 3256.7.6 - Once the means to auto-populate the BSI for all open provider receivables assigned at a provider level, the "Input Data Provider Overpayment Report" (8008R1 FISS Report), should be included in the FISS updates. This report is generated when any new activity on the Cost Settlement Receivables, whether a new determination or any other activity, occurs. This is a daily report from FISS utilized to enter new receivables or any update activity to the receivables to POR. With the BSI being included on these reports, there should be consistency with FISS and the POR. Answer: **POR business experts will modify the PR120 to include the BSI and will make the new record layout available to the FISS maintainer.**

31. Revisions to the Medicare Financial Management Manual 180.1.7 – Will contractors be able to request Adhoc Reports to include all BSI's on one report? Or, will separate Adhoc Reports be required for each BSI? It was not clear with

the manual revision. It would be more effective to be able to make the request to include all BSI's on one report. Answer: **Yes, all the BSIs for a contractor number can be included in one report. The FI can also request a report with a set of records for only one BSI.**

32. There are 2 PT files. Both say CR 3256, but they have different "Summary of Changes ," based on different parts of the CR. Shouldn't these be combined? Answer: **CMS will combine the manual transmittals into one document for the final package.**

WPS

33. The instruction at the top of page 3 of the br3256.doc file attached indicates: "All Shared Systems shall add the indicator to outgoing claims transactions to CWF and shall add the indicator to workload and management reports." The MCS is not required to carry the Business Segment on internal records, who will be responsible to verify the workload sent to CWF is the same as reported via 1565 and 2590 reports? Answer: **The workload reports sent to CWF for the PULSE system will continue as currently, reflecting the transactions for the contractor number**. **For the carriers, that have only one BSI per contractor number, the PULSE and CROWD reports should still be comparable.**

The following questions were received after the CR was issued in Final:

VIPS

34. In Attachment 1, the following information is listed for KS:

    00650 KSB_
    00651 KSB_
    00655 NBB_

    In the Medicare Financial Management Manual in the CR the following information is listed for Kansas:

    00650 KSB_
    00651 MOB_
    00655 NBB_

    Is the BSI for 00651 KSB_ or MOB_? Answer: **The BSI for 00651 is MOB_. CMS will correct the table.**

    Also, we wanted to reiterate what KS asked in question #40 and #41 in the 1/26/2004 Q&A document that 00651 is actually 00740 in VMS. All claims will continue to be submitted to CWF under 00740 for the 00651 contractor number. Does CMS foresee a problem with this? Answer: **The inconsistency with the contractor numbers has been referred to the Office of Information Systems which will prepare a response and action plan.**

35. In Attachment 1, the following information is listed for Puerto Rico and the Virgin Islands: 00973 PRB_
00974 VIB_

In the Medicare Financial Management Manual in the CR the following info is listed: 00973 PRB_ * includes Virgin Islands.

Please note that 00973 and 00974 are currently sent to CWF as separate carrier numbers, so a BSI is necessary for the VI. Is VIB_ the correct BSI for 00974 or is it PRB_? For CROWD reporting, Puerto Rico (Ida Casablanca) has noted that they submit 00974 and 00973 separately. Answer: **The correct BSI for 00974 is VIB_. CMS will correct the table.**

36. We have reviewed the latest info on INFOMAN for CWF changes. Because it is still early, we wanted to find out if there are any CWF plans to edit this information. Will CWF be validating the BSI submitted? If so, will there be a new error? If in an unusual circumstance, will CWF accept a HUBC/HUDC with a blank BSI? If not, will there be a new error returned or an existing one? Answer: **CWF will not be editing for the BSI. There will be no edits at all- not even for the presence of the BSI. If it comes in, it will be processed. You will not see anything in CWF's INFOMAN for any edits.**

UGS Qs &As for CR 3256

37. Will there be any special funding available for system modifications and increased staffing needs? Answer: **There will be no additional funding; the system changes required under CR 3256 shall be implemented within the current operating budget.**

38. What will the impact be on the Performance Based Outcome Pilot for UGS? Answer: **The Performance Based Outcome Pilot will be discontinued as of 10/04. CR 3256 has no impact on the Performance Based Outcome Pilot for UGS.**

39. Are you aware of any other contractors who have systems that already have made modifications to meet the reporting requirements? Answer: **CR 3256 has an implementation date of 10/01/04. Contractors are required to make changes to their systems at that time. The FISS maintainer is currently developing their modifications.**

40. Will more than 1 person be able to enter into CROWD system at one time? Answer: **Only one person at a time will be able to enter data on one form in CROWD, just as it is now. But multiple users can log into the CROWD system at the same time, so if an intermediary has several people who have access to the system, several users could be entering data on different forms at the same time**.

41. How many CROWD reports will UGS be expected to submit under the new reporting system? Answer: **UGS has 4 contractor ID numbers (00450, 00452, 00453, and 00454), and currently submits 4 separate sets of CROWD reports. Under the new expanded system UGS will submit 9 sets of CROWD reports; one each for the Part A workloads for WI, MI, CA, HI, NV, VA and WV, and one each for the RHHI work at WI and CA.**

42. Will the QICs be reporting Hearing Officer and ALJ data in CROWD? Answer: **The QICs are independent contractors and will not be reporting data in CROWD.**

43. How will the reporting of overlapping data for Fair Hearings and ALJs be handled in 10/04? Answer: **The work is tentatively scheduled to transition first from the FI to the QIC and then from the Carrier to the QIC. Therefore, the Carriers and FIs will continue to report in CROWD as long as they perform this work, until any pending workload relevant to these fields is completed.**