CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-06 Medicare Financial Management	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 248	**Date: December 19, 2014**
	Change Request 8906

SUBJECT: Revision of Pub. 100-06 - Medicare Financial Management Manual, Chapter 6 - Intermediary and Carrier Financial Reports, and Pub. 100-09 - Medicare Contractor Beneficiary and Provider Communications, Chapter 6 - Provider Customer Service Program

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to remove from Pub. 100-06, Chapter 6, and Pub. 100-09, Chapter 6, the requirements for Medicare Administrative Contractors (MACs) to report provider call center telecommunications data, provider Internet portal transaction data, and provider and beneficiary written inquiry workload data to the Contractor Reporting of Operational and Workload Data (CROWD) system. Such reporting is duplicative, as the MACs report these data to the Provider Inquiries Evaluation System (PIES) in accordance with Pub. 100-09, Chapter 6. In Pub. 100-06, Chapter 6, we are marking as "Inactive" "SECTION D: MISCELLANEOUS DATA, **INQUIRIES**, within section 20.4, and all of section 130.3, entitled "Part B - Inquiries."

EFFECTIVE DATE: January 23, 2015
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 23, 2015

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	6/Table of Contents
R	6/20.4/Body of Report
R	6/130.3/Part B - Inquiries

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

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-06	Transmittal: 248	Date: December 19, 2014	Change Request: 8906

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I. GENERAL INFORMATION

A. Background: Medicare Administrative Contractors (MACs) currently report provider and beneficiary inquiry workload data to the Contractor Reporting of Operational and Workload Data (CROWD) system on a monthly basis. These data are currently reported on CMS-1566 Form D and CMS-1565 Form B. MACs also report these same data to the Provider Inquiries Evaluation System (PIES) on a monthly basis. The purpose of this CR is to eliminate the reporting of the same data to two different systems by making "inactive" the applicable content of IOM Pub. 100-06, Chapter 6 (specifically, "SECTION D: MISCELLANEOUS DATA, INQUIRIES" within section 20.4 and all of section 130.3, "Part B - Inquiries") and by deleting section 70.5 from IOM Pub. 100-09, Chapter 6 that instructs MACs to report provider and beneficiary inquiry workload data to CROWD.

B. Policy: Section 921 of the Medicare Prescription Drug, Improvement, and Modernization Act, P.L. 108-173.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
8906 - 06.1	Medicare Administrative Contractors (MACs) shall implement the requirements contained within IOM Pub. 100-06, Chapter 6.	X	X	X	X					CROWD, RRB-SMAC

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility		
		A/B MAC	DME	CED

		A	B	H H H	M A C	I
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Patricia Peyton, 410-786-1812 or Patricia.Peyton@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

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

ATTACHMENTS: 0

Medicare Financial Management Manual

Chapter 6 – *Medicare Administrative Contractor (MAC)* Financial Reports

Table of Contents

(Rev.248, Issued: 12-19-14)

20.4 - Body of Report

(Rev. 175, Issued: 10-28-10, Effective: 04-01-11, Implementation: 04-04-11)

(Rev.248, Issued: 12-19-14, Effective: 01-23-15, Implementation: 01-23-15)

SECTION A: INITIAL BILL PROCESSING OPERATION

The intermediary completes every type of bill column (1 through 6) for each reporting item as described below. It includes data on all bills received for initial processing from providers (including all RHCs) directly or indirectly through a RO, another intermediary, etc. It also includes data on demand bills and no-pay bills submitted by providers with no charges and/or covered days/visits. It does not include:

- Bills received from institutional providers if they are incomplete, incorrect, or inconsistent, and consequently returned for clarification. Individual controls are not required for them;
- Adjustment bills;
- Misdirected bills transferred to another intermediary;
- HHA bills where no utilization is chargeable and no payment has been made, but which it has requested only to facilitate record keeping processes (There is no CMS requirement for HHAs to submit no payment non-utilization chargeable bills.); and
- Bills paid by an HMO and processed by the intermediary.
- Claims submitted by HHAs under the HH PPS with three-digit classification 3-2-9 or 3-3-9 are processed as adjustments to a previously submitted RAP record. However, the intermediary counts both HHPPS RAPs and claims as initial bills for this report. It does not exempt HH PPS claims as adjustments.

Opening Pending

Line 1 - Pending End of Last Month - The system will pre-fill the number pending from line 13 on the previous month's report.

Line 2 - Adjustments - If it is necessary to revise the pending figure for the close of the previous month because of inventories, reporting errors, etc., the intermediary enters the adjustment. It reports bills received near the end of the reporting month and placed under computer control sometime after the reporting month as bills received in the reporting month and **not** as bills received in the following month. In the event that some bills may not have been counted in the proper month's receipts, it counts them as adjustments to the opening pending in the subsequent month.

It enters on line 2 any necessary adjustments, preceded by a minus sign for negative adjustments, as appropriate.

Line 3 - Adjusted Opening Pending - The system will sum line 1 + line 2 to calculate the adjusted opening pending.

Receipts

Line 4 - Received During Month – The intermediary enters the total number of bills received for initial processing during the month.

It counts all bills immediately upon receipt regardless of whether or not they are put into the processing operation with the exception of those discussed below.

NOTE: It counts bills submitted by providers electronically after they have passed intermediary consistency edits. Prior to that time, it may return these bills or the entire tape reel (where magnetic tape is the medium of submission) without counting them as "received." However, once the bills or tapes have passed consistency edits and are counted as received, it uses the actual receipt date, not the date the edits are passed, in calculating pending and processing times.

If a bill belonging to one of the above-excluded categories is inadvertently counted as an initial bill received (e.g., certain adjustment bills unidentifiable at the time of receipt), the intermediary subtracts it from the receipt count when the bill is correctly identified.

Line 5 - Electronic Media Bills - The intermediary reports the net number of bills included on line 4 which were received in paperless form via electronic media from providers or their billing agencies and read directly into the intermediary claims processing system. It does not count on this line bills that it received in hardcopy and entered using an Optical Character Recognition (OCR) device. It does not count any bills received in hardcopy and transferred into electronic media by any entity working for it directly or under subcontract.

Clearances

Line 6 - Total CWF Bills (7 + 8) – The intermediary reports the number of initial bills (described in lines 7 and 8 below) processed through CWF and posted to CWF history. It does **not** include bills sent to CWF and rejected, unless they were resubmitted and posted to CWF history in the reporting month. It reports these bills in the month that it moves the bill to a processed location in the intermediary system after receipt of the host's response to pay or deny.

Line 7 - Payment Approved (CWF) – The intermediary enters the number of initial bills for which **it approved some payment** and for which the CWF host responded accepting the intermediary determination. It includes bills for which it approved payment in full or in part as a result of a determination that both the beneficiary and the provider were without fault (liability waiver). (See the Medicare Claims Processing Manual, Chapter 30, Financial Liability Protections.) The intermediary reports here those fully adjudicated, approved-for-payment bills for which it has received a response from the host and are holding only due to the payment floor.

Line 8 - No Payment Approved (CWF) - The intermediary enters the number of initial bills processed through CWF during the month for which it approved no payment. It reports here those bills for which payment is not made because the deductible has not yet been met and payment is therefore applied to the deductible.

Line 9 - Total Non-CWF Bills (10 + 11) - The intermediary reports the number of initial bills (described in lines 10 and 11 below) processed outside CWF. Non-CWF bills are those either rejected by or not submitted to CWF that the intermediary finally adjudicates outside of CWF and, therefore, are not posted to its history in the reporting month. The intermediary reports these bills as non-CWF, even if it plans to submit an informational record in the future. It reports such bills in the month in which it made the determination as to their final disposition.

It does **not** include home health bills where no utilization is chargeable and no payment has been made, but which it requested only to facilitate record keeping processes.

Line 10 - Payment Approved (Non-CWF) - The intermediary enters the number of initial bills processed outside CWF for which **it approved some payment**. It includes bills for which it approved payment in full or in part as a result of a determination that both the beneficiary and the provider were without fault (liability waiver). (See the Medicare Claims Processing Manual, Chapter 30, Financial Liability Protections.)

Line 11 - No Payment Approved (Non-CWF) – The intermediary enters the number of initial bills processed outside CWF during the month for which it approved no payment.

Line 12 - Total Processed - The intermediary reports the sum of lines 6 and 9.

NOTE: It reports as processed on line 12 those bills it has moved to a processed location after being accepted by the host and is holding only due to the payment floor. However, for pages 2-12 of this report, it reports these bills as processed in the month during which the scheduled payment date falls (which may be in a subsequent reporting period).

The intermediary reports HMO bills it paid on line 12 and on pages 2-12. It does not report those bills paid by HMOs and processed by the intermediary on line 12 or on pages 2-12. It reports such HMO paid bills only on line 39 of page 1.

Closing Pending

Line 13 - Pending End of Month - The system will calculate the number of bills pending at the end of the month by adding line 3 (adjusted opening pending) to line 4 (receipts) and subtracting line 12 (total processed). The intermediary does not report as pending those bills that it has moved to a processed location after being accepted by the host and is holding only due to the payment floor. It reports such bills as processed on line 12.

Line 14 - Pending Longer Than 1 Month – The intermediary reports the number of bills included in line 13 pending longer than 1 month, i.e., those received prior to the reporting month but not processed to completion by the end of the reporting month. For example, for the reporting month of October 2001, it reports the number of bills pending at the end of October 2001 which had been received prior to October 1, 2001. It excludes bills received in the reporting month.

Line 15 - Pending Longer Than 2 Months - The intermediary reports the number of bills included in line 13 pending longer than 2 months, i.e., those received prior to the month preceding the reporting month but not processed to completion by the end of the reporting month. For example, for the reporting month of October 2001, it reports the number of bills pending at the end of October 2001 that had been received prior to September 1, 2001. It excludes bills received in the reporting month and one month prior to the reporting month.

Bill Investigations

Line 16 - Bill Investigations Initiated - The intermediary enters the number of initial bills that, for purposes of processing the claim to completion, required **outside** contact (via telephone, correspondence, or on-site visit) with providers, social security offices, or beneficiaries during the month. This includes contacting outside parties to resolve problems with covered level of care determinations, insufficient medical information or missing, inconsistent, or incorrect items on the bill. It does not count routine submissions by providers of additional medical evidence with bills as investigations in themselves. It counts only the number of bills requiring investigation, **not** the number of contacts made. It excludes bills reported as investigated in a prior month from this count even if the investigation continued into the reporting month. It does **not** count as bills investigated those returned to providers because they were incomplete, incorrect or inconsistent, and consequently were not counted as "receipts."

SECTION B: ADJUSTMENT BILLS

This section includes data on the number of adjustment bills processed and pending for the reporting month, including those generated by providers, PROs, or as a result of MSP or other activity. In reporting adjustment bills, the intermediary counts only the number of original bills requiring adjustment, not both the debit and credit

Claims submitted by HHAs under the HH PPS with three-digit classification 3-2-9 or 3-3-9 are processed as adjustments to a previously submitted RAP record. However, both HHPPS RAPs and claims are counted as initial bills. The intermediary does not report HH PPS claims as adjustments.

Clearances

Line 17 - Total CWF Processed (18+19+20+21) - The intermediary reports the number of adjustment bills processed through CWF during the month. It counts adjustment bills as processed in final only when acceptance from CWF is received. Since §3664 precludes the processing of a utilization adjustment bill until CWF accepts the bill upon which the adjustment action is based, no utilization adjustment billing action may be processed until CWF has accepted the original bill.

Line 18 - PRO Generated (CWF) - The intermediary reports the number of adjustment bills included in line 17 which were generated by PROs.

Line 19 - Provider Generated (CWF) - The intermediary reports the number of adjustment bills included in line 17 which were generated by providers.

Line 20 - MSP (CWF) - The intermediary reports the number of adjustment bills included in line 17 which were generated as a result of MSP activity.

Line 21 - Other (CWF) - The intermediary reports the number of adjustment bills included in line 17 which were generated by other than PROs, providers, or MSP activity. It includes HMO adjustments where the HMO acted as an intermediary and made payment on the initial bill.

Line 22 - Total Non-CWF Processed (23+24+25+26) - The intermediary reports the number of adjustment bills that it processed outside of CWF during the month. It counts such adjustment bills as processed in final only when no further action is required.

If it receives an adjustment bill from a provider when the original bill is still in its possession, it takes the final adjustment action on the original bill before it is submitted to CWF. It counts the adjustment bill as cleared when acceptance of the original bill is received from CWF.

Line 23 - PRO Generated (Non-CWF) - The intermediary reports the number of adjustment bills included in line 22 which were generated by PROs.

Line 24 - Provider Generated (Non-CWF) - The intermediary reports the number of adjustment bills included in line 22 which were generated by providers.

Line 25 - MSP (Non-CWF) - The intermediary reports the number of adjustment bills included in line 22 which were generated as a result of MSP activity.

Line 26 - Other (Non-CWF) - The intermediary reports the number of adjustment bills included in line 22 that were generated by other than PROs, providers, or MSP activity. It includes HMO adjustments where the HMO acted as an intermediary and made payment on the initial bill.

Pending

Line 27 - Total Pending (28+29+30+31) - The intermediary reports the number of adjustment bills which were not processed to completion by the end of the reporting month.

Line 28 - PRO Generated – The intermediary reports the number of adjustment bills included in line 27 which were not processed to completion by the end of the reporting month and which were generated by PROs.

Line 29 - Provider Generated - The intermediary reports the number of adjustment bills included in line 27 which were not processed to completion by the end of the reporting month and which were generated by providers.

Line 30 - MSP - The intermediary reports the number of adjustment bills included in line 27 which were not processed to completion by the end of the reporting month and which were generated by MSP activity.

Line 31 - Other - The intermediary reports the number of adjustment bills included in line 27 which were not processed to completion by the end of the reporting month and which were generated by it or by a source other than PROs, providers, or MSP activity. It includes HMO adjustments not processed to completion where the HMO acted as an intermediary and made payment on the initial bill.

SECTION C: MEDICAID CROSSOVER BILLS

This section presents data on the volume of Medicaid crossover bills sent to Medicaid State agencies or their fiscal agents.

Clearances

Line 32 - Transmitted to State Agencies - The intermediary enters the total number of Medicaid crossover bills transmitted to State agencies or their fiscal agents in the reporting month.

Line 33 - Transmitted Electronically – The intermediary enters the number of bills included in line 32 which were transmitted via electronic media to State agencies or their fiscal agents.

SECTION D: MISCELLANEOUS DATA

INQUIRIES *(Inactive)*

This section presents data on the volume of provider or beneficiary inquiries that were **processed** during the reporting month. Include only **processed** inquiries dealing with Medicare bill processing issues. These issues correspond to the workload budgeted under line 1 of the CMS-1523 budget form.

The intermediary counts inquiries as follows:

Beneficiary - It counts one per contact (telephone, walk-in, or written), regardless of the number of bills being questioned. For example, if a letter from a beneficiary requests information on the status of one or more bills, it counts the response (interim or final) as one written beneficiary inquiry. It counts each completed reply, terminated telephone conversation, or in-person discussion as processed, regardless of the need for subsequent contact on the same issue. Responses resulting from additional intermediary follow up or analysis, or from additional contact by the beneficiary, are separate inquiries. Beneficiary inquiries include those made by anyone on behalf of the beneficiary, **except** by a provider.

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

It includes or excludes beneficiary and provider inquiries as follows:

- It counts as inquiries requests for Medicare information from beneficiaries or providers or their representatives that are directed to it for response.

- It does not count processed inquiries that are concerned solely with its line of business.

- It does not count inquiries concerned with professional relations activities.

- It does not count inquiries related solely to payment issues, MR or utilization review, MSP, audits, etc. These are areas for which it receives separate Medicare funding. This exclusion achieves comparability with the CMS-1523 budget form.

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

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

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

- It counts misdirected **telephone** inquiries referred to another source for a final response. It does not count misdirected written inquiries.

- It does not count inquiries that are, in fact, explicit or implicit requests for reconsiderations or hearing. See Medicare Claims Processing Manual, Chapter 29, Appeals of Claims Decisions, for specifics on what is a request for reconsideration or review.

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

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

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

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

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

OPTICAL CHARACTER RECOGNITION BILLS

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

BILLS PAID BY HMOs

Line 39 - Total HMO Bills Processed - It enters the number of bills that were paid by HMOs and processed by it during the reporting month. It reports HMO bills paid by it on line 12 but **does not** report such bills on line 39.

MEDICARE SUMMARY NOTICES (MSNs)

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

130.3 - Part B – Inquiries *(Inactive)*

(Rev. 175, Issued: 10-28-10, Effective: 04-01-11, Implementation: 04-04-11)

The carrier reports the number of responses it processed as a result of inquiries from, or on behalf of, Medicare beneficiaries or providers during the reporting month. It reports only inquiries processed related to the Medicare program. It excludes inquiries addressing its private line of business. It bases the data on actual counts, not on estimates or samples.

The carrier counts inquiries as follows:

Beneficiary - It counts one inquiry per contact (telephone, written, walk-in), regardless of how many claims the beneficiary inquires about. For example, if a beneficiary writes it about the status of two claims, it counts the response as one beneficiary written inquiry. It counts responses to re-contacts made by that beneficiary as an additional inquiry. It counts any inquiry made by a beneficiary, or by anyone on behalf of the beneficiary, except a provider.

Provider - It counts one inquiry per contact. For example, if a provider calls or writes it regarding the status of 10 claims, it counts the response as one provider-written or phone inquiry. It counts any inquiry made by a provider, or anyone on behalf of the provider, except a beneficiary. It counts inquiries regardless of whether they relate to assigned or unassigned claims.

- It counts beneficiary and provider inquiries as follows:

- It counts Medicare inquiries directed to it for a response if they are requests for information from beneficiaries or providers (physicians/suppliers) or their representatives.

- It does not count, as inquiries, professional relations activities and contacts (i.e., its training programs for providers on new requirements).

- It counts voice inquiries captured electronically as telephone inquiries, and electronic mail inquiries as written inquiries. It does not count electronic inquiries if the provider can access the carrier system to determine claim status without its involvement.

- It does not count inquiries related specifically to the physician fee freeze or MSP. (This is to achieve comparability with the CMS-1524 budget form, where all costs related to the fee freeze and MSP are reported on separate lines.)

- It counts congressional inquiries in the appropriate category (i.e., as a beneficiary inquiry if made on behalf of a beneficiary, and as a provider inquiry if made on behalf of a provider).

- It counts inquiries made by the RO or the SSA DO in the appropriate category if the inquires are on behalf of a beneficiary or a provider and relate to a specific claim. It does not count the inquiries if they are of a general nature (i.e., ongoing liaison necessary during monitoring of day-to-day operations).

- It does not count Part A inquiries if it handles all Part A inquiries for an intermediary on a routine basis. In this case, it charges the related costs to the intermediary. It does not include the volume of work on the CMS-1565.

- It counts misdirected telephone inquiries (i.e., those that must be referred to another source for response) as processed telephone inquiries. It does not count misdirected written inquiries.

- It does not count requests for reviews or hearings as inquiries. (See The Medicare Claims Processing, Beneficiary Correspondence and Administrative Appeals, for definitions of reviews and hearings.) It reports reviews and hearings on the CMS-2590, not on the CMS-1565.