CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-06 Medicare Financial Management	Centers for Medicare & Medicaid Services (CMS)
Transmittal 265	**Date: March 16, 2016**
	Change Request 8998

Transmittal 263, dated February 5, 2016, is being rescinded and replaced by Transmittal 265 to correct business requirement 8998.6, which references the incorrect ASC X12 276 transaction loop, and update Section V CONTACTS, Pre-Implementation Contact(s) information. All other information remains the same.

SUBJECT: Contractor Reporting of Operational and Workload Data (CROWD) Form 5 Update with Revisions to Pub. 100-06 Medicare Financial Management Manual, Chapter 6

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update Contractor Reporting of Operational and Workload Data (CROWD) Form 5. Several of the reporting metrics being captured in CROWD Form 5 are duplicative of data captured in the Provider Inquiries Evaluation System (PIES) in accordance with Pub. 100-09, Chapter 6. Therefore, Pub. 100-06, Chapter 6 and CROWD Form 5 are being updated to remove all eligibility reporting and internet portal reporting.

EFFECTIVE DATE: July 1, 2016
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 5, 2016

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	6/450/Medicare Contractor Transaction Report (CROWD Form 5)
R	6/450.2/Heading
R	6/450.3/Body of Report
R	6/450.4/Exhibit 1

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 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.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-06	Transmittal: 265	Date: March 16, 2016	Change Request: 8998

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SUBJECT: Contractor Reporting of Operational and Workload Data (CROWD) Form 5 Update with Revisions to Pub. 100-06 Medicare Financial Management Manual, Chapter 6

EFFECTIVE DATE: July 1, 2016
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I. GENERAL INFORMATION

A. Background: Medicare Administrative Contractors (MACs) are currently reporting electronic data interchange (EDI) data to the Contractor Reporting of Operational and Workload Data (CROWD) system on a monthly basis. MACs also report some of the same EDI data to the Provider Inquiries Evaluation System (PIES) on a monthly basis. Therefore, the purpose of this Change Request (CR) is to eliminate the reporting on the same data to two different systems by revising the necessary sections of IOM Pub. 100-06, Chapter 6, that requires this reporting and the sections that contain exhibits of forms where these data would be reported on CROWD Form 5. Instruction will also be provided to the CROWD Contractor to update the form accordingly.

B. Policy: Affordable Care Act, Section 1104

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	
8998.1	Contractors shall implement the requirements contained within IOM Pub. 100-06, Chapter 6.	X	X	X	X	X	X	X		
8998.2	Contractor shall make changes to CROWD Form 5 to remove old lines 2, 3, 4, 6, 7, and 14.									CROWD
8998.3	Contractor shall remove the column (no title identified) between the Type of Transaction and Electronic column as this column previously held the electronic version which is now included with the transaction title.									CROWD

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
8998.4	Contractor shall count the number of accepted claim status requests (ASC X12 276) received by line of business (Part A, Part B and DME) per Medicare Administrative Contractor (MAC) and report it in the Shared System Maintainer CROWD Form 5 report (FISS Rpt. 352 and MCSH99RDMCT).					X	X			
8998.5	Contractors shall report the Accepted Claim Status requests on new Line 1 of the modified CROWD Form 5 Report.	X	X	X	X					
8998.6	The Contractor shall count each occurrence of the unique trace or claim transaction number (ICN/DCN/CCN) as assigned by the provider (e.g., in the ASC X12 276, use TRN02 or REF02 of the 2200D loop) as a separate claim status request being received daily from the CEDI flat file, total them up for the time period and add them to the GDIT - EFCWD1 report.							X		
8998.7	Contractor shall remove the 4010A1 line from old Line 1 (now line 2 in the updated report) – Responses to Claim Status Inquiries.									CROWD
8998.8	The Contractor shall update new line 2 to read "RESPONSES TO CLAIM STATUS INQUIRIES (5010). This removes the "s" from Claims. Additionally, Contractor shall modify the heading between new line 5 and 6 to state, "PROCESSED CLAIM ACTIONS AND DDE RESPONSES DATA". This also removes the "s" from Claims.									CROWD
8998.9	Contractor shall remove all reporting requirements under Column 3, Internet/Portal except for Remittance Advices posted in new line 3. Additionally, column 3 shall be titled INTERNET/PORTAL.									CROWD
8998.10	Contractor shall add 277 into the column titled "Electronic" on new Line 2 - Responses to Claim Status Inquiries.									CROWD
8998.11	Contractor shall add a new Line 1 to CROWD Form 5 titled: ACCEPTED CLAIM STATUS REQUESTS and add 276 into the column titled "Electronic" on Line 1.									CROWD

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
8998.12	Contractor shall remove the 4010A1 line from old Line 8 – Remittance Advices Number Sent.									CROWD
8998.13	Contractor shall remove the 4010A1 line and 5010 line from old Line 5 – Prior Authorizations of Advanced Determinations of Medicare Coverage. This removes capturing prior authorization counts on CROWD Form 5.									CROWD
8998.14	Contractor shall update the column heading in CROWD Form 5 for new line 5 Dollar Amounts Associated with Payment, to read column 1: EFT and Column 2: Paper Checks. This would then remove the previous reference to 835 and SPR.									CROWD
8998.15	The contractor shall move the column heading from CROWD Form 5 which states "DME MACS ONLY" to between line 9 and 10. This column heading is currently between line 1 and line 2.									CROWD
8998.16	Contractor shall remove the column heading from CROWD Form 5 between old line 7 and line 8 which states "ALL CONTRACTORS".									CROWD
8998.17	Contractor shall remove “HIQA/ELCA/ELGB/ELGH, CWF” from the column 2 heading in line 11 – Electronic Claims Processed. Only DDE shall remain in the column heading.									CROWD
8998.18	Contractor shall modify the row heading within CROWD Form 5, following line 5 to read, "**PROCESSED CLAIM ACTIONS and DDE RESPONSES DATA**". This row heading removed IVR. Additionally, the IVR column (Column 3) following "PROCESSED CLAIMS ACTIONS and DDE RESPONSES DATA" should be removed.									CROWD
8998.19	Contractor shall add line 10 to CROWD Form 5 to add back in NCPDP Retail Pharmacy Drug Claims Processed for version D.0.							X		CROWD
8998.20	Contractor shall renumber the CROWD Form 5 lines to be the following: 1. Accepted Claim Status Requests									CROWD

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	2. Responses to Claim Status Inquiries 3. Remittance Advices – Number Sent 4. Number of Payments to Providers or Suppliers 5. Dollar Amounts Associated W/Payments 6. Electronic Claims Processed 7. DDE Claim Adjustments Rec'd 8. DDE Claim Status Responses 9. Paper Claims Processed 10. NCPDP Retail Pharmacy Drug Claims Processed									
8998.21	The contractors shall update the CROWD Form 5 reports (FISS Report 352) and report manuals to confirm with the updates identified in Pub. 100-06, Chapter 6 as well as renumber the CROWD Form 5 lines to comply with the requirement of this CR.					X				
8998.22	The contractors shall update the CROWD Form 5 reports (MCS H99RDMCT) and report manuals to confirm with the updates identified in Pub. 100-06, Chapter 6 as well as renumber the CROWD Form 5 lines to comply with the requirement of this CR.						X			
8998.23	The contractors shall update the CROWD Form 5 reports (GDIT - EFCWD1) and report manuals to confirm with the updates identified in Pub. 100-06, Chapter 6 as well as renumber the CROWD Form 5 lines to comply with the requirement of this CR.							X		

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	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): Anna Meisheid, 410-786-0588 or anna.meisheid@cms.hhs.gov, Matthew Klischer, 410-786-7488 or Matthew.Klischer@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 -
Part A and Part B Medicare Administrative Contractor*s* (*A/B* MAC*s*) Reports

Table of Contents
(Rev 265, 03-16-16)

Transmittals for Chapter 6

450 – Medicare Contractor Transaction Report (*CROWD* Form 5)

450 – Medicare Contractor Transaction Report (*CROWD* Form 5)

(Rev.265, Issued: 03-16-16, Effective: 07-01-16, Implementation: 07-05-16)

A/B and DME MACs must prepare and submit to CMS each month the Medicare Contractor Transaction Report (*CROWD* Form 5) showing their Electronic Data Interchange (EDI) and manual transactions workload under the health insurance program. A separate report is required for each office assigned a separate *workload* number.

450.2 - Heading

(Rev.265, Issued: 03-16-16, Effective: 07-01-16, Implementation: 07-05-16)

The report is referenced as Form 5 in the CROWD system. The *A/B and DME MAC* completes the ADD/*UPDATE*/DELETE criteria screen with the appropriate information to bring the reporting format to its screen.

450.3 – Body of Report

(Rev.265, Issued: 03-16-16, Effective: 07-01-16, Implementation: 07-05-16)

A. General Report Content Requirements

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

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

All of the data to be reported on *CROWD* Form 5 is for the prior calendar month. *CROWD* Form 5 data must be entered by *the A/B and DME MACs* by the 15th of each month. Data due from a shared system must be available for *the A/B and DME MACs* use by the 5th of the month following the month during which the data were collected. Certain types of data must be collected by individual *A/B and DME MACs*. When applicable, that data must also be tracked for each calendar month.

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

B. Line and Column CROWD Form 5 Completion Requirements

CROWD reports must be submitted by *A/B and DME MACs*. They cannot currently be filed by shared system or CWF maintainers. Appropriate rows have been identified for the reporting of 4010A1 data. Appropriate additional rows have also been added to allow for the reporting of version 5010 data. Where no version is appropriate for a row there is no version listed.

Line 1 – Line 1 –Shared systems shall track and report the number of claim status flat file requests sent from each of their A/B and DME MAC. Each A/B and DME MAC is to report that total in column 1. Shared systems are to count each occurrence of the unique trace or claim transaction number

(ICN/DCN/CCN) as assigned by the provider (e.g., in the ASC X12 276, use TRN02 or REF02 of the 2200D loop) as a separate claim status request

Line *2* – Responses to Claim Status Inquiries – Shared systems must track the number of claim status flat file responses sent to each of their *A/B and DME MAC* for translation into *ASC* X12 277 transactions. Each *A/B and DME MAC* is to report that total in column 1. Shared systems are to count each occurrence of the unique trace or claim transaction number (ICN/DCN/CCN) as assigned by the provider (e.g., in the *ASC X12* 277, use TRN02 or REF02 of the 2200E loop) as a separate claim status response. Include both positive (able to furnish requested status) as well as negative (unable to furnish requested status for some reason, such as unable to locate a claim for that HIC on that day) responses in the count, but do not include queries that were rejected as incomplete or incorrect.

Line *3* – Remittance Advices-Number Sent – Shared systems are to track the number of *ASC X12* 835 flat files sent *to* their *A/B and DME MAC*. They must report each occurrence of an *ASC X12* 835 ST to SE segment *sent* as a separate electronic remittance advice (ERA) transaction for counting purposes. If a provider is sent both an electronic and a paper remittance advice for the same group of claims, they are to count them separately as one electronic and one non-electronic remittance advice. The *A/B and DME MACs* must report the total number of ERAs in column 1.

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

The A/B and DME MACs must track and report the number of remittance advices posted to the Internet/Portal. This count shall include the number of Internet Remittance Advices posted no matter if the provider is receiving a remittance advice in another format. A/B and DME MACs must report this total in column 3 (INTERNET/PORTAL).

Line *4* – Number of Payments to Providers or Suppliers– Shared systems are to track the number of electronic fund transfers (EFTs) and paper checks for provider claim payments that the *A/B and DME MACs* were to issue. The EFT total must represent the total of all provider claim payments issued via EFTs, regardless if issued in conjunction with an *ASC X12* 835 ERA or an SPR. The paper check total must be the total of paper checks sent in conjunction with an SPR or an *ASC X12* 835. In some cases, a remittance advice might not have any payment because all the claims were denied, entire payment due a provider is being withheld to recoup an overpayment, or payments to a provider are being held in an escrow account pending completion of an investigation. As result, the number of payments does not always equal the number of SPRs and ERAs issued. *A/B and DME MACs* must report the EFT total in column 1 and the paper check total in column 2.

Line *5* – Dollar Amounts Associated w/Payments – Shared systems must track the dollar value of the EFTs and checks issued by their *A/B and DME MACs* for provider claim payments each month. The *A/B and DME MAC* must report the dollar value of the EFTs in column 1 and of the paper checks in column 2.

Line *6* – Electronic Claims Processed—Shared systems must track the following information which each *A/B and DME MAC and* must enter as indicated in *CROWD F*orm 5:

- In the column *1*, the total of processed electronic *ASC* X12 837 claims *(exclude Direct Data Entry (DDE)* claims sent to *A/B MACs (A)*) *for version 4010 and 5010*.

- In the column *2*, all electronic claims processed that were submitted via DDE screens. (DDE claims are considered HIPAA-compliant, but are to be reported separately here from the number of received *ASC X12* 837 claims.) Non- *A/B MACs (A)*, who do not accept claims via DDE, must enter zero.

Line *7* —DDE Claim Adjustments Received—FISS must track the number of adjustments submitted via DDE for claims (it does not matter for reporting in this line whether the claims themselves were submitted via DDE). If multiple adjustments are made during the same connection session to the same claim, they must be reported as one adjustment. If multiple claims are adjusted during the same session by a provider or clearinghouse, FISS must count each claim separately regardless of the number of fields modified in each of those claims. The A/B MACs *(A)* must report the total number of adjustments in column 2.

Line *8* —DDE Claim Status Responses—Shared systems must track the number of claim status responses issued via a DDE screen. *A/B and DME MAC* must report that number in column *2*. If a provider can use a single claim status DDE screen to obtain status information for multiple claims during the same session, the shared systems must count each claim for which status information is supplied as a separate query response. The *A/B and DME MAC* must report that number in column *2*. *The A/B and DME MAC shall report the number of remittance advices posted to the Internet/Portal in Column 3.*

Line *9* —Paper Claims Processed—Shared systems shall track the total number of paper claims processed per contractor and each *A/B and DME MAC* shall report their *UB-04* or CMS-1500 total in column 2.

Line 10 – National Council of Prescription Drug Plans (NCPDP) Retail Pharmacy Drug Claims processed. VMS shall track the number of NCPDP claims processed. VMS is to count each unique occurrence of a claims control number as a separate claim. The DME MACs are to report this number is column 1.

450.4 – Exhibit 1

(Rev.265, Issued: 03-16-16, Effective: 07-01-16, Implementation: 07-05-16)

TYPE OF TRANSACTION	**ELECTRONIC**	**NON-ELECTRONIC** (MANUAL PROCESSES)	***INTERNET/ PORTAL***
ALL CONTRACTORS			
1. ACCEPTED CLAIM STATUS REQUESTS	***276***		
2. RESPONSES TO CLAIM STATUS INQUIRIES *(5010)*	***277***		
3. REMITTANCE ADVICES—NUMBER SENT *(5010)*	***835***	***SPR***	***Posted***
4. NUMBER OF PAYMENTS TO PROVIDERS OR SUPPLIERS	***EFT***	***Paper Checks***	
5. DOLLAR AMOUNTS ASSOCIATED W/ PAYMENTS *(5010)*	***EFT***	***Paper Checks***	
PROCESSED CLAIM ACTIONS and DDE RESPONSES DATA	***HIPAA***	***DDE***	
6. ELECTRONIC CLAIMS PROCESSED *(4010A1)*			
(5010)			
7. DDE CLAIM ADJUSTMENTS REC'D			
8. DDE CLAIM STATUS RESPONSES			
9. PAPER CLAIMS PROCESSED			
DME MACs ONLY			
10. NCPDP RETAIL PHARMACY DRUG CLAIMS PROCESSED (D.0)			