| CMS Manual System | **Department of Health & Human Services (DHHS)** |
|---|---|
| Pub 100-06 Medicare Financial Management | **Centers for Medicare & Medicaid Services (CMS)** |
| **Transmittal 98** | **Date: JUNE 16, 2006** |
| | **Change Request 5120** |

**SUBJECT: Correction of CROWD Form 5 Reporting for Internet Pilot Carriers**

**I. SUMMARY OF CHANGES:** CR 3864 directed Internet pilot carriers to report the number of claim status responses issued via the Internet based on the number of Claim Control Numbers (CCNs) involved. Those carriers reported after CR 3864 was issued that it is not possible to use the CCN to report that total when issued via the Internet, but that they could calculate the total using their existing software based on the number of Health Insurance Claim (HIC) numbers for which they issued claim status information during the month. They were told this is an acceptable alternative. The manual is being corrected to correlate with the actual method that will be used by them April 1, 2006 and later.

**NEW / REVISED MATERIAL**
**EFFECTIVE DATE**: April 1, 2006
**IMPLEMENTATION DATE**: July 17, 2006

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

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

| R/N/D | Chapter / Section / Subsection / Title |
|---|---|
| **R** | 6/450.3/Body of Report |
| | |

**III. FUNDING:**
No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.

**IV. ATTACHMENTS:**

Business Requirements
Manual Instruction

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

# Attachment - Business Requirements

| Pub. 100-06 | Transmittal: 98 | Date: June 16, 2006 | Change Request 5120 |
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**SUBJECT: Correction of CROWD Form 5 Reporting for Internet Pilot Carriers**

## I. GENERAL INFORMATION

### A. Background:

CR 3864 effective April 01, 2006, expanded CROWD Form 5 and contained a manual transmittal with completion instructions for the fields on the form. Subsequent to release, CMS was notified by two carriers currently piloting use of the Internet for release of claim status and beneficiary eligibility information that the Internet software does not permit claim status responses to be reported based upon the number of claim control numbers for which claims status information is furnished. The responses are instead tracked according to the number of beneficiary Health Insurance Claim (HIC) numbers for which claim status is reported. The Internet pilot carriers were given permission to use HIC to count the number of the claim status responses issued during the month for which data is reported, and were told that the manual would be modified to correspond to their current reporting capability.

The Internet pilot carriers are able to report the total of beneficiary eligibility responses by HIC, as required in CR 3864, but there was other wording in the manual instruction for reporting of this total by Internet pilot carriers that does not correlate with actual practices so this is also being corrected in this CR. As result of these changes, the Internet pilot carriers will not be required to make expensive changes to enable reporting of claim status information by claim control number and the manual will reflect actual practices. No shared system changes are required by this CR.

**B. Policy:** The Government Performance Reporting Act (GPRA) mandates that federal agencies track certain activities performed on behalf of the government, including the number by types of electronic data interchange (EDI) transactions processed, and the impact of EDI processing on costs to conduct the functions covered by EDI transactions. As result, CMS not only needs to collect data on the number of different types of EDI transactions, but also of the same types of activities when conducted via Interactive Voice Response (IVR), direct data entry, and the Internet. This correction to the completion instructions for Internet query response reporting is being made for GPRA tracking.

## II. BUSINESS REQUIREMENTS

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

| Requirement Number | Requirements | Responsibility (“X” indicates the columns that apply) | | | | | |
|---|---|---|---|---|---|---|---|
| | | FI | RHH | Car | DME | Shared System Maintainers | Other |

| | | | | | | FISS | MCS | VMS | CWF | |
|---|---|---|---|---|---|---|---|---|---|---|
| 5120.1 | Carriers approved to participate in an Internet pilot for reporting of claim status information shall use the number of HICs for which claim status responses are issued to calculate the number of these responses issued each month. | | | X | | | | | | Applies to Internet pilot carriers only. |
| 5120.2 | Carriers approved to participate in an Internet pilot for reporting of claim status information shall report the total calculated in business requirement 1 on line 1, column 3 of CROWD Form 5. | | | X | | | | | | Applies to Internet pilot carriers only. |

## III. PROVIDER EDUCATION

| Requirement Number | Requirements | Responsibility ("X" indicates the columns that apply) | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | FI | RHHI | Carrier | DMERC | Shared System Maintainers | | | | Other |
| | | | | | | FISS | MCS | VMS | CWF | |
| | None. | | | | | | | | | |

## IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

### A. Other Instructions: CR 3864

| X-Ref Requirement # | Instructions |
|---|---|
| 3864.30 | CR 3864 |

### B. Design Considerations: N/A

| X-Ref Requirement # | Recommendation for Medicare System Requirements |
|---|---|
| | |

### C. Interfaces: N/A

### D. Contractor Financial Reporting /Workload Impact: N/A

**E. Dependencies: N/A**

**F. Testing Considerations: N/A**

## V. SCHEDULE, CONTACTS, AND FUNDING

| | |
|---|---|
| **Effective Date***: April 01, 2006<br><br>**Implementation Date:** July 17, 2006<br><br>**Pre-Implementation Contact(s):** Kathleen Simmons@cms.hhs.gov, 410-786-6157<br><br>**Post-Implementation Contact(s):** Kathleen Simmons@cms.hhs.gov, 410-786-6157 | **No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 budgets.** |

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

## 450.3 – Body of Report

***(Rev. 98, Issued: 06-16-06; Effective: 04-01-06; Implementation: 07-17-06)***

### 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 an EFT authorization is issued), or the date the remittance advice is issued in the event no check/EFT was due. An NCPDP claim is considered "processed" on the date when it has passed all front end edits and is passed to the Core System for processing.

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

All of the data to be reported on form 5 is for the prior calendar month. Form 5 data must be entered by carriers and FIs by the 15th of each month. Data due from a shared system or from CWF must be available for carrier or FI use by the 5th of the month following the month during which the data were collected. Certain types of data must be collected by individual carriers or FIs. When applicable, that data must also be tracked for each calendar month.

### B. Line and Column CROWD Form 5 Completion Requirements

CROWD reports must be submitted by carriers and FIs. They cannot be filed by shared system or CWF maintainers.

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

*Carriers participating in an Internet pilot that involves claim status data do not obtain their information from a shared system and do not record responses by transaction number (DCN or CCN). They are to track responses by HIC instead. Pilot contractors must report on line 1, column 3, the total of HICs for which they issued claim status responses during the prior month. They are also to 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 record under that HIC) responses in the count, but are to exclude any claim status responses that may have*

*been issued via DDE or an IVR, or that were rejected as incomplete or incorrect in the total reported in column 3. Internet pilot carriers may report their claim status data by primary contractor number rather than by State, e.g., Wisconsin Physician Services serves Michigan as well as Wisconsin but may report their Internet data under the contract number that applies to Wisconsin.*

Line 2 – Responses to Eligibility Inquiries – Shared systems are to track the number of flat file eligibility responses they send to their carriers and FIs for issuance in electronic legacy formats. Shared systems must exclude from their per carrier and FI totals, the number of these eligibility flat file records produced using CWF HIQA/ELGA/ELGB or HUQA responses. Carriers and FIs are to report the shared system total in column 1. Eligibility responses to be issued via DDE, IVR, or the Internet must also be excluded from these totals. Each unique occurrence of an individual beneficiary HIC number must be counted as a separate eligibility response. A response indicating that no record could be located for a beneficiary is considered a valid response. Include both positive (able to furnish eligibility information) as well as negative (unable to furnish eligibility information) responses in the count.

In the event a carrier or FI uses a source of data other than the shared system or HIQA/ELGA/ELGB, HUQA or other CWF responses to issue any legacy format electronic eligibility responses, that carrier or FI must track the number of those responses issued. If eligibility data is received both from the shared system, CWF responses, and an alternate source, the carrier and FI must total the numbers from the shared system, CWF, and the alternate source and report that total in column 1.

*Carriers that operate a pilot to allow providers to obtain beneficiary eligibility data via the Internet* must track the number of individual eligibility responses they issue. These carriers must report the number of electronic eligibility responses issued in any format via an Internet pilot. Each unique occurrence of an individual beneficiary HIC number must be counted as a separate eligibility response. Eligibility responses issued via non-Internet DDE/PPTN or an IVR must be excluded from the monthly total reported in column 3. *Internet pilot carriers may report their eligibility data by primary contractor number rather than by State, e.g., Wisconsin Physician Services serves Michigan as well as Wisconsin but may report their Internet data under the contract number that applies to Wisconsin.*

Line 3 – HUQA Eligibility Responses--In lieu of use of DDE, a number of clearinghouses and large providers have been permitted to submit eligibility queries directly to data centers to obtain beneficiary eligibility data from CWF. The incoming query identifies the c*ontractor* responsible for processing of claims for the provider requesting the eligibility data, enabling the CWF maintainer to track and notify each c*ontractor* of the total number of clearinghouse and provider HUQA eligibility responses processed through CWF.

C*ontractors* are to report the number of HUQA eligibility responses issued by CWF for beneficiaries in their service area on line 3. This CWF number must include HUQAs sent to clearinghouses or large providers through the data centers, as well as HUQAs that the contractors might have requested to obtain beneficiary eligibility data for IVR responses or other purposes. The CWF maintainer must report the number of HUQA responses issued in the CWF operating report (ORPT) file.

> NOTE: RACF clearance is needed for access to the ORPT file. CWF staff within a c*ontractor's* operation should have access to this file. Staff members in a contractor's EDI department that do not have access to this file should be able to obtain this CWF data through their CWF colleagues or by obtaining RACF clearance through their security office to access this file.

Line 4--Coordination of Benefit (COB) Claims Issued to Trading Partners (includes Medigap, but does not include NCPDP) – Shared systems must track the number of 837 COB flat file transactions they send to their users for translation into a COB transaction. Each different CLM01 entry in an 837, or alternately, each unique occurrence of the patient's HIC number must be counted as a separate COB transaction. The carriers and FIs must enter this total in column 1.

NOTE: Lines 5, 6 and 7 are to be completed by DMERCs/DMACs only (*A new change request will be issued when reporting changes contained in CR 3864 are to be implemented by the DMERCs/DMACs.)*

Line 5 – Prior Authorization or Advance Determination of Medicare Coverage Requests – DMERCs*/DMACs* are to track and report the number of these decisions issued. (This count should not include telephone discussions about Medicare coverage, but only those cases which result in issuance of specific prior authorization or advance determination decisions.)

Line 6 – National Council of Prescription Drug Plans (NCPDP) Retail Pharmacy Drug Claims Processed – VMS must track the number of NCPDP claims processed. VMS is to count each unique occurrence of a claim control number as a separate claim. The DMERCs*/DMACs* are to report this number in column 1.

Line 7 – Outgoing COB NCPDP Claims for Retail Pharmacy Drugs Processed (including NCPDP Medigap) – VMS must track the number of NCPDP COB transactions sent to DMERCs*/DMACs* for translation and issuance to trading partners or the COBC. VMS is to count each unique occurrence of a claim control number as a separate NCPDP COB claim. DMERCs*/DMACs* are to report this total in column 1.

Line 8 – Remittance Advices-Number Sent – Shared systems are to track the number of 835 version 4010A1 flat files sent their contractors. They must report each occurrence of an 835 ST to SE version 4010A1 segment set as a separate electronic remittance advice (ERA) transaction for counting purposes. If a provider

is sent both an electronic and a paper remittance advice for the same group of claims, they are to count them separately as one electronic and one non-electronic remittance advice. The contractors must report this total in column 1.

The shared system must also track the number of standard paper remittance (SPR) flat files sent their users for printing in each calendar month. Contractors must report this total in column 2.

In column 3, if the Medicare 835 HIPAA contingency plan has not yet been terminated, shared systems must track the number of all non-version 4010A1 electronic remittance advice flat files issued their users for translation. The contractors must enter this number in column 3.

The total number of remittance advice records furnished via the Internet is to be reported in column 4. A separate CR will be issued concerning reporting of remittance advice information on the Internet for access by the provider for which the record is prepared. In anticipation of this requirement, a field has been added for reporting of the total number of Internet remittance advice flat files records that were issued in the prior month. Information concerning responsibility for tracking of this number and the effective date on which reporting of this number will begin will be included in the implementation instruction for use of the Internet for this purpose.

Line 9 – Number of Payments to Providers – Shared systems are to track the number of electronic fund transfers (EFT) and paper checks for provider claim payments that the contractors were to issue. The EFT total must represent the total of all provider claim payments issued via EFTs, regardless if issued in conjunction with an 835 version 4010A1 ERA, an SPR, or a legacy format ERA. The paper check total must be the total of paper checks sent in conjunction with an SPR, an 835 version 4010A1, or a legacy format ERA. In some cases, a remittance advice might not have any payment because all the claims were denied, the 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. Contractors must report the EFT total in column 1 and the paper check total in column 2.

Line 10 – Dollar Amounts Associated with Payments – Shared systems must track the dollar value of the EFTs/checks issued by their contractors for provider claim payments each month. The contractors must report the dollar value of the EFTs in column1 and of the paper checks in column 2.

Line 11 – Electronic Claims Processed Data—Shared systems must track the following information which each contractor must enter as indicated in form 5:

- In the first column, the total of processed electronic X12 837 version 4010.A.1 claims (exclude DDE claims sent to FIs; A requirement for DMERCs*/DMACs* to include the total of NCPDP claims received in this column will be added in a later transmittal.).

- In the second column, all electronic claims processed that were submitted via DDE screens. (DDE claims are considered HIPAA-compliant, but are to be reported separately here from the number of received 837 version 4010.A.1 claims.) Non-FIs who do not accept claims via DDE must enter zero.

- In the third column, electronic claims transactions processed to completion that were received in a non-HIPAA format such as an earlier version of the X12 837, or any version of the NSF or the UB-92 flat file prior to termination of the Medicare HIPAA claim contingency plan. *Leave blank post- October 1, 2005.*

**NOTE:** For lines 12-14, shared systems and contractors must limit reporting to those transactions for which their providers can obtain the type of data noted using DDE (excludes those CWF HUQA eligibility responses reported on line 3) or an IVR. Medicare contractors that do not offer a DDE screen or IVR for the type of information listed on a particular unshaded line must enter zero. CWF uses an HIQA, ELGA or ELGB query screen and response for DDE eligibility requests and must report the monthly total of each of those response types in the ORPT file for contractor access.

Line 12—DDE Claim Adjustments Received—FISS must track the number of adjustments submitted via DDE for claims (it does not matter for reporting in this line whether the claims themselves were submitted via DDE). If multiple adjustments are made during the same connection session to the same claim, they must be reported as one adjustment. If multiple claims are adjusted during the same session by a provider or clearinghouse, FISS must count each claim separately regardless of the number of fields modified in each of those claims. The FIs must report the total number of adjustments in column 2.

Line 13—DDE/IVR Claim Status Inquiries—Shared systems must track the number of claim status responses issued via a DDE screen. Contractors must report that number in the second column. If a provider can use a single claim status DDE screen to obtain status information for multiple claims during the same session, the shared systems must count each claim for which status information is supplied as a separate query response. The contractor must report that number in the second column

If a shared system supplies claim status data for reporting via IVR, the shared system must track those responses and the contractor must report that number in the fourth column. If a contractor or a data center at their direction, “screen scrapes”

shared system data to obtain claim status information used to respond via IVR, a shared system would not be able to record the number of responses issued using that data. In that situation, the contractor or data center must count the number of these responses issued via IVR and report that number in the fourth column. Count each ICN/DCN for which status is reported as a separate claim status response.

Line 14—Eligibility Inquiries—CWF must track the number of DDE (HIQA, ELGA or ELGB) and clearinghouse/provider or other HUQA eligibility responses issued per contractor during the prior month and report those numbers in the CWF ORPT file. Contractors must report the total of those numbers in the second column. If a provider can use a single eligibility DDE screen to obtain information on more than one beneficiary during the same session, each HIC for which eligibility data is furnished must be counted as a separate response.

If a contractor obtains eligibility data from their shared system for preparation of responses to any IVR eligibility inquiries, the number of HICs for which eligibility responses are issued must be tracked by the shared system. If a contractor uses any alternate source of eligibility data for some IVR eligibility responses, that contractor must track the number of eligibility responses they issue using the alternate source, and report the total of the shared system and alternate source eligibility responses in the fourth column. If a provider can request beneficiary eligibility data for multiple beneficiaries during the same IVR session, each HIC for which an eligibility data is issued must be counted as a separate response.

Line 15—Paper Claims Processed—Both the National Uniform Claim Committee (NUCC) and the National Uniform Billing Committee (NUBC) have approved new versions of their paper claim forms to enable reporting of NPIs as well as other provider identifiers. *CMS will issue separate instructions that will indicate when the transition periods will occur for each of the forms.*

In anticipation of these changes, a new line has been added to form 5 to enable CMS to monitor the progress of provider transition from the "old" to the new paper claim forms. *Effective with the beginning of the transition period for each new/revised form,* the shared systems must track the number of paper claims submitted under the "old" and the "new" version of each paper claim form. The contractors will then enter those numbers in the appropriate blocks in form 5. No information is to be reported in the fields on line 15 for the revised 1500 and the UB-04 paper forms prior to the start of the transition period for each of those forms. Reporting of data for these fields will terminate three months after the transition periods end for the "old" claim forms.