CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-06 Medicare Financial Management	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 171	**Date: May 28, 2010**
	Change Request 6969

SUBJECT: Expansion of Form 5 of the Contractor Reporting of Operational and Workload Data (CROWD)

I. SUMMARY OF CHANGES: Chapter 6, subsection 450.3 is being revised to announce the 5010 updates and to remove version 4010A1 language from lines 8, 9, and 11. Chapter 6, subsection 450.4 is being revised to address changes being made to Form 5 of CROWD to reflect version 5010 data. CMS needs this information to measure performance for the annual CMS Government Performance Reporting Act (GPRA) Report.

EFFECTIVE DATE: *January 1, 2011
IMPLEMENTATION DATE: October 4, 2010 Except for VMS, which is analysis and design only January 3, 2011 VMS

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

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	6/450.3/Body of Report
R	6/450.4/Exhibit 1

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
Funding for implementation activities will be provided to contractors through the regular budget process.

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

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

Attachment – Business Requirements

Pub. 100-06	Transmittal: 171	Date: May 28, 2010	Change Request: 6969

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EFFECTIVE DATE: January 1, 2011

IMPLEMENTATION DATE: October 4, 2010 **–** Except for VMS, which is analysis and design only
January 3, 2011 – VMS

I. GENERAL INFORMATION

A. Background: Chapter 6, **s**ubsections 450.3 (Body of Report) and 450.4 (Exhibit 1) are being revised to address changes being made to Form 5 of CROWD to reflect version 5010 data. Shared system maintainers, A/B MACs, carriers, RHHIs, and FIs will need to begin to collect version 5010 data for inclusion into CROWD Form 5. The CMS previously directed CROWD Form 5 changes in CRs 3257, 3864, and 4274. A/B MACs, Carriers, RHHIs, and FIs will now be required to include version 5010 monthly data in the appropriate Form 5 rows in a similar manner as they do today for 4010A1 data. Some data will not be broken down by version. CMS needs this information to measure performance for the annual CMS Government Performance Reporting Act (GPRA) Report.

This change request Change Request (CR) is specific to DME MACs, as well as Part A and Part B (A/B) MACs which are, as of this time, in a position to implement 005010, specifically the following Jurisdictions: J1, J3, J4, J5, J9, J10, J12, J13, and J14. Other MACs, not currently in a position to implement 005010, shall provide level of effort estimates only if they will be in a position to become 5010 operational prior to the effective date of this CR. A/B MACs currently in Corrective Action Plan (CAP) or under a protest condition need not reply to this CR at this time. A future CR will address these MAC jurisdictions.

Estimates for this CR should include a breakdown as part of the Level of Effort (LOE) response, utilizing the following table to be included in the "Estimate-Specific Comments" portion of the LOE template, to follow the Investment Lifecycle Phases.

Investment Lifecycle Phase	Total Hours	Total Cost
Pre-Implementation/CR Review		
Design & Engineering Phase		
Development Phase		
Testing Phase		
Implementation Phase		

Note that the Pre-Implementation/CR Review costs will not be funded under the unique funding situation for the 5010/D.0 project, but instead out of the MAC's pot of hours for Pre-Implementation/CR Review.

B. Policy: The GPRA requires that the CMS monitor the rate of usage of individual types of electronic data interchange (EDI) transactions to determine the full benefits attributable to use of EDI. EDI is not the only means of conducting certain types of business. The same types of business may be performed using direct data entry (DDE) screens, interactive voice response (IVR) technology, on paper, or in the case of certain pilots, via the Internet.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6969.1	The CMS CROWD contractor shall make changes to the CROWD system to allow for submission of version 4010A1 data as well as version 5010 data as shown in chapter 6, subsection 450.4 (Exhibit 1) beginning with January 1, 2011 data (reported in February 2011).										CMS's CROWD contractor
6969.2	FISS shall make the appropriate changes to the 352 report which is used to update the CROWD Form 5 report.						X				
6969.3	Shared system maintainers shall report additional version 5010 data for the prior month by each of their A/B MACs, DME MACs, carriers, FIs, or RHHIs as they currently report CROWD Form 5 for version 4010A1 data per CR 3257, CR 3864, and CR 4274.						X	X	X		
6969.4	Contractors shall begin reporting CROWD Form 5 the additional version 5010 data starting February 15, 2011 (for January 2011 data) as they currently report today for version 4010A1 per CR 3257, CR 3864, and CR 4274.	X	X	X	X	X					
6969.5	Contractors and shared system maintainers shall develop appropriate test data as needed.	X	X	X	X	X	X	X	X		

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	None.										

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:

X-Ref Requirement Number	Recommendations or other supporting information:
	None.

Section B: For all other recommendations and supporting information, use this space: CR 3257, CR 3864, and CR 4274.

V. CONTACTS

Pre-Implementation Contact(s): Matt Klischer, matthew.klischer@cms.hhs.gov.

Post-Implementation Contact(s): Matt Klischer, matthew.klischer@cms.hhs.gov.

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers,* use only one of the following statements:

Funding for implementation activities will be provided to contractors through the regular budget process.

Section B: *For Medicare Administrative Contractors (MACs),* include the following statement:

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.

450.3 – Body of Report

(Rev.171, Issued 05-28-10, Effective: 01-01-11, Implementation: 10-04-10 /01-03-11 VMS-analysis and design)

A. General Report Content Requirements

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

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

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

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

B. Line and Column CROWD Form 5 Completion Requirements

CROWD reports must be submitted by carriers, DME MACs, A/B MACs and FIs. They cannot currently be filed by shared system or CWF maintainers. *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 (i.e. IVR), there is no version listed.*

Line 1 – Responses to Claim Status Inquiries – Shared systems must track the number of claim status flat file responses sent to each of their carriers, DME MACs, A/B MACs and FIs for translation into X12 277 transactions. Each carrier, DME contractor, A/B MAC and FI is to report that total in column 1. Shared systems are to count each occurrence of the unique trace or claim transaction number (ICN/DCN/CCN) as assigned by the provider (e.g., in the 277, use TRN02 or REF02 of the 2200E loop) as a separate claim status response. Include

both positive (able to furnish requested status) as well as negative (unable to furnish requested status for some reason, such as unable to locate a claim for that HIC on that day) responses in the count, but do not include queries that were rejected as incomplete or incorrect.

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

Line 2 – Responses to Eligibility Inquiries – Shared systems are to track the number of eligibility responses they may send in a flat file to each of their carriers, DME MACs, A/B MACs and FIs for issuance electronically in legacy formats. Shared systems must exclude from their carrier, DME contractor, A/B MAC and FI totals, the number of these eligibility flat file records produced using CWF HUQA responses. Carriers, DME MACs, A/B MACs and FIs are to report the shared system total in column 1. Eligibility responses to be issued via DDE, IVR, or the Internet must also be excluded from the line 2, column 1 total. DDE and IVR totals are to be entered on line 14. Each unique occurrence of an individual beneficiary HIC number must be counted as a separate eligibility response. A response indicating that no record could be located for a beneficiary is considered a valid response. Include both positive (able to furnish eligibility information) as well as negative (unable to furnish eligibility information) responses in the count.

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

Line 3 – HUQA Eligibility Responses--In lieu of use of DDE or the 270/271, a number of clearinghouses and large providers have been permitted to submit eligibility queries directly to data centers to obtain beneficiary eligibility data from CWF. The incoming query identifies the contractor responsible for processing of claims for the provider requesting the

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

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

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

Line 4—Reserved for future reporting needs.

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

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

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

Line 7 –Reserved for future reporting needs.

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

Line 8 – Remittance Advices--Number Sent – Shared systems are to track the number of 835 flat files sent their carriers, DME MACs, A/B MACs or FIs. They must report each occurrence of an 835 ST to SE segment set as a separate electronic remittance advice (ERA) transaction for counting purposes. If a provider is sent both an electronic and a paper remittance advice for the same group of claims, they are to count them separately as one electronic and one non-electronic remittance advice. The carriers, DME MACs, A/B MACs and FIs must report the total number of ERAs in column 1.

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

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

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

Line 9 – Number of Payments to Providers or Suppliers– Shared systems are to track the number of electronic fund transfers (EFTs) and paper checks for provider claim payments that the carriers, DME MACs, A/B MACs and FIs were to issue. The EFT total must represent the total of all provider claim payments issued via EFTs, regardless if issued in conjunction with an 835 ERA or an SPR. The paper check total must be the total of paper checks sent in conjunction with an SPR or an 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. Carriers, DME MACs, A/B MACs and FIs must report the EFT total in column 1 and the paper check total in column 2.

Line 10 – Dollar Amounts Associated w/Payments – Shared systems must track the dollar value of the EFTs and checks issued by their carriers, DME MACs, A/B MACs and FIs for provider claim payments each month. The carriers, DME MACs, A/B MACs and FIs must report the dollar value of the EFTs in column1 and of the paper checks in column 2.

Line 11 – Electronic Claims Processed—Shared systems must track the following information which each carrier, DME contractor, A/B MAC and FI must enter as indicated in form 5:

- In the first column, the total of processed electronic X12 837 claims (exclude DDE claims sent to FIs).

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

NOTE: For lines 12-14, shared systems, carriers, DME MACs, A/B MACs and FIs must limit reporting to those transactions for which their providers can obtain the type of data noted using DDE (exclude those CWF HUQA eligibility responses reported on line 3) or an IVR. Medicare contractors that do not offer a DDE screen or IVR for the type of information listed on a particular unshaded line must enter zero. CWF uses HIQA, ELGA, ELGB and ELGH queries to respond to DDE eligibility requests. The CWF maintainer must report the monthly total of each of those response types in the ORPT file for carrier, FI, DME MAC or A/BMAC access.

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

Line 13—DDE/IVR Claim Status Responses—Shared systems must track the number of claim status responses issued via a DDE screen. Carriers, DME MACs, A/B MACs and FIs must report that number in the second column. If a provider can use a single claim status DDE screen to obtain status information for multiple claims during the same session, the shared systems must count each claim for which status information is supplied as a separate query response. The carrier, DME contractor, A/B MAC or FI must report that number in the second column.

If a shared system supplies claim status data for reporting via IVR, the shared system must track those responses and the carrier, DME contractor, A/B MAC or FI must report that number in the third column. If a carrier, DME contractor, A/B MAC, FI, or a data center, "screen scrapes" shared system data to obtain claim status information used to respond via IVR, a shared system would not be able to record the number of responses issued using that data. In that situation, the carrier, DME contractor, A/B MAC or FI must count the number of these responses issued via IVR and report that number in the third column. Count each HIC/date of service for which status is reported as a separate claim status response.

Line 14—CWF or IVR Eligibility Responses—CWF must track the number of DDE (HIQA, ELGA, ELGB or ELGH) responses issued per carrier, DME contractor, A/B MAC and FI during the prior month as applicable and report the numbers in the CWF ORPT file. Carriers, DME MACs, A/B MACs and FIs must report the CWF total in the second column. If a provider can use a single eligibility DDE screen to obtain information on more than one beneficiary during the same session, each HIC for which eligibility data is furnished must be counted as a separate response by CWF.

If a carrier, DME MAC, A/B MAC or FI obtains eligibility data from their shared system or an alternate source for IVR eligibility responses, that carrier, DME MAC, A/B MAC or FI must track the number of eligibility responses they issue using the shared system and alternate source eligibility data and report that total in the third column of line 14. Alternate

sources would include CWF, the CMS central office eligibility database under a pilot and any other eligibility data repository not separately listed here that may be available for the contractor's use. If a provider can request beneficiary eligibility data for multiple beneficiaries during the same IVR session, each HIC for which an eligibility data is issued must be counted as a separate response.

Line 15—Paper Claims Processed—Shared systems shall track the total number of paper claims processed per contractor and each carrier, A/B MAC, DME MAC and FI shall report their UB-04 or CMS-1500 (08/05) total in column 2.

450.4 – Exhibit 1

(Rev.171, Issued 05-28-10, Effective: 01-01-11, Implementation: 10-04-10 /01-03-11 VMS-analysis and design)

TYPE OF TRANSACTION			ELECTRONIC	NON-ELECTRONIC (MANUAL PROCESSES)	INTERNET
ALL CONTRACTORS					
1. RESPONSES TO CLAIMS STATUS INQUIRIES		***4010A1***			
		5010			
2. RESPONSES TO ELIGIBILITY INQUIRIES (Exclude HUQA)					
3. HUQA ELIGIBILITY RESPONSES					
4. Reserved for Future Use					
DME MACs ONLY					
5. PRIOR AUTHORIZATIONS OR ADVANCED DETERMINATIONS OF MEDICARE COVERAGE ISSUED		***4010A1***			
		5010			
6. NCPDP RETAIL PHARMACY DRUG CLAIMS PROCESSED		***5.1***			
		D.0			
7. Reserved for Future Use					
ALL CONTRACTORS					
8. REMITTANCE ADVICES—NUMBER SENT	***4010A1***	**835**	**SPR**		**Internet RA**
	5010	**835**	**SPR**		**Internet RA**
9. # OF PAYMENTS TO PROVIDERS OR SUPPLIERS		**# EFT**	**# Paper Checks**		
10. DOLLAR AMOUNTS ASSOCIATED W/ PAYMENTS		**EFT $**	**Paper Checks $**		
PROCESSED CLAIMS ACTIONS and DDE/IVR RESPONSES DATA		**HIPAA**	**DDE, HIQA/ ELGA/ELGB/**	**IVR**	

			ELGH, CWF		
11. ELECTRONIC CLAIMS PROCESSED	***4010A1***				
	5010				
12. DDE CLAIM ADJUSTMENTS REC'D					
13. DDE/IVR CLAIM STATUS RESPONSES					
14. CWF or IVR ELIGIBILITY RESPONSES					
15. PAPER CLAIMS PROCESSED					