| CMS Manual System | Department of Health & Human Services (DHHS) |
| --- | --- |
| Pub 100-06 Medicare Financial Management | Centers for Medicare & Medicaid Services (CMS) |
| **Transmittal:12894** | **Date: October 17, 2024** |
| | **Change Request 12743** |

**SUBJECT: Migration of the Contractor Reporting of Operational and Workload Data (CROWD) to the Centers for Medicare & Medicaid Services (CMS) Enterprise Portal – Internet-Only Manual (IOM) Updates**

**I. SUMMARY OF CHANGES:** The purpose of this Change Request (CR) is to update the IOMs to reflect the changes being implemented via the One-Time Notification (OTN) CMS CR 12742 that requires the contractors to utilize the CMS Enterprise Portal for CROWD and discontinue use of the legacy system.

Chapters 5 and 6 of the IOM Publication (Pub.) 100-05 and Chapter 6 of the IOM Pub. 100-06 have been updated to reflect this change.

**EFFECTIVE DATE: November 1, 2024**
**Unless otherwise specified, the effective date is the date of service.*
**IMPLEMENTATION DATE: November 1, 2024**

***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 | 6/10/Monthly Intermediary and Carrier Workload Report (Form CMS-1566 and CMS-1565) - General |
| R | 6/10/10.2/Due Date |
| R | 6/20/20.1/Heading |
| R | 6/20/20.4/Body of Report |
| R | 6/30/30.1/Heading |
| R | 6/30/30.5/Heading |
| R | 6/50/50.2/Due Date |
| R | 6/60/60.1/Heading |
| R | 6/60/60.4/Body of Report |
| R | 6/70/70.1/Heading |
| R | 6/70/70.5/Completing Medicare Fraud Unit Quarterly Workload Status Report, CMS-1566B – General (Inactive) |
| R | 6/70/70.6/Heading (Inactive) |
| R | 6/70/70.7/Checking Reports (Inactive) |
| R | 6/70/70.8/Type of Fraud Workload Item (Inactive) |
| R | 6/70/70.9/Body of Report (Inactive) |
| R | 6/70/70.10/Completing Quarterly Periodic Interim Payment (PIP) Report, CMS-1566C - General |
| R | 6/70/70.11/Heading |
| R | 6/70/70.14/Quarterly Supplement to the Intermediary Workload Report - CMS-1566A, Pages 1,2,3 |
| R | 6/70/70.15/Medicare Fraud Unit Quarterly Workload Status Report - CMS-1566B |
| R | 6/70/70.18/Heading (Inactive) |
| R | 6/70/70.19/Checking Reports (Inactive) |
| R | 6/70/70.20/Type of Provider (Inactive) |

| R/N/D | CHAPTER / SECTION / SUBSECTION / TITLE |
|---|---|
| R | 6/70/70.21/Completing Lines One through Eleven - Workload Operations (Inactive) |
| R | 6/70/70.22/Completing Lines Twelve through Seventeen - Reason for Denial Recommendation (Inactive) |
| R | 6/70/70.23/Completing Lines Eighteen through Twenty-Two - Reason for Return (Inactive) |
| R | 6/70/70.24/Completing Lines Twenty-Three through Twenty-Six - Application Processing Times (Inactive) |
| R | 6/70/70.25/Completing Lines Twenty-Seven through Thirty-One - Age of Applications Pending (Inactive) |
| R | 6/70/70.26/Completing Lines Thirty-Two through Thirty-Seven - CHOW Workloads (Inactive) |
| R | 6/90/Monthly Intermediary Part A and Part B Appeals Report (Form CMS-2591) |
| R | 6/90/90.2/Due Date |
| R | 6/100/100.1/Heading |
| R | 6/130/130.1/Heading |
| R | 6/130/130.2/Part A - Monthly Workload Operations |
| R | 6/130/130.4/Part C - Miscellaneous Claims Data |
| R | 6/140/140.1/Heading |
| R | 6/170/170.2/Heading |
| R | 6/190/Checking Reports Prior to Submittal to CMS |
| R | 6/220/220.2/Due Date |
| R | 6/240/240.1/Heading |
| R | 6/250/Completing Medicare Fraud Unit Quarterly Workload Status Report, CMS-1565B – General (Inactive) |
| R | 6/270/270.1/Heading |
| R | 6/270/270.2/Part D - Selected Claim Data by Participation Status |
| R | 6/280/280.1/Heading |

| R/N/D | CHAPTER / SECTION / SUBSECTION / TITLE |
|---|---|
| R | 6/290/Completing Health Professional Shortage Area (HPSA) Quarterly Report, Form CMS-1565E - General |
| R | 6/290/290.1/Heading |
| R | 6/290/300/Exhibits |
| R | 6/310/Carrier Beneficiary Overpayment Activity Report (Form CMS-2174) - General (Inactive) |
| R | 6/320/Completing Carrier Beneficiary Overpayment Activity Report (Inactive) |
| R | 6/330/Completion of Items on Form CMS-2174 (Inactive) |
| R | 6/330/330.1/Heading |
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| R | 6/360/360.1/Heading |
| R | 6/360/360.2/Section A - Carrier Appeal Requests |
| R | 6/360/360.3/Section B - ALJ Hearings |
| R | 6/360/360.5/Section D - Limitation of Liability (Claim Counts) |
| R | 6/390/390.2/Due Date |
| R | 6/400/400.1/Heading |
| R | 6/400/400.4/Physician/Limited License Physician Specialty Codes |
| R | 6/400/400.5/Non-Physician Practitioner/Supplier Specialty Codes |
| R | 6/420/Exhibit |
| R | 6/460/460.1/General |
| R | 6/460/460.2/Section I – Redeterminations |
| R | 6/480/480.1/Heading |

**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: 12894 | October 17, 2024 | Change Request: 12743 |
|---|---|---|---|

**SUBJECT: Migration of the Contractor Reporting of Operational and Workload Data (CROWD) to the Centers for Medicare & Medicaid Services (CMS) Enterprise Portal – Internet-Only Manual (IOM) Updates**

**EFFECTIVE DATE: November 1, 2024**
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**I. SUMMARY OF CHANGES:** The purpose of this Change Request (CR) is to update the IOMs to reflect the changes being implemented via the One-Time Notification (OTN) CMS CR 12742 that requires the contractors to utilize the CMS Enterprise Portal for CROWD and discontinue use of the legacy system.

Chapters 5 and 6 of the IOM Publication (Pub.) 100-05 and Chapter 6 of the IOM Pub. 100-06 have been updated to reflect this change.

## II. GENERAL INFORMATION

**A. Background:** CMS is migrating CROWD to the CMS Enterprise Portal and decommissioning the legacy system.

**B. Policy:** Contractors shall utilize the CMS Enterprise Portal for CROWD, effective November 1, 2024, and discontinue use of the legacy system, effective October 16, 2024, in accordance with the OTN CMS CR 12742.

Chapter 6 of the IOM Pub. 100-06 has been updated accordingly to reflect this change.

## III. 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 | |
| 12743 - 06.1 | Contractors shall be aware of the updates to Pub. 100-06, Chapter 6. | X | X | X | X | | | | | CROWD, RRB-SMAC |

## IV. PROVIDER EDUCATION

None

**Impacted Contractors:** None

## V. SUPPORTING INFORMATION

**Section A: Recommendations and supporting information associated with listed requirements:**

*"Should" denotes a recommendation.*

| X-Ref Requirement Number | Recommendations or other supporting information: |
|---|---|
| 12743 - 06.1 | Refer to the OTN CMS CR 12742 for more information regarding the migration of CROWD to the CMS Enterprise Portal. |

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

## VI. CONTACTS

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

## VII. 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
## Part A and Part B Medicare Administrative Contractors (A/B MACs) Reports

**Table of Contents**
***(Rev.12894; 10-17-24)***


70.5 - Completing Medicare Fraud Unit Quarterly Workload Status Report, CMS-1566B - General *(Inactive)*

70.6 - Heading *(Inactive)*

70.7 - Checking Reports *(Inactive)*

70.8 - Type of Fraud Workload Item *(Inactive)*

70.9 - Body of Report *(Inactive)*

70.15 - Medicare Fraud Unit Quarterly *W*orkload Status Report - CMS-1566B

70.18 - Heading *(Inactive)*

70.19 - Checking Reports *(Inactive)*

70.20 - Type of Provider *(Inactive)*

70.21 - Completing Lines One through Eleven - Workload Operations *(Inactive)*

70.22 - Completing Lines Twelve through Seventeen - Reason for Denial Recommendation *(Inactive)*

70.23 - Completing Lines Eighteen through Twenty-Two - Reason for Return *(Inactive)*

70.24 - Completing Lines Twenty-Three through Twenty-Six - Application Processing Times *(Inactive)*

70.25 - Completing Lines Twenty-Seven through Thirty-One - Age of Applications Pending *(Inactive)*

70.26 - Completing Lines Thirty-Two through Thirty-Seven - CHOW Workloads *(Inactive)*

90 - Mont*h*ly Intermediary Part A and Part B Appeals Report (Form CMS-2591)

250 - Completing Medicare Fraud Unit Quarterly Workload Status Report, CMS-1565B - General *(Inactive)*

310 - Carrier Beneficiary Overpayment Activity Report (Form CMS-2174) - General *(Inactive)*

320 - Completing Carrier Beneficiary Overpayment Activity Report *(Inactive)*

330 - Completion of Items on Form CMS-2174 *(Inactive)*

## 10 - Monthly Intermediary and Carrier Workload Report (Form CMS-1566 and CMS-1565) - General

***(Rev.12894; 10-17-24; Effective:11-01-24; Implementation:11-01-24)***

**A3-3892 and B3 13300**

Intermediaries and carriers must prepare and submit to CMS each month the appropriate workload report (Form CMS-1566 for intermediaries and Form CMS-1565 for carriers) showing their workloads under the health insurance program. A separate report is required for each office assigned a separate contractor number. A separate report is required for each *Business Segment Identifier (BSI)* assigned to the contractor, even if a separate contractor number is not assigned.

## 10.2 - Due Date

***(Rev.12894; 10-17-24; Effective:11-01-24; Implementation:11-01-24)***

**A3-3892.2**

The report is transmitted to CMS CO via PC or terminal as soon as possible after the end of the month being reported, but no later than the 10th of the following month using instructions in the Contractor Reporting of Operational and Workload Data (CROWD) User Guide *available via the CMS Enterprise Portal*.

## 20.1 - Heading

***(Rev.12894; 10-17-24; Effective:11-01-24; Implementation:11-01-24)***

**A3-3893.1**

This report is referenced as Form D *for* CROWD. The intermediary *submits* the appropriate information *for the reporting period for each office assigned a separate contractor number and BSI*. It *reports* the number of working days scheduled for the reporting period, less any days where no claims were processed as a result of a strike, snowstorm, etc. It does not count Saturdays, Sundays, or holidays.

## 20.4 - Body of Report

***(Rev.12894; 10-17-24; Effective:11-01-24; Implementation:11-01-24)***

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 *reports* 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 *reports* 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 *reports* 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 *reports* 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 *reports* 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 *reports* 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 *reports* 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 *reports* 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 *reports* 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 *reports* 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 counts 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 *reports* 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 *reports* 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 *reports* the number of MSNs mailed to beneficiaries during the reporting month.

## 30.1 - Heading

***(Rev.12894; 10-17-24; Effective:11-01-24; Implementation:11-01-24)***

**A3-3894.1**

These pages are referenced as Form U (pages 2-11) and Form E (pages 12-21) *for* CROWD. The intermediary *submits* the appropriate information *for the reporting period for each office assigned a separate contractor number and BSI*.

## 30.5 - Heading

***(Rev.12894; 10-17-24; Effective:11-01-24; Implementation:11-01-24)***

**A3-3894.5**

This page is referenced as Form W *for* CROWD. The intermediary *submits* the appropriate information *for the reporting period for each office assigned a separate contractor number and BSI*.

## 50.2 - Due Date

***(Rev.12894; 10-17-24; Effective:11-01-24; Implementation:11-01-24)***

**A3-3896.2**

Transmit the Quarterly Supplement to CMS CO via PC or terminal as soon as possible after the reporting quarter but no later than the 15th of the following month. Use instructions in the CROWD User Guide *available via the CMS Enterprise Portal*.

## 60.1 - Heading

***(Rev.12894; 10-17-24; Effective:11-01-24; Implementation:11-01-24)***
**A3-3897.1**

These pages are referenced as Form C *for* CROWD. *It submits* the appropriate information *for the reporting period for each office assigned a separate contractor number and BSI*.

## 60.4 - Body of Report

***(Rev.12894; 10-17-24; Effective:11-01-24; Implementation:11-01-24)***
**A3-3897.4**

**Section A: Bills Processed by State of Provider** - The intermediary reports in this section the claims workload for each State for which you service one or more providers. Break out by State the number of initial bills (including demand and no-pay bills) reported as processed on line 12 of Form D (see §20.4) over the 3 months of the reporting quarter.

**NOTE:** Categorize the information reported by the State of the individual **provider**, not the home office, if it is part of a chain organization.

**Line 1 - All** - For each column 1 through 6, the system will sum the number of claims reported on the individual State lines completed below. The numbers so calculated by the system must equal the sum of the numbers reported on line 12 of Form D for the 3 months of the reporting quarter.

**State Lines** - In the column just left of column (1), the intermediary *reports* the two-digit postal abbreviation of each State (or FO for foreign claims) which includes at least one provider for which you processed claims during the quarter.

It *reports* opposite each listed State the number of initial bills processed during the reporting quarter for providers located in the State. It reports the data in total in column 1, and by type of bill in columns 2 through 6.

## 70.1 - Heading

***(Rev.)***
**A3-3898.1**

This page is referenced as Form I *for* CROWD. *It submits* the appropriate information *for the reporting period for each office assigned a separate contractor number and BSI*.

## 70.5 – Completing Medicare Fraud Unit Quarterly Workload Status Report, CMS-1566B – General *(Inactive)*

***(Rev.12894; 10-17-24; Effective:11-01-24; Implementation:11-01-24)***

**A3-3898.5**

The intermediary prepares and submits to CMS each quarter a report on the number of fraud workload items handled by your Medicare fraud unit. This information is required by CMS to budget for fraud and abuse activities, as well as to monitor the flow of work through the fraud units. Submit this form via CROWD no later than the 15th day following the close of the reporting quarter.

## 70.6 – Heading *(Inactive)*

***(Rev.12894; 10-17-24; Effective:11-01-24; Implementation:11-01-24)***

**A3-3898.6**

This page is referenced as Form M in the CROWD system. Complete the ADD/UPDATE/DELETE DATA criteria screen with the appropriate information to bring the reporting format to your screen.

## 70.7 – Checking Reports *(Inactive)*

***(Rev.12894; 10-17-24; Effective:11-01-24; Implementation:11-01-24)***

**A3-3898.7**

Before submitting Form M to CMS, check for completeness and arithmetical accuracy. Use the following checklist:

- For all columns, line 1 must equal line 8 of Form M for the previous quarter.
- For all columns, line 1 + line 2 = line 3.
- For all columns, line 6 + line 7 = line 5.
- For all columns, line 3 + line 4 – line 5 = line 8.
- For all lines, column 1 = column 2 + column 3 + column 4.

## 70.8 – Type of Fraud Workload Item *(Inactive)*

***(Rev.12894; 10-17-24; Effective:11-01-24; Implementation:11-01-24)***

**A3-3898.8**

The intermediary reports fraud workload items in the following columns for all lines of Form M:

**Column (1) – Total** – All fraud workload items.

**Column (2) – Beneficiary Complaints** – The intermediary reports the number of complaints received from, or on behalf of, beneficiaries alleging fraud. Do not include complaints filed with the Office of the Inspector General (OIG) Hotline.

**Column (3) – OIG Hotline** – The intermediary reports the number of complaints received via the OIG Hotline.

**Column (4) – Referrals and Other** – The intermediary reports referrals and any other workload received by the fraud unit (e.g., provider complaints, internally generated referrals from medical review, special requests from OIG or CMS).

## 70.9 – Body of Report *(Inactive)*

***(Rev.12894; 10-17-24; Effective:11-01-24; Implementation:11-01-24)***

**A3-3898.9**

**Line 1 – Opening Pending** – The system will pre-fill the number pending from line 8 of the previous quarter's report.

**Line 2 – Adjustments** – If it is necessary to revise the pending figure for the close of the previous quarter because of inventories, reporting errors, etc., enter the adjustment on this line. Precede negative adjustments with a minus sign.

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

**Line 4 – Workload Received** – The intermediary reports the number of complaints and referrals received in the fraud unit during the reporting period.

**Line 5 – Total Cleared** – The system will sum line 6 + line 7 to calculate the total number of complaints and referrals cleared by the fraud unit during the reporting period.

**Line 6 – Cleared by Contractor** – The intermediary reports the number of complaints and referrals cleared by the fraud unit by means other than referral to the OIG or designated agency. Include those that were:

- Closed as not substantive or not a fraud issue.

- Closed as not a fraud issue but referred to another contractor component for their review or action.

- Closed as not being a fraud issue but referred to an external component other than the OIG.

**Line 7 – Cleared by Referral** – The intermediary reports the number of complaints and referrals that were incorporated into cases referred formally to the OIG or designated agency for action (e.g., sanctions or prosecution).

**Line 8 – Closing Pending** – The system will calculate the closing pending for the quarter by adding line 3 to line 4 and subtracting line 5.

## 70.10 – Completing Quarterly Periodic Interim Payment (PIP) Report, CMS-1566C – General

***(Rev12894; Issued:10-17-24-Effective: 11-01-24; Implementation:11-01-24)***

**A3-3898.10**

The intermediary prepares and submits to CMS each quarter a report on the number of providers that you pay using the PIP method. This information is required so that CMS can monitor the number of providers being paid using the PIP method at each intermediary and nationally. Submit the form via CROWD no later than the 15th day following the close of the reporting quarter.

## 70.11 – Heading

***(Rev.12894; 10-17-24; Effective:11-01-24; Implementation:11-01-24)***

**A3-3898.11**

This page is referenced as Form Q *for* CROWD. *It submits* the appropriate information *for the reporting period for each office assigned a separate contractor number and BSI*.

## 70.14 - Quarterly Supplement to the Intermediary Workload Report - CMS-1566A, Pages 1,2,3

*(Rev.12894; 10-17-24; Effective:11-01-24; Implementation:11-01-24)*

**A3-3898.14**

**QUARTERLY SUPPLEMENT TO INTERMEDIARY WORKLOAD REPORT**
**HFCA-1566A, PAGES 1 & 2 (CROWD FORM C)**
**INTERMEDIARY NUMBER_______ REPORT PERIOD_______**

| | **SECTION A: BILLS PROCESSED BY STATE OF PROVIDER** | | **TOTAL 1** | **INP HOSP 2** | **OUTPATIENT 3** | **SNF 4** | **HHA 5** | **OTHER 6** |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |
| 1 . | | TOTAL - ALL | | | | | | |
| | | STATE CODE | XXXXXXXXXXX | XXXXXXXXX | XXXXXXXXXXXX | XXXX | XXXXX | XXXXXX |
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**QUARTERLY SUPPLEMENT TO INTERMEDIARY WORKLOAD REPORT**
**HFCA-1566A, PAGE 3 (CROWD FORM I)**

**INTERMEDIARY NUMBER_______**
**REPORT PERIOD_______**

| | TOTAL<br>1 | INPATIENT<br>2 | OUTPATIENT<br>3 | SNF<br>4 | HHA<br>5 | OTHER<br>6 |
|---|---|---|---|---|---|---|
| SECTION B: BILL DENIAL DATA | XXXXXXX | XXXXXXXXXX | XXXXXXXXXXX | XXXX | XXXX | XXXXX |
| 1. BILLS DENIED - TOTAL | | | | | | |
| 1A. MEDICAL - SUBJECT TO WAIVER | XXXXXX | XXXXXXXXXX | XXXXXXXXXXX | XXXXXX | XXXXXX | XXXXXX |
| 1B. MEDICAL - NOT SUBJECT TO WAIVER | XXXXXX | XXXXXXXXXX | XXXXXXXXXXX | XXXXXX | XXXXXX | XXXXXX |
| 1C. NONMEDICAL TOTAL | XXXXXXX | XXXXXXXXXX | XXXXXXXXXXX | XXXXXX | XXXXXX | XXXXXX |
| 1D. NONMEDICAL MSP | XXXXXXX | XXXXXXXXXX | XXXXXXXXXXX | XXXXXX | XXXXXX | XXXXXX |
| 2. BILLS PAID UNDER WAIVER TOTAL | | | | | | |
| 2A. INITIAL BILLS PAID UNDER WAIVER | | | | | | |

**Quarterly Supplement To Intermediary Workload Report (Cont.)**

**QUARTERLY SUPPLEMENT TO INTERMEDIARY WORKLOAD REPORT**
**HFCA-1566A, PAGE 3 (CROWD FORM I)**

**INTERMEDIARY NUMBER_______**
**REPORT PERIOD_______**

| | **TOTAL 1** | **INPATIENT 2** | **OUTPATIENT 3** | **SNF 4** | **HHA 5** | **OTHER 6** |
|---|---|---|---|---|---|---|
| 3. AMOUNT REIMBURSED UNDER WAIVER | | | | | | |
| 3*A*. AMOUNT ON INITIAL BILLS | | | | | | |
| SECTION C: DAY/VISIT DATA | XXXXXXX | XXXXXXXXXX | XXXXXXXXXXX | XXXX | XXXX | XXXXX |
| 4. DAYS/VISITS PROCESSED | XXXXXXX | XXXXXXXXXX | XXXXXXXXXXX | | | XXXXX |
| 5. DAYS/VISITS DENIED TOTAL NO-PAY BILLS | XXXXXXX | XXXXXXXXXX | XXXXXXXXXXX | | | XXXXX |
| 5A. MEDICAL - SUBJECT TO WAIVER | XXXXXXX | XXXXXXXXXX | XXXXXXXXXXX | | | XXXXX |
| 5B. MEDICAL - NOT SUBJECT TO WAIVER | XXXXXXX | XXXXXXXXXX | XXXXXXXXXXX | | | XXXXX |
| 5C. NONMEDICALS | XXXXXXX | XXXXXXXXXX | XXXXXXXXXXX | | | XXXXX |

**QUARTERLY SUPPLEMENT TO INTERMEDIARY WORKLOAD REPORT**
**HFCA-1566A, PAGE 3 (CROWD FORM I)**

**INTERMEDIARY NUMBER_______**
**REPORT PERIOD_______**

| | **TOTAL**<br>**1** | **INPATIENT**<br>**2** | **OUTPATIENT**<br>**3** | **SNF**<br>**4** | **HHA**<br>**5** | **OTHER**<br>**6** |
|---|---|---|---|---|---|---|
| 6. DAYS/VISITS PAID UNDER WAIVER - TOTAL | XXXXXXX | XXXXXXXXXX | XXXXXXXXXXX | | | XXXXX |
| 6A. DAYS/VISITS ON INITIAL BILLS | XXXXXXX | XXXXXXXXXX | XXXXXXXXXXX | | | XXXXX |

**QUARTERLY SUPPLEMENT TO INTERMEDIARY WORKLOAD REPORT**
**HFCA-1566A, PAGE 3 (CROWD FORM I)**

**INTERMEDIARY NUMBER______ REPORT PERIOD______**

| | **TOTAL 1** | **INPATIENT 2** | **OUTPATIENT 3** | **SNF 4** | **HHA 5** | **OTHER 6** |
|---|---|---|---|---|---|---|
| SECTION D: DEMAND BILL DATA | XXXXXXX | XXXXXXXXXX | XXXXXXXXXXX | XXXX | XXXX | XXXXX |
| 7. TOTAL DEMAND BILLS | | | | | | |
| 7A. FULL/PARTIAL REVERSALS | | | | | | |
| 7B. DAYS/VISITS ON REVERSALS | XXXXXXX | XXXXXXXXXX | XXXXXXXXXXX | | | XXXXX |
| SECTION E: NO-PAY BILLS | XXXXXXX | XXXXXXXXXX | XXXXXXXXXXX | XXXX | XXXX | XXXXX |
| 8. TOTAL NO-PAY BILLS | | | | | | |
| 8A. DAYS/VISITS ON NO-PAY BILLS | XXXXXXX | XXXXXXXXXX | XXXXXXXXXXX | | | XXXXX |
| 8B. MSP NO-PAY BILLS | | | | | | |

## 70.15 - Medicare Fraud Unit Quarterly *W*orkload Status Report - CMS-1566B

*(Rev.12894; 10-17-24; Effective:11-01-24; Implementation:11-01-24)*

**A3-3898.15**

**MEDICARE FRAUD UNIT QUARTERLY WORKLOAD STATUS REPORT**
**HFCA-1566B (CROWD FORM M)**

**INTERMEDIARY NUMBER_______ REPORT PERIOD_______**

| **FRAUD WORKLOAD ITEM** | **TOTAL**<br>**1** | **BENEFICIARY COMPLAINT**<br>**2** | **OIG HOTLINE**<br>**3** | **REFERRAL & OTHERS**<br>**4** |
|---|---|---|---|---|
| 1. OPENING PENDING | | | | |
| 2. ADJUSTMENTS | | | | |
| 3. ADJUSTED PENDING | | | | |
| 4. WORKLOAD RECEIVED | | | | |
| 5. TOTAL CLEARED | | | | |
| 6. BY CONTRACTOR | | | | |
| 7. BY REFERRAL | | | | |
| 8. CLOSING PENDING | | | | |

## 70.18 - Heading *(Inactive)*

*(Rev.12894; 10-17-24; Effective:11-01-24; Implementation:11-01-24)*

**A3-3898.18**

This report is referenced as Form 3 in the CROWD system. Complete the ADD/UPDATE/DELETE DATA criteria screen with the appropriate information to bring the reporting format to your screen.

## 70.19 - Checking Reports *(Inactive)*

*(Rev.12894; 10-17-24; Effective:11-01-24; Implementation:11-01-24)*

**A3-3898.19**

Before submitting Form 3 to CMS, check for completeness and arithmetical accuracy. Use the following checklist:

- For all lines, column 1 must equal the sum of columns 2-16.
- For all columns, line 1 must equal line 11 from the previous quarter.
- For all columns, line 3 must equal line 1 plus line 2.
- For all columns, line 6 must equal line 4 plus line 5.
- For all columns, line 10 must equal the sum of lines 7-9.
- For all columns, line 11 must equal line 3 plus line 6 minus line 10.
- For all columns, the sum of lines 12-17 must equal line 8.
- For all columns, the sum of lines 18-22 must equal line 9.
- For all columns, the sum of lines 23-26 must equal line 10.
- For all columns, the sum of lines 27-31 must equal line 11.
- For all columns, line 32 must equal line 37 from the previous quarter.
- For all columns, line 34 must equal line 32 plus line 33.
- For all columns, line 37 must equal line 34 plus line 35 minus line 36.
- For all columns, line 32 must be less than or equal to line 1.
- For all columns, line 34 must be less than or equal to line 3.
- For all columns, line 35 must be less than or equal to line 6.
- For all columns, line 36 must be less than or equal to line 10.
- For all columns, line 37 must be less than or equal to line 11.

## 70.20 - Type of Provider *(Inactive)*

*(Rev.12894; 10-17-24; Effective:11-01-24; Implementation:11-01-24)*

**A3-3898.20**

The intermediary reports provider enrollment application data in the following columns for all lines on Form 3.

Column (1) - Total - The sum of columns 2-16 for each line.

Column (2) - Accredited Hospital - Provider applications indicating provider type as an accredited hospital.

Column (3) - Non-Accredited Hospital - Provider applications indicating provider type as a non-accredited hospital.

Column (4) - Religious Nonmedical Health Care Facility - Hospital - Provider applications indicating provider type as a Religious Nonmedical Health Care Facility - hospital.

Column (5) - Rural Primary Care Hospital - Provider applications indicating provider type as a rural primary care hospital.

Column (6) - SNF - Provider applications indicating provider type as a skilled nursing facility (i.e., long term care facility).

Column (7) - HHA. - Provider applications indicating provider type as a home health agency.

Column (8) - Hospice - Provider applications indicating provider type as a hospice facility.

Column (9) - ESRD - Provider applications indicating provider type as an end stage renal disease dialysis facility.

Column (10) - CORF - Provider applications indicating provider type as a comprehensive outpatient rehabilitation facility.

Column (11) - RHC - Provider applications indicating provider type as a rural health clinic.

Column (12) - FQHC - Provider applications indicating provider type as a federally qualified health center.

Column (13) - CMHC - Provider applications indicating provider type as a community mental health center.

Column (14) - IHS - Provider applications indicating provider type as an Indian Health Service facility.

Column (15) - Outp. Speech Path./Phy.Ther - Provider applications indicating provider type as either outpatient speech pathology or outpatient physical therapy facility.

Column (16) - Other - Provider applications indicating provider type other than those defined for columns 1 through 15.

## 70.21 - Completing Lines One through Eleven - Workload Operations *(Inactive)*

***(Rev.12894; 10-17-24; Effective:11-01-24; Implementation:11-01-24)***

**A3-3898.21**

Line 1 - Pending End of Last Quarter - The CROWD system will automatically enter the value from line 11 on the previous quarter's report.

Line 2 - Adjustments to Pending - If it is necessary to revise the pending figure for the close of the previous quarter because of inventories taken or reporting errors discovered, enter the adjustment here. Adjustments can be positive or negative values. If entering a negative value, precede the number with a minus (-) sign.

Line 3 - Adjusted Opening Pending -The CROWD system will automatically sum the values on lines 1 and 2.

Line 4 - New Applications Received - The intermediary enters the number of applications received for the first time during the reporting quarter.

Line 5 - Returned Applications Resubmitted - The intermediary enters the number of applications received during the reporting quarter that had previously been received and returned to the applicant for correction/completion.

Line 6 - Total Applications Received -The CROWD system will automatically sum the values and lines 4 and 5.

Line 7 - Applications Recommended for Approval - The intermediary enters the number of applications that you recommended for approval (i.e., Medicare number issued) during the reporting quarter.

Line 8 - Applications Recommended for Denial - The intermediary enters the number of applications that you recommended for denial during the reporting quarter.

Line 9 - Applications Returned - The intermediary enters the number of applications returned to the applicant for corrections/completion during the reporting quarter.

Line 10 - Total Applications Processed -The CROWD system will automatically sum the values on lines 7, 8, and 9.

Line 11 - Pending End of Quarter -The CROWD system will automatically compute the number of applications pending at the end of the reporting quarter by adding the value on line 3 to the value on line 6 and then subtracting the value on line 10.

## 70.22 - Completing Lines Twelve through Seventeen - Reason for Denial Recommendation *(Inactive)*

***(Rev.12894; 10-17-24; Effective:11-01-24; Implementation:11-01-24)***

**A3-3898.22**

Line 12 - Sanctioned From Medicare - The intermediary enters the number of applications that you recommended for denial because the applicant is currently excluded/sanctioned from Medicare.

Line 13 - Debarred/Excluded by Other Federal Agency - The intermediary enters the number of applications that you recommended for denial because the applicant had been disbarred, suspended, or excluded by any other Federal agency.

Line 14 - Not Professionally Licensed - The intermediary enters the number of applications that you recommended for denial because the applicant was not professionally licensed.

Line 15 - Business Address Invalid - The intermediary enters the number of applications that you recommended for denial because the applicant had an invalid business address.

Line 16 - Business Location Not Licensed - The intermediary enters the number of applications that you recommended for denial because the applicant=s business location was not properly licensed.

Line 17 - CMS Requirements Not Met - The intermediary enters the number of applications that you recommended for denial because the applicant did not meet all CMS requirements.

### 70.23 - Completing Lines Eighteen through Twenty-Two - Reason for Return *(Inactive)*

***(Rev.12894; 10-17-24; Effective:11-01-24; Implementation:11-01-24)***

**A3-3898.23**

Line 18 - Incomplete - The intermediary enters the number of applications returned to the applicant because the application was incomplete.

Line 19 - Unverifiable Information - The intermediary enters the number of applications returned to the applicant because the application included unverifiable information.

Line 20 - Not Signed - The intermediary enters the number of applications returned to the applicant because the applicant did not sign the certification statement.

Line 21 - Invalid Billing Agreement - The intermediary enters the number of applications returned to the applicant because the billing agreement did not meet CMS requirements.

Line 22 - Other - The intermediary enters the number of applications returned to the applicant for any reason other than the ones indicated on lines 18 through 21.

### 70.24 - Completing Lines Twenty-Three through Twenty-Six - Application Processing Times *(Inactive)*

***(Rev.12894; 10-17-24; Effective:11-01-24; Implementation:11-01-24)***

**A3-3898.24**

Line 23 - Number Under 21 Days - The intermediary enters the number of applications processed in less than 21 days from the date of receipt.

Line 24 - Number in 21-30 Days - The intermediary enters the number of applications processed in 21 through 30 days from the date of receipt.

Line 25 - Number in 31-40 Days - The intermediary enters the number of applications processed in 31 through 40 days from the date of receipt.

Line 26 - Number Over 40 Days - The intermediary enters the number of applications processed in more than 40 days from the date of receipt.

### 70.25 - Completing Lines Twenty-Seven through Thirty-One - Age of Applications Pending *(Inactive)*

***(Rev.12894; 10-17-24; Effective:11-01-24; Implementation:11-01-24)***

**A3-3898.25**

Line 27 - Number Under 11 Days Old - The intermediary enters the number of applications included in line 11 which are 1-10 days old.

Line 28 - Number 11-20 Days Old - The intermediary enters the number of applications included in line 11 which are 11-20 days old.

Line 29 - Number 21-30 Days Old - The intermediary enters the number of applications included in line 11 which are 21-30 days old.

Line 30 - Number 31-40 Days Old - The intermediary enters the number of applications included in line 11 which are 31-40 days old.

Line 31 - Number Over 40 Days Old - The intermediary enters the number of applications included in line 11 which are over 40 days old.

## 70.26 - Completing Lines Thirty-Two through Thirty-Seven - CHOW Workloads *(Inactive)*

***(Rev.12894; 10-17-24; Effective:11-01-24; Implementation:11-01-24)***

**A3-3898.26**

The intermediary reports in this section counts of your workloads dealing with CHOW notices included in lines 1, 2, 3, 6, 10, and 11.

Line 32 - Pending End of Last Quarter - The CROWD system will automatically enter the value from line 37 on the previous quarter's report. (This count represents the number of CHOWs included in line 1.)

Line 33 - Adjustments to Pending - If it is necessary to revise the pending figure for the close of the previous quarter because of inventories taken or reporting errors discovered, enter the adjustment here. Adjustments can be positive or negative values. If entering a negative value, precede the number with a minus (-) sign. (This count represents the number of CHOWs included in line 2.)

Line 34 - Adjusted Opening Pending -The CROWD system will automatically sum the values in lines 32 and 33. (This count represents the number of CHOWs included in line 3.)

Line 35 - CHOWs Received - The intermediary enters the number of applications shown in line 6 that represents CHOWs received during the reporting quarter.

Line 36 - CHOWs Processed - The intermediary enters the number of applications shown in line 10 that represents CHOWs processed during the reporting quarter.

Line 37 - Pending End of Quarter -The CROWD system will automatically compute the number of CHOWs pending at end of the reporting quarter by adding the value on line 34 to the value on line 35 and then subtracting the value on line 36. (This count represents the number of CHOWs included in line 11.)

## 90 – Mont*h*ly Intermediary Part A and Part B Appeals Report (Form CMS-2591)

***(Rev.12894; 10-17-24; Effective:11-01-24; Implementation:11-01-24)***

At the end of each month, prepare and transmit to CMS a report summarizing activity on Part A reconsiderations, Part A Administrative Law Judge (ALJ) hearings, Part B reviews, and Part B hearings during the month. Complete a separate report for each office assigned a separate intermediary number.

Form CMS-2591 is subject to the Paperwork Reduction Act and requires approval by the Office of Management and Budget (OMB). OMB approval has been requested.

## 90.2 – Due Date

***(Rev.12894; 10-17-24; Effective:11-01-24; Implementation:11-01-24)***

Transmit the CMS-2591 to CO via PC or terminal. Use instructions in the CROWD User Guide *available via the CMS Enterprise Portal*.

The report is due as soon as possible after the end of the reporting month but no later than the 15th of the month following the end of the reporting month.

## 100.1 – Heading

***(Rev.12894; 10-17-24; Effective:11-01-24; Implementation:11-01-24)***

*This report is referenced as Form J for CROWD. It submits the appropriate information for the reporting period for each office assigned a separate contractor number and BSI.*

## 130.1 - Heading

***(Rev.12894; 10-17-24; Effective:11-01-24; Implementation:11-01-24)***

**B3-13302.1**

This report is referenced as Form B *for* CROWD. The carrier *submits* the appropriate information *for the reporting period for each office assigned a separate contractor number and BSI*. It *reports* the number of working days scheduled for the reporting period, less any days where no claims were processed as a result of a strike, snowstorm, etc. It does not count Saturdays, Sundays, or holidays.

## 130.2 - Part A - Monthly Workload Operations

***(Rev.12894; 10-17-24; Effective:11-01-24; Implementation:11-01-24)***

This part of the report presents data on carrier claims processing activity during the reporting period. Counts of claims (real and replicate) processed, total claims (real and replicate) pending, or pending from prior months must reflect the actual status of claims (real or replicate) workloads as of the last day of the reporting calendar month. Data shown must be based on reliable counts of all claims (real or replicate) processing activity and the entire "in-house" pending workload. This data may not be derived from estimates.

If a single claim is split into two or more real claims, or into one real claim and one or more replicate claims, the carrier considers each split (real and replicate) as a separate, distinct claim for purposes of counting claims. The original real claim is a receipt for the month in which it was received. It counts a claim split from the original, or identified as a replicate, as a receipt for the month in which it is actually created or in which its system recognizes it as a separate claim. To determine the age of pending claims, the carrier considers the receipt date as the date the original claim was received and not the date it was split from another claim.

It reports, in Part A, only data relating to initial claims (real and replicate) actions. It does not report data on requests for, or dispositions of, reviews, hearings, or reopenings of initial claim actions.

**Opening Pending**

Line 1. Claims Pending End of Last Month - The system will pre-fill the number pending from line 17 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, the carrier *reports* the adjustment, preceded by a minus sign for negative adjustments, as appropriate. Adjustments normally result from:

- Private claims incorrectly counted as Medicare claims;
- Beneficiary inquiries or other correspondence incorrectly counted as Medicare claims; and
- Claims consisting of one or more continuation forms incorrectly counted as more than one Medicare claim.

The carrier reports claims received near the end of the reporting month, and placed under computer control sometime after the reporting month, as claims received in the reporting month. It does not count them as claims received in the following month. If some claims have not been counted in the proper month's receipts, it counts them as adjustments to the opening pending in the subsequent month.

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

**Receipts**

Line 4. Total Claims Received During Month - The carrier *reports* all real claims received during the month and all split and replicate claims generated (recognized) during the month. (See the Medicare Claims Processing Manual for a discussion of what constitutes a claim.) Claims received include all claims received in its mailroom during the reporting month even though some of them were placed under computer control in the following month. (See §120.1 for counting receipts.)

The carrier counts claims submitted electronically after they have passed its consistency edits. Prior to that time, it may return these bills or the entire tape (where magnetic tape is the medium of submission), as necessary, without counting them as received. However, once the claims 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.

Line 5. Transferred to Other Carriers - The carrier reports the number of claims received, but transferred to other carriers or Part A intermediaries, during the month because the claimant submitted the claim to the wrong contractor. It includes claims transferred in their entirety or split off from other claims because they contained services from physicians/suppliers outside of their carrier jurisdiction.

Line 6. Net Number of Claims Received - The carrier shows the net number of claims (real and replicate) received after subtracting those transferred.

Line 7. Electronic Media Claims Received - The carrier reports the net number of claims included in line 6 which were received in paperless form via electronic media from providers or their billing agencies and read directly into its claims processing system. It does not count on this line claims that it received in hardcopy and entered using an Optical Character Recognition (OCR) device. It does not count any claims received in hardcopy and transformed into electronic media by any entity working for it directly or under subcontract.

It counts claims which are split automatically by computer, without manual intervention, as electronic media claims. This includes "required" splits only. (See the Medicare Claims Processing Manual. It excludes replicate claims).

**Claims Processed**

Line 8. Total CWF Claims - The carrier reports the number of initial claims (described in lines 9, 10 and 11 below) processed through Common Working File (CWF) and posted to CWF history. It does not include claims sent to CWF and rejected, unless they were resubmitted and posted to CWF history in the reporting month. The counts entered in lines 9, 10 and 11 are exclusive of each other and represent the total number of CWF claims (real or replicate) processed during the month. On page 1, it reports these claims in the month it move the claim to a processed location in its system after receipt of the host's response to pay, apply entirely toward the deductible or deny in full. For pages 2-9, it reports these claims as processed in the month during which the scheduled payment date falls, which may be in a subsequent reporting period.

Line 9. Claims Paid - The carrier reports the number of initial CWF claims (real or replicate) that it approved for payment and for which the CWF host responded by accepting its determination during the month. It reports only

claims which are completely processed. If payment is made on part of a claim and the remainder of the claim requires no payment or is denied for any reason, it reports the claim as paid. It reports claims that have been fully adjudicated, with a response having been received from the CWF host, and that are being held only due to the payment floor.

Line 10. Claims Applied Towards Deductible - The carrier *reports* the number of CWF claims (real or replicate) for which no payment was made because the deductible had not been met. It includes claims for which all charges were applied toward the deductible, as well as those for which some charges were denied.

Line 11 Claims Denied - The carrier reports the number of CWF claims (real or replicate) for which all services were denied because, for example, the beneficiary was not eligible for Part B benefits, the filing limitation was exceeded, or services were not covered.

Line 12. Total Non-CWF Claims - The carrier reports the number of initial claims (real or replicate) processed outside CWF. Non-CWF claims are those either rejected by or not submitted to CWF which it finally adjudicates outside of CWF and are, therefore, not posted to its history in the reporting month. It reports these claims as non-CWF, even if it plans to submit an informational record in the future. Also, it reports these claims in the month in which it made the determination as to their final disposition.

Line 13. Claims Approved - Of those claims reported on line 12 as not processed through CWF, the carrier reports the number approved for payment or with all charges applied toward the deductible.

Line 14. Claims Denied - Of those claims reported on line 12, the carrier reports the number on which all services were denied.

Line 15. Total Claims Processed - The carrier reports the sum of lines 8 and 12.

Line 16. Replicate Claims Processed - The carrier reports the number of replicate claims included under Total Claims Processed, line 15, column (1). Replicate claims are those claims split off from original (real) claim. Replicate claims are generally created because of computer line item limitations, the carrier is making partial payments, or it is carving out individual specialty types of services. (See the Medicare Claims Processing Manual, Publication 100-04, Chapter 1, Section 70.2.).

**Closing Pending**

Line 17. Claims Pending at End of Month - The system calculates the number of bills pending at the end of the month by adding line 3 (adjusted opening pending) to line 6 (net receipts) and subtracting line 15 (total processed). It does not report as pending those bills that the carrier has moved to a processed location after being accepted by the host and are holding only due to the payment floor. It reports such bills as processed on line 17.

**Distribution by Days Elapsed Since Receipt**

Line 18. 1-15 Days - The carrier *reports* the number of claims, by type, included in line 17 which are 1-15 days old.

Line 19. 16-30 Days - The carrier *reports* the number of claims, by type, included in line 17 which are 16-30 days old.

Line 20. 31-60 Days - The carrier *reports* the number of claims, by type, included in line 17 which are 31-60 days old.

Line 21. 61-90 Days - The carrier *reports* the number of claims, by type, included in line 17 which are 61-90 days old.

Line 22. Over 90 Days - The carrier *reports* the number of claims, by type, included in line 17 which are over 90 days old.

**Claim Investigations**

Line 23. Number of Claims Investigated During Month - The carrier reports the number of claims (real and replicate) that required contact during the month by telephone, correspondence, or automatic inquiry with physician, beneficiary, supplier, or social security office, or other entities outside the carrier for missing, incorrect, or inconsistent information. It counts only the number of claims investigated, not the number of contacts made.

## 130.4 - Part C - Miscellaneous Claims Data

***(Rev.12894; 10-17-24; Effective:11-01-24; Implementation:11-01-24)***

**Medicaid Crossover Claims** - This part of the report represents data on the volume of Medicaid crossover claims.

Line 28 Number Transferred to State Agencies - The carrier *reports* the total number of Medicaid crossover claims transferred to State agencies or their fiscal agents in the reporting month.

Line 29 Number Transferred Electronically - The carrier *reports* the total number of Medicaid crossover claims reported in line 28 which were transferred in the reporting month to State agencies, or their fiscal agents, via electronic media.

**Optical Character Recognition Claims**

Line 30 Total Claims - The carrier *reports* the number of claims received in hardcopy and entered using an OCR device. It does not count these claims as EMC claims on line 7, page 1, or in column 6, pages 2-9.

**Medicare Summary Notices (MSNs)**

Line 31 Total MSNs Mailed - The carrier *reports* the number of MSNs mailed to beneficiaries during the reporting month.

## 140.1 - Heading

***(Rev.12894; 10-17-24; Effective:11-01-24; Implementation:11-01-24)***

**B3-13305.1**

These pages are referenced as Form T (pages 2-9) and Form E (pages 10-11) *for* CROWD. It *submits* the appropriate information *for the reporting period for each office assigned a separate contractor number and BSI*.

## 170.2 - Heading

***(Rev.12894; 10-17-24; Effective:11-01-24; Implementation:11-01-24)***

**B3-13308.2**

This page is referenced as Form V *for* CROWD. The carrier *submits* the appropriate information *for the reporting period for each office assigned a separate contractor number and BSI*.

## 190 - Checking Reports Prior to Submittal to CMS

***(Rev.12894; 10-17-24; Effective:11-01-24; Implementation:11-01-24)***

**B3-13310**

Prior to transmitting performance reports to CMS the carrier checks for the following:

- Completeness;
- Accuracy; and
- Internal consistency.

It uses the following checklists to assure accuracy and consistency:

A. Page One of Report (CROWD Form B)

- Line 1 of current report must be equal to line 17 of previous report for all columns; Line 1 + Line 2 = Line 3 for all columns;
- Line 4 - Line 5 = Line 6 for all columns;
- Line 7 should be equal to or less than Line 6 for all columns;
- Line 9 + Line 10 + Line 11 = Line 8 for all columns;
- Line 13 + Line 14 = Line 12 for all columns;
- Line 8 + Line 12 = Line 15 for all columns;
- Line 3 + Line 6 - Line 15 = Line 17 for all columns;
- For each line of this page (except for lines 16, 28, 29 and 30), column 1 must equal the sum of columns 2 and 3;
- Line 16 should be equal to or less than Line 15 for column 1;
- Lines 18 + 19 + 20 + 21 + 22 = Line 17 for all columns;
- Lines 25 + 26 + 27 = Line 24 for all columns; and
- Line 29 should be equal to or less than line 28.

B. Pages Two through Eleven (CROWD Forms T and E)

- For each of lines 1-38 on pages 2-9, column 1 = column 2 + 3 + 4 + 5;
- For each of lines 1-38 on pages 2-9, column 6 must be equal to or less than column 1;
- The sum of lines 1-37 must be equal to line 38 for all columns;
- Each data item on page 9, lines 1-38 = the sum of the corresponding data items on pages 2-7;
- Each data item on page 8, lines 1-38, must be equal to or less than the corresponding data item on page 2;
- For each of lines 1-38 on pages 10 and 11, column 1 must be less than or equal to column 2 on pages 8 and 9, respectively;
- For each of lines 1-38 on pages 10 and 11, column 2 must be less than or equal to column 3 on pages 8 and 9, respectively; and
- For each of lines 1-38 on pages 10 and 11, column 3 must be less than or equal to column 4 on pages 8 and 9, respectively.

C. Page Twelve (CROWD Form V) -

- For each line, column 1 = the sum of columns 2 - 7;
- For each column, line 1 = the sum of lines 2 - 10;
- For each column, line 11 = the sum of lines 12 - 20; and
- For each line, column 8 must be equal to or less than column 2.

D. Page Thirteen (CROWD Form R) *(Inactive)*

(Line 2 divided by line 3) times 100 = line 4 for all columns.

## 220.2 - Due Date

***(Rev.12894; 10-17-24; Effective:11-01-24; Implementation:11-01-24)***

**B3-13320.2**

The carrier transmits Forms CMS-1565A, CMS-1565B, CMS-1565C, and CMS-1565D to CO via PC or terminal as soon as possible after the end of the reporting quarter, but no later than the 15th of the following month, using instructions in *the* CROWD User Guide *available via the CMS Enterprise Portal*. With the exception of the due date, it applies these same instructions to Form CMS-1565E. The due date for the CMS-1565E is 75 days following the reporting quarter.

**The carrier does not submit hardcopies of the reports.**

## 240.1 - Heading

***(Rev.12894; 10-17-24; Effective:11-01-24; Implementation:11-01-24)***

**B3-13322.1**

This report is referenced as Form A *for* CROWD. The carrier *submits* the appropriate information *for the reporting period for each office assigned a separate contractor number and BSI*.

## 250 - Completing Medicare Fraud Unit Quarterly Workload Status Report, CMS-1565B - General *(Inactive)*

***(Rev.12894; 10-17-24; Effective:11-01-24; Implementation:11-01-24)***

**B3-13323**

The carrier prepares and submits to CMS each quarter a report on the number of fraud workload items handled by its Medicare fraud unit. This information is required by CMS to budget for fraud and abuse activities, as well as to monitor the flow of work through the fraud units. It submits this form via CROWD no later than the fifteenth day following the close of the reporting quarter.

## 270.1 - Heading

***(Rev.12894; 10-17-24; Effective:11-01-24; Implementation:11-01-24)***

**B3-13325.1**

This report is referenced as Form G *for* CROWD. The carrier *submits* the appropriate information *for the reporting period for each office assigned a separate contractor number and BSI*. It must submit Form A for the reporting quarter before the system will allow it to submit Form G for the same quarter.

## 270.2 - Part D - Selected Claim Data by Participation Status

***(Rev.12894; 10-17-24; Effective:11-01-24; Implementation:11-01-24)***

This part provides CMS with current quarterly workload data on the results of carrier activity in processing claims for physician and non-physician services according to the participation status of the physician/supplier. It also provides important related information on reasonable charge determinations, the extent to which claims for such services are being denied, and the amount of charges disallowed.

The carrier reports only data relating to **initial** claims (real and replicate) actions. It does not report data on the disposition of reviews, hearings, or reopenings of initial claim actions.

It reports data for lines 1-34 for each column (participation/assignment status) as defined in the Medicare Claims Processing Manual, Publication 100-04, Chapter 1, Section 30. unless otherwise stated. Specialty codes for physicians and non-physicians are listed in the Medicare Claims Processing Manual, Chapter 26, Sections 10.8.2 and 10.8.3.

**Line 1. Number of Claims Approved** - total number of claims, processed to completion during the quarter, which were paid or applied to the deductible. Claims paid or applied toward the deductible are those

reported in lines 9, 10, and 13 of Form B. The system will pre-fill columns 1 and 3 based on the total of these lines from the monthly reports.

**Line 2. Physician Only** - number of claims included in line 1 involving physician services only.

**Line 3. Physician and Non-Physician** - number of claims included in line 1 involving both physician and non-physician services on the same claim. The carrier shows all claims in this category under the "Non-Participant-Unassigned" column 3. Therefore, the numbers for columns 1 and 3 should be equal.

**Line 4. Non-Physician Only** - number of claims included in line 1 involving non-physician services only.

**Line 5. Number of Covered Services** - total number of **covered** services on the claims approved as shown on line 1. The carrier does not include services for which charges were completely disallowed.

**Line 6. Physician** - number of physician services included in line 5. The carrier includes in this count the covered services from the claims shown in line 2 plus the covered **physician** services from the claims shown in line 3.

**Line 7. Non-Physician** - number of non-physician services included in line 5. The carrier includes in this count the covered services from the claims shown in line 4 plus the covered **non-physician** services from the claims shown in line 3.

**Line 8. Amount of Covered Charges** - total amount (rounded to the nearest dollar) of billed charges for the covered services shown in line 5. For those services in which any charges were reduced as a result of reasonable charge, medical necessity, or global fee/rebundling determinations, the carrier reports the total covered charges prior to such reductions. The system will pre-fill columns 1 and 3 with the data reported in the respective columns on line 1 of Form A for the same quarter.

**Line 9. Physician** - total amount (rounded to the nearest dollar) of billed charges for the covered physician services shown in line 6. For those services in which any charges were reduced as a result of reasonable charge, medical necessity, or global fee/rebundling determinations, the carrier reports the total covered charges prior to such reductions.

**Line 10. Non-Physician** - total amount (rounded to the nearest dollar) of billed charges for the covered non-physician services shown in line 7. For those services in which any charges were reduced as a result of reasonable charge, medical necessity, or global fee/rebundling determinations, the carrier reports the total covered charges prior to such reductions.

**Line 11. Number of Claims Where Billed Charges Were Reduced** - number of claims (real and replicate) reported on line 1 as approved in which any charges were reduced as a result of reasonable charge/fee schedule, medical necessity, or global fee/rebundling determinations. The carrier counts a claim only once, regardless of the number of services reduced or the different categories of reductions that apply. Some examples of such reductions are:

a. Charges over allowed rental limits
b. Tests included in a battery of tests,
c. Fee covered in basic allowance or surgical allowance,
d. Service included in office charge or surgery fee.

**Line 12. Physician Only** - number of claims included in line 11 involving physician services only.

**Line 13. Physician and Non-Physician** - number of claims included in line 11 involving both physician and non-physician services on the same claim. The carrier shows all claims in this category under the "Non-Participant-Unassigned" column 3. Therefore, the numbers for columns 1 and 3 should be equal.

**Line 14. Non-Physician Only** - number of claims included in line 11 involving non-physician services only.

**Line 15. Number of Covered Services Where Charges Were Reduced** - From the claims shown in line 11, the carrier *reports* the number of covered services in which any charges were reduced as a result of reasonable charge determinations, medical necessity reductions, or global fee/rebundling reductions. It includes services where a fee is deemed to have been included in a global fee, such as postsurgical care. (See examples given for line 11.)

**Line 16. Physician** - number of covered physician services included in line 15. This count includes those services where charges were reduced on the claims shown in line 12, plus the **physician** services where charges were reduced on the claims shown in line 13.

**Line 17. Non-Physician** - number of covered non-physician services included in line 15. This count includes those services where charges were reduced on the claims shown in line 14, plus the **non-physician** services where charges were reduced on the claims shown in line 13.

**Line 18. Total Amount of Reduction** - total amount (rounded to the nearest dollar) by which the services reported in line 15 were **reduced** as a result of reasonable charge, medical necessity, or global fee/rebundling determinations. The system will pre-fill columns 1 and 3 with the sum of the data reported in the respective columns on lines 3, 5, and 7 of Form A for the same quarter.

**Line 19. Physician** - total amount (rounded to the nearest dollar) by which charges for physician services reported in line 16 were reduced as a result of reasonable charge, medical necessity, or global fee/rebundling determinations.

**Line 20. Non-Physician** - total amount (rounded to the nearest dollar) by which charges for non-physician services reported in line 17 were reduced as a result of reasonable charges, medical necessity, or global fee/rebundling determinations.

**Line 21. Number of Claims Denied in Full** - total number of claims, processed to completion during the quarter, in which charges for all services were completely disallowed. This number must equal the sum of the numbers reported in lines 11 and 14 of Form B for the three months of the quarter. The system will pre-fill columns 1 and 3 based on the total of these lines from the monthly reports.

**Line 22. Physician Only** - number of claims included in line 21 involving physician services only.

**Line 23. Physician and Non-Physician** - number of claims included in line 21 involving both physician and non-physician services on the same claim. The carrier shows all claims in this category under the "Non-Participant- Unassigned" column 3. Therefore, the numbers for columns 1 and 3 should be equal.

**Line 24. Non-Physician Only** - number of claims included in line 21 involving non-physician services only.

**Line 25. Number of Claims Denied in Full or in Part** - sum of (1) those claims (real and replicate) reported as denied in full in line 21, plus (2) those claims (real and replicate) reported as approved on line 1 in which some services, but not all, were denied. The system will pre-fill columns 1 and 3 with the data reported in the respective columns on line 8 of Form A for the same quarter.

**Line 26. Physician Only** - number of claims included in line 25 involving physician services only.
**Line 27. Physician and Non-Physician** - number of claims included in line 25 involving both physician and non-physician services on the same claim. The carrier shows all claims in this category under the "Non-Participant-Unassigned" column 3. Therefore, the numbers for columns 1 and 3 should be equal.

**Line 28. Non-Physician Only** - number of claims included in line 25 involving non-physician services only.

**Line 29. Number of Denied Services** - number of services for which charges were fully or partially denied on the claims shown in line 25.

**Line 30. Physician** - number of denied physician services included in line 29. The carrier includes in this count the denied services from the claims shown in line 26 plus the denied **physician** services from the claims shown in line 27.

**Line 31. Non-Physician** - number of denied non-physician services included in line 29. The carrier includes in this count the denied services from the claims shown in line 28, plus the denied **non-physician** services from the claims shown in line 27.

**Line 32. Amount Disallowed** - total amount (rounded to the nearest dollar) of charges disallowed on the services shown in line 29. The system will pre-fill columns 1 and 3 with the data reported in the respective columns on line 9 of Form A for the same quarter.

**Line 33. Physician** - total amount (rounded to the nearest dollar) included in line 32 as disallowed which represented physician services as reported in line 30.

**Line 34. Non-Physician** - total amount (rounded to the nearest dollar) included in line 32 as disallowed which represented non-physician services as reported in line 31.

## 280.1 - Heading

***(Rev.12894; 10-17-24; Effective:11-01-24; Implementation:11-01-24)***

**B3-13326.1**

This report is referenced as Form N *for* CROWD. The carrier *submits* the appropriate information *for the reporting period for each office assigned a separate contractor number and BSI*.

## 290 - Completing Health Professional Shortage Area (HPSA) Quarterly Report, Form CMS-1565E - General

***(Rev.)***

The carriers/Part B MACs prepare and submit to CMS each quarter a report on information regarding incentive payments made to physicians who render covered Medicare services in HPSAs (see Pub. 100-04, Chapter 12, §§90.4 – 90.4.7) on the results of its review of sample claims for HPSA incentive payments processed during the reporting quarter. It submits this report via CROWD no later than the 75$^{th}$ day following the close of the reporting quarter.

## 290.1 - Heading

***(Rev.12894; 10-17-24; Effective:11-01-24; Implementation:11-01-24)***

This report is referenced as Form S *for* CROWD. The carrier/Part B MAC *submits* the appropriate information *for the reporting period for each office assigned a separate contractor number and BSI*.

## 300 - Exhibits

***(Rev.12894; 10-17-24; Effective:11-01-24; Implementation:11-01-24)***

**B3-13329**

**Exhibit 1 -** Medicare Program Quarterly Supplement To The Carrier Performance Report CMS-1565a (Crowd Form A)

MEDICARE PROGRAM QUARTERLY SUPPLEMENT TO THE CARRIER PERFORMANCE REPORT
CMS-1565A (CROWD FORM A)

| **CARRIER** | | | **REPORTING PERIOD (QUARTER AND YEAR)** |
|---|---|---|---|
| | **NUMBER AND TYPE OF CLAIM** | | |
| REPORTING ITEM | **TOTAL - 1** | **ASSIGNED - 2** | **UNASSIGNED - 3** |
| A. CLAIMS REDUCED OR DENIED COVERED CHARGES<br>1. Tot. Cvrd. Charges For All Claims | | | |
| REAS. CHG./FEE SCHED. REDUCTIONS<br>2. No. of Clms w/Reas Chg/Fee Sched Red | | | |
| 3. Amount of Reduction (in $) | | | |
| MEDICAL NECESSITY REDUCTIONS<br>4. Number of Claims w/ Med. Nec. Red. | | | |
| 5. Amount of Reduction (in $) | | | |
| GLOBAL FEE/REBUNDLING REDUCTIONS<br>6. No. of Claims w/ Glo. Fee/Rebun Red. | | | |
| 7. Amount of Reduction (in $) | | | |
| DENIALS<br>8. Claims Denied in Full or in Part<br>9. Amount Disallowed (in $) | | | |
| REASONS FOR DENIAL | NUMBER OF ITEMS DENIED (1) | AMOUNT DISALLOWED (2) | NUMBER OF CLMS DENIED (3) |
| 10. Claimant Ineligible | | | |
| 11. Filing Limitation Exceeded | | | |
| 12. Duplicate Claim | | | |
| 13. Services Not Covered | | | |
| 14. Services Not Medically Necessary | | | |
| 15. MSP | | | |
| 16. Missing Information | | | |
| 17. Global Fee/Rebundling | | | |
| 18. Other | | | |
| 19. Total | | | |

FORM-CMS 1565A

**Exhibit 2 - Medicare Fraud Unit Quarterly Workload Status Report - CMS-1565B (CROWD FORM M)**

**MEDICARE FRAUD UNIT QUARTERLY WORKLOAD STATUS REPORT**
**CMS-1565B (CROWD FORM M)**

CARRIER NUMBER_____________________________
REPORT PERIOD________________________________

| **FRAUD WORKLOAD ITEM** | **TOTAL 1** | **BENEFICIARY COMPLAINT 2** | **OIG HOTLINE 3** | **REFERRAL & OTHERS 4** |
|---|---|---|---|---|
| 1. OPENING PENDING | | | | |
| 2. ADJUSTMENTS | | | | |
| 3. ADJUSTED PENDING | | | | |
| 4. WORKLOAD RECEIVED | | | | |
| 5. TOTAL CLEARED | | | | |
| 6. BY CONTRACTOR | | | | |
| 7. BY REFERRAL | | | | |
| 8. CLOSING PENDING | | | | |

FORM-CMS 1565B

**Exhibit 3 - Medicare Program Quarterly Supplement To The Carrier Performance Report CMS-1565C (Crowd Form G)**

**MEDICARE PROGRAM QUARTERLY SUPPLEMENT TO THE CARRIER PERFORMANCE REPORT CMS-1565C (CROWD FORM G) CARRIER REPORTING PERIOD**

| **REPORTING ITEM** | **TOTAL 1** | **NON-PAR ASSIGNED 2** | **NON-PAR UNASSGNED 3** | **PARTICI-PANTS 4** |
|---|---|---|---|---|
| 1. CLAIMS APPROVED: TOTAL | | | | |
| 2. PHYS ONLY | | | | |
| 3. PHYS AND NONPHYS | | | | |
| 4. NONPHYS ONLY | | | | |
| 5. COVRD SERVICES: NUMBER | | | | |
| 6. PHYS | | | | |
| 7. NONPHYS | | | | |
| 8. AMT COVRD CHRGS: TOTAL | | | | |
| 9. PHYS | | | | |
| 10. NONPHYS | | | | |
| 11. CLAIMS REDUCED: TOTAL | | | | |
| 12. PHYS ONLY | | | | |
| 13. PHYS AND NONPHYS | | | | |
| 14. NONPHYS ONLY | | | | |
| 15. COVRD SRVCS RED: NUM | | | | |
| 16. PHYS | | | | |
| 17. NONPHYS | | | | |
| 18. AMOUNT REDUCED: TOTAL | | | | |
| 19. PHYS | | | | |
| 20. NONPHYS | | | | |
| 21. FULL DENIALS: NUMBER | | | | |
| 22. PHYS ONLY | | | | |
| 23. PHYS AND NONPHYS | | | | |
| 24. NONPHYS ONLY | | | | |
| 25. FULL/PART DENIALS: NUM | | | | |
| 26. PHYS ONLY | | | | |
| 27. PHYS AND NONPHYS | | | | |
| 28. NONPHYS ONLY | | | | |
| 29. DENIED SERVICES: NUM | | | | |
| 30. PHYS | | | | |
| 31. NONPHYS | | | | |
| 32. AMT DISALLOWED: TOTAL | | | | |
| 33. PHYS | | | | |
| 34. NONPHYS | | | | |

FORM-CMS 1565C

**Exhibit 4 - Comprehensive Limiting Charge Compliance Program Quarterly Report CMS-1565d (Crowd Form N)**

**COMPREHENSIVE LIMITING CHARGE COMPLIANCE PROGRAM QUARTERLY REPORT - CMS-1565D (CROWD FORM N)**

CARRIER NUMBER________________ REPORT PERIOD___________________

| | **COLUMN 1** | **COLUMN 2** |
|---|---|---|
| 1. LCERs SENT TO IND PHYSICIANS<br>2. LCERs SENT TO GROUP PRACTICES<br>3. LCERs SENT TO ALL OTHER PROVIDERS<br>4. TOTAL LCERs SENT FOR PERIOD<br>5. TOTAL CLAIMS ON LCERs SENT<br>6. CLAIMS SELECTED FOR VERIFICATION<br>7. BENEFICIARIES W/CLAIMS ON LCERS<br>8. TOTAL DOLLARS ALLOWED<br>9. DOLLARS IN ECESS OF LMTNG CHARGE | | |
| 10. $1.00-$4.99<br>11. $5.00-$499.99<br>12. $500+<br>13. TOTAL | # OF PROCEDURES | TOTAL $ VALUE |
| 14. VERIFICATIONS POSTED TO LCEF<br>15. NOT REQUESTED ON LCER<br>16. UNACCEPTABLE VERIFICATIONS | | |
| 17. LCMRs SENT TO IND PHYSICIANS<br>18. LCMRs SENT TO GROUP PRACTICES<br>19. LCMRs SENT TO ALL OTHER PROVIDERS<br>20. TOTAL LCMRs SENT FOR PERIOD<br>21. SRLs SENT TO IND PHYSICIANS<br>22. SRLs SENT TO GROUP PRACTICES<br>23. SRLs SENT TO ALL OTHER PROVIDERS<br>24. TOTAL SRLs SENT FOR PERIOD | | |

FORM-CMS 1565D

**Exhibit 5 - Health Professional Shortage Area (HPSA) Quarterly Report**

**HEALTH PROFESSIONAL SHORTAGE AREA (HPSA) QUARTERLY REPORT CMS-1565E (CARRIERS ONLY - CROWD FORM S)**

Screen 1

CARRIER NAME______________________________

CARRIER NUMBER____________________________

CMS-1565E REPORT PERIOD____________________
CURRENT QUARTER PAYMENTS
PHYSICIANS RECEIVING CHECKS:

1. TOTAL
2. URBAN HPSA'S
3. RURAL HPSA'S

AMOUNT OF INCENTIVE PAYMENTS:

4. TOTAL
5. URBAN HPSA'S
6. RURAL HPSA'S

**Exhibit 6 - Health Professional Shortage Area (HPSA) Quarterly Report CMS-1565E (Carriers Only - Crowd Form S)**

## HEALTH PROFESSIONAL SHORTAGE AREA (HPSA) QUARTERLY REPORT CMS-1565E (CARRIERS ONLY - CROWD FORM S)

Screen 2

| CARRIER NAME | CMS-1565E |
|---|---|
| CARRIER NUMBER | REPORT PERIOD |

CURRENT QUARTER REVIEWS

7. PHYSICIANS REVIEWED
8. PHYSICIANS PAID INCORRECTLY
9. CLAIMS REVIEWED
10. CLAIMS PAID INCORRECTLY
11. INCENTIVE AMOUNT PAID INCORRECTLY

PRIOR QUARTER(S) REVIEWS
12. PHYSICIANS REVIEWED
13. PHYSICIANS NONCOMPLIANT 2 QRTS.
14. PHYSICIANS NONCOMPLIANT 3 QRTS.
15. PHYSICIANS NONCOMPLIANT 4+ QRTS.
16. CLAIMS REVIEWED
17. CLAIMS PAID INCORRECTLY
18. INCENTIVE AMOUNT PAID INCORRECTLY

**Exhibit 7 - Health Professional Shortage Area (HPSA) Quarterly Report**

**HEALTH PROFESSIONAL SHORTAGE AREA (HPSA) QUARTERLY REPORT - CMS-1565E (CARRIERS ONLY - CROWD FORM S)**

Screen 3

CARRIER NAME ____________________ CMS-1565E
CARRIER NUMBER __________________ REPORT PERIOD ________________

| ERROR DESCRIPTIONS | # OF CLAIMS CURRENT QUARTER | # OF CLAIMS PRIOR QUARTER |
|---|---|---|
| 19. OFFICE IN, SERVICE OUTSIDE HPSA | | |
| 20. OFFICE OUTSIDE, SERV. OUTSIDE HPSA | | |
| 21. MULTI-OFFICE, SERVICE NON-HPSA OFF. | | |
| 22. BENE. IN HPSA, SERVICE OUTSIDE HPSA | | |
| 23. PROV. CODE PRIOR TO EFF. DATE HPSA | | |
| 24. SERVICE AREA NO LONGER HPSA | | |
| 25. NON-PHYSICIAN PRACTITIONER | | |
| 26. NON-PHYSICIAN SERVICE | | |
| 27. CARRIER PROVIDED INCORRECT INFO. | | |
| 28. CARRIER PUBLISHED INCORRECT NOTICE | | |
| 29. CARRIER KEYING/PROCESSING ERROR | | |
| 30. OTHER | | |

## 310 - Carrier Beneficiary Overpayment Activity Report (Form CMS-2174) - General *(Inactive)*

***(Rev.12894; 10-17-24; Effective:11-01-24; Implementation:11-01-24)***

**B3-13350**

At the end of each calendar quarter (i.e., December, March, June, September) the carrier prepares and submits to CMS a report summarizing beneficiary overpayment activity completed during the reporting quarter. It completes a separate report for each carrier office that has been assigned a separate carrier number.

## 320 - Completing Carrier Beneficiary Overpayment Activity Report *(Inactive)*

***(Rev.12894; 10-17-24; Effective:11-01-24; Implementation:11-01-24)***

**B3-13351**

## 330 - Completion of Items on Form CMS-2174 *(Inactive)*

***(Rev.12894; 10-17-24; Effective:11-01-24; Implementation:11-01-24)***

**B3-13360**

### 330.1 - Heading

***(Rev.12894; 10-17-24; Effective:11-01-24; Implementation:11-01-24)***

**B3-13360.1**

*This report is referenced as Form O for CROWD.* The carrier enters its ID number in the number box. In the space labeled "Reporting Period" it enters the fiscal quarter and year (e.g., 0190 for October-December 1989) for which the report is prepared.

### 350.2 - Due Date

***(Rev.12894; 10-17-24; Effective:11-01-24; Implementation:11-01-24)***

**B3-13400.2**

The carrier transmits form CMS-2590 to CO via PC or terminal. It uses instructions in the CROWD User Guide *available via the CMS Enterprise Portal*.

The report is due as soon as possible after the end of the reporting month but no later than the 15th of the month following the end of the reporting month.

### 360.1 - Heading

***(Rev.12894; 10-17-24; Effective:11-01-24; Implementation:11-01-24)***

**B3-13410.1**

*This report is referenced as Form H for CROWD.* The carrier *submits the appropriate information for the reporting period for each office assigned a separate contractor number and BSI*.

### 360.2 - Section A - Carrier Appeal Requests

***(Rev.12894; 10-17-24; Effective:11-01-24; Implementation:11-01-24)***

**B3-13410.2**

Section A: Carrier Appeal Requests - This part concerns data from the Part B appeals process. The number of appeals requested (received), completed, and pending reflects the status of the workload as of the last day of the reporting month. The carrier bases data on actual counts of each activity and not on sampling or other estimating techniques.

APPEALS FALL INTO THE FOLLOWING CATEGORIES:

**Column (1) Total Reviews** - The first formal level of appeal following denial of a Part B claim. It is a second look by a different employee at the claim and supporting evidence. (See The Medicare Claims Processing Manual, Chapter 30, Beneficiary Correspondence and Appeals). The carrier does not count duplicate review requests or review requests received before it has made an initial determination on a claim. It counts one review per request received. With the exception of line 7, it does not count the number of claims or beneficiaries involved in the requests. It reports in Column (1) data relating to all types of reviews (both those requested in writing and those conducted by telephone).

**Column (2) Telephone Reviews** - The carrier reports in this column, data on those reviews included in column 1 that were conducted by telephone. It reports data in this column on lines 6, 7, 9, 10, 11, and 12 only.

**Column (3) Carrier Hearings** - This column represents independent determinations on claims for which the party has appealed the carrier review decision. Such independent determinations are rendered by Hearing Officers (HO) that the carrier assigns. The amount in controversy must be at least $100. (See The Medicare Claims Processing Manual, Chapter 30, Beneficiary Correspondence and Appeals)

The carrier counts one hearing per request received (i.e., form CMS-1965 or equivalent written request). It includes hearings requested that do not meet the minimum $100 requirements and are subsequently dismissed. With the exception of line 7, it does not count the number of claims or beneficiaries involved in the requests. (It reports claim counts in line 7.) It does not count hearing requests that qualify for an ALJ hearing (i.e., Part B hearings are those hearings that a hearing officer adjudicates, as opposed to an ALJ). See definition for Section D.

It does not count requests for HO hearings received after it has rendered an OTR decision in lines 1-32 of the report. It counts these cases only in lines 33, 34, 35, 36, and 38 as appropriate.

**Line 1. Opening Pending** - It *reports*, under the appropriate columns, the numbers of reviews on line 18 and hearings reported on line 28 as the closing pending on the previous month's report.

**Line 2. Adjustments to Pending** - If it is necessary to revise the pending figure for the close of the previous month because of inventories or reporting errors, the carrier *reports* the adjustment. It reports requests received near the end of the reporting month and placed under control sometime after the reporting month as received in the reporting month, not as requests received in the subsequent month. If some cases were not counted in the proper month's receipts, it counts them as adjustments to the opening pending in the subsequent month.

If line 3 of the current month differs from the closing pending of the previous month, there must be an entry in line 2 for the current month. The carrier precedes the entry by a "+" or "-," as appropriate.

**Line 3. Adjusted Pending** - It *reports* the result of line 1 + line 2 (taking into account the "-" sign, if any).

**Line 4. Requests Received** - It *reports*, under the appropriate columns, the number of review and hearing requests received during the reporting month. (See definitions for columns 1 and 3 for a discussion of what constitutes a request for a review and hearing.) It includes requests transferred to it by other contractors if it incurs the administrative costs for processing the appeals, and reports the costs on the Interim Expenditure Report (Form CMS-1524).

If one physician submits one request involving several assigned claims (and several beneficiaries), the carrier counts this as one request. If one beneficiary submits a request involving several unassigned bills (from several different physicians), it counts this as one request. If an appellant submits more than one request (for different claims) at different times, the carrier counts each request.

**NOTE:** See definition of column (3) for instructions on hearings requested subsequent to OTR decisions.

**Line 4A. Medical Necessity Documentation Denials** - The carrier *reports* the number of requests included in line 4 that involved initial claim denials for lack of medical documentation.

**Line 5. Transferred** - The carrier reports, under column 1, the number of review requests it transferred to other carriers because it did not process the original claim(s). It reports, under column 3, the number of hearing requests transferred to other carriers because the claimant is not within the original carrier's geographical area, or the claim was transferred to ROs because the issues are outside the HO's responsibility. (See The Medicare Claims Processing Manual, Chapter 30, Beneficiary Correspondence and Appeals) For columns 1 and 3, if it reported a review or hearing as transferred, it does not report any information regarding it on lines 6-39. The transfer is the final action.

**Line 6. Requests Cleared** - The carrier reports, under the appropriate columns, the total number of all reviews, telephone reviews, and hearings completed during the month. It reports all completed reviews and hearings, regardless of the final outcome, i.e., affirmation, reversal, withdrawal, or dismissal. It considers a review cleared when the final determination (EOMB or other notice - including dismissal) is printed or typed, or upon notification of withdrawal by the appellant. In the case of a reversal, it considers the case cleared when it initiates the adjustment action.

A hearing is cleared when the decision is signed, or one of the following conditions is present:

- The claimant indicates satisfaction with the OTR decision;
- The claimant indicates after the OTR decision the desire to proceed with an ALJ hearing (if the amount in controversy is $500 or more);
- The HO dismisses the hearing request; or
- The appellant withdraws the hearing request.

The carrier does not consider a hearing completed upon release of an OTR decision unless the appellant specifically requested an OTR hearing. It does not count the OTR hearing as completed until it has completed all follow-up actions as required in The Medicare Claims Processing Manual, Chapter 30, Beneficiary Correspondence and Appeals. If, as a result of follow-up actions, the appellant requests an in-person or telephone hearing after release of the OTR decision, the OTR hearing and decision are not counted on the report with the exception noted below. If the appellant does not appear for the subsequent hearing, the hearing is dismissed. The dismissal is the final action. However, the decision to record in lines 9-11 is the OTR decision.

**NOTE:** If the carrier closes a review or hearing after the end of a reporting month, but before the report is due on the fifteenth of the subsequent month, it does not count it until the subsequent month's report.

**Line 7. No. of Claims Involved** - The carrier *reports* the total number of claims (as defined in §§3000-3000.2) involved in the appeals reported as cleared during the month on line 6. For example, if it processes decisions for two hearings in the month, one of which involved three claims, and the other involved seven claims, it reports 10 claims under column 3.

**Line 8. Amount in Controversy** - For the hearings reported as affirmed (line 9) or reversed (line 11), during the month, the carrier shows the total dollar amount in controversy on the initial hearing request. (See The Medicare Claims Processing Manual, Chapter 30, Beneficiary Correspondence and Appeals on how to determine the amount in controversy.) It shows results rounded to the nearest dollar.

**Line 9. Affirmations** - Under the appropriate columns, the carrier shows the number of all reviews, telephone reviews, and hearings completed during the month in which the previous determination was completely upheld, e.g., no change was made. All parts of all claims in a case must be upheld in order to be counted as an affirmation. An OTR hearing decision does not count as a previous decision if the appellant

subsequently requests an in-person or telephone hearing. If the in-person/telephone hearing is dismissed because the appellant did not appear, or the request was withdrawn, the carrier uses the OTR decision to determine if the case is counted here.

See line 11 for partial affirmations. (They are not included here.)

If the carrier upholds its original determination, but pays under limitation of liability, it counts the review or hearing determination as an affirmation. It reports the appropriate information in Section D.

**Line 10. Dism./Withdr** - The carrier reports, under the appropriate columns, the number of all reviews, telephone reviews, and hearings that were withdrawn by the appellant or dismissed (before determination) by the carrier or the HO. It reports here and in lines 4 and 6 an appeal that is requested and withdrawn or dismissed within the same month. If the appellant requests an in-person or telephone hearing after receiving an OTR decision and the carrier dismisses the hearing because the appellant failed to appear, the OTR decision is the final decision, not the dismissal. Similarly, for a withdrawal, the OTR decision is used.

A dismissal at the review level is done when written correspondence or a telephone conversation has been identified as a review request, but the claimant does not have the right to an appeal. Misrouted correspondence is not a dismissal. If the carrier has incorrectly counted such correspondence as a review on a previous report, it uses line 2 (adjustments to pending) to correct the count. It does not count a duplicate request for review on the report. Likewise, it does not count on the report a request for review received before an initial claim determination has been rendered. (It considers the request an inquiry.)

**Line 11. Reversals (Full or Part**) - Under the appropriate columns, the carrier shows the number of all reviews, telephone reviews, and hearings completed during the month in which at least part of the prior determination was reversed (e.g., a change was made and some or all of the new determination was in favor of the appellant). For example, if a review or hearing involves several claims, and the initial determinations for some of the claims are affirmed and some are reversed, the review or hearing decision is a reversal. An OTR hearing decision does not count as a previous decision if the appellant subsequently requests an in-person or telephone hearing. If the in-person/telephone hearing is dismissed because the appellant did not appear, or the request was withdrawn, the carrier uses the OTR decision to determine if the case is counted here.

**Line 12. Amount Awarded** - For cases included in line 11 where the issue on the appeal was not a reasonable charge determination, the carrier shows the amount of allowed charges for services where the determination was reversed. It shows charges after reasonable charge reductions, but prior to application of deductible and coinsurance amounts. If the issue was a reasonable charge reduction, it shows the additional amount allowed. It rounds results to the nearest dollar.

Computing Time to Process Carrier Reviews for Lines 13-17

For lines 13-17, the carrier uses the matrix below to determine the number of days from receipt to completion of all reviews (both written and telephone). The date of receipt in all written review requests is the day the processing carrier received it in its corporate mailroom. The date of receipt in all telephone review requests is the day the processing carrier received the request on the dedicated lines or in the dedicated area.

| Situation | Date Completed |
|---|---|
| The appellant withdraws the request | The date the carrier is notified of the withdrawal |
| Carrier dismisses the request or affirms the original determination | The date of the notice |
| Carrier processes the request to reversal | The date the carrier initiates the adjustment request |

**Line 13. Review Processing Time - Average** - The average number of days from receipt of the review request to the date of completion for all review requests (both written and telephone).

To compute the average number of days from request to completion, the carrier divides the total days elapsed for all requests cleared in the month by the number of requests cleared. It rounds results to the nearest day. It calculates the days elapsed for an individual request by subtracting the Julian date of receipt of the request from the Julian date of completion.

If the request is cleared in the year following the year of receipt, the carrier adds 365 or 366 to the result, as appropriate. (Otherwise, it will get a negative number.) If a case is cleared the same day it is received, it considers the case to require one day.

**NOTE:** The carrier includes all cases cleared regardless of whether they were affirmed, reversed, dismissed, or withdrawn.

**Line 14. Reviews Completed in 1-30 Days** - The number of reviews that required 1-30 days to complete. If a case is cleared the same day it is received, the carrier considers it to require 1 day.

**Line 15. Reviews Completed in 31-45 Days** - The number of reviews that required 31-45 days to complete.

**Line 16. Reviews Completed in 46-60 Days** - The number of reviews that required 46-60 days to complete.

**Line 17. Reviews Completed Over 60 Days** - The number of reviews that required more than 60 days to complete.

**Line 18. Closing Pending-Reviews** - The total number of reviews that have not been completed by the end of the reporting month.

**Line 19. Reviews Pending 1-30 Days** - The number of reviews included in line 18 that have been pending 1-30 days, inclusive, at the end of the reporting month.

**Line 20. Reviews Pending 31-45 Days** - The number of reviews included in line 18 that have been pending 31-45 days, inclusive, at the end of the reporting month.

**Line 21. Reviews Pending 46-60 Days** - The number of reviews included in line 18 that have been pending 46-60 days, inclusive, at the end of the reporting month.

**Line 22. Reviews Pending Over 60 Days** - The number of reviews included in line 18 that have been pending more than 60 days at the end of the reporting month.

Computing Time to Process Carrier Hearings for Lines 23-27

For lines 23-27, the carrier uses the matrix below to determine the number of days from receipt to completion of hearings. The date of receipt in all cases is the day the carrier who is processing the case received it in its corporate mailroom. In out-of-area cases the receipt date is the date that the second carrier received the request.

| Situation | Date Completed |
|---|---|
| An OTR decision is made and the appellant accepts the decision or decides to go directly to an ALJ hearing. | The date of the OTR decision. |
| An OTR decision is made, and the appellant chooses in a timely fashion, to proceed with the in-person or telephone hearing. | The date of the second decision. If the appellant does not appear, and the carrier dismisses the hearing, it uses the date of the dismissal notice. |

| | |
|---|---|
| An in-person or telephone hearing is held without an OTR decision. | The date of the decision. |
| The appellant withdraws the hearing request. | The date the carrier was notified of the withdrawal. |
| The HO dismisses the hearing request. | The date of the dismissal notice. |

**Line 23. Hearing Processing Time - Average** - The carrier reports the average number of days from the receipt of the hearing request to the date of completion. See methodology under line 13.

**Line 24. Hearings Completed in 1-60 Days** - The number of hearings that required 1-60 days to complete. If a case is cleared the same day it is received, the carrier considers it to require 1 day.

**Line 25. Hearings Completed in 61-90 Days** - The number of hearings that required 61-90 days to complete.

**Line 26. Hearings Completed in 91-120 Days** - The number of hearings that required 91-120 days to complete.

**Line 27. Number Completed Over 120 Days** - The number of cases that required 121 days or more to complete.

**Line 28. Closing Pending-Hearings** - The total number of hearings that have not been completed by the end of the reporting month.

**Line 29. Hearings Pending 1-60 Days** - The number of hearings included in line 28 that were pending 1-60 days, inclusive, at the end of the reporting month.

**Line 30. Hearings Pending 61-90 Days** - The number of hearings included in line 28 that were pending 61-90 days, inclusive, at the end of the reporting month.

**Line 31. Hearings Pending 91-120 Days** - The number of hearings included in line 28 that were pending 91-120 days, inclusive, at the end of the reporting month.

**Line 32. Hearings Pending Over 120 Days** - The number of hearings included in line 28 that were pending more than 120 days at the end of the reporting month.

HEARING RESULTS

Hearings fall into the following categories:

**Column (1) On-the-Record with No Subsequent Hearings** - This column represents hearings where:

- The appellant originally requested an OTR hearing.
- The appellant indicated that the appellant was satisfied with the OTR decision, or
- That the appellant wished to proceed with an ALJ hearing (if the amount in controversy is $500 or more). In addition, if the appellant requests an in-person or telephone hearing subsequent to an OTR decision, but the hearing is dismissed or withdrawn, it is included here and not in columns (2) or (3).

**Column (2) All Telephone** - This column represents hearings where the appellant requested and had a telephone hearing subsequent to an OTR hearing decision, or a telephone hearing was held without a prior OTR decision. The carrier counts <u>all</u> telephone hearings including those where the appellant did not follow-up timely to the OTR notice but later requested a telephone hearing.

**Column (3) All In-Person** - This column represents hearings where the appellant requested and had an in-person hearing subsequent to an OTR hearing decision, or an in-person hearing was held without a prior OTR decision. The carrier counts all in-person hearings including those where the appellant did not follow-up timely to the OTR notice but later requested an in-person hearing.

**Column (4) Number in 120 Days** - For the total cases included in line 35, columns 2 and 3, the carrier shows for lines 37-39 the numbers that were completed within 120 days of receipt. It uses the methodology shown for lines 23-27 to determine the completion date. Where an OTR decision is made and the appellant chooses to not follow-up timely and later requests either an in-person or telephone hearing, the carrier measures the completion time for this second reported hearing from the date of receipt of the original request to the date of the second decision. If the appellant does not appear, it dismisses the hearing, and uses the date of notice of dismissal as its date completed.

**Line 33. Reversals** - Under the appropriate columns, the carrier shows the number of OTR, telephone, and in-person hearings completed in the month in which at least part of the review determination was reversed; i.e. a change was made and some, or all, of the new determination was in favor of the appellant. (See line 11 for a definition of a reversal.)

**Line 34. Affirmation** - Under the appropriate columns, the carrier shows the number of OTR, telephone, and in-person hearings completed in the month in which the review determination was completely upheld; i.e., no change was made. (See line 9 for a definition of affirmation.)

**Line 35. Total Decisions** - The carrier *reports* the total number of hearing decisions completed during the month that resulted in a reversal or affirmation (exclude dismissals and withdrawals). This includes those hearings shown in lines 9 and 11.

**Line 36. Number in 120 Days** - For cases included in line 35, the carrier shows the number that were completed within 120 days of receipt. It uses the methodology shown in column (4) to determine the completion date.

**Line 37. No Previous OTR Held** - For cases included in line 35, columns (2) and (3), the carrier reports the number where it held the telephone or in-person hearing without first making an OTR decision (i.e., the OTR hearing was bypassed.) In column (4), it reports the number of cases included in either column (2) or (3) that were completed within 120 days.

**Line 38. Previous OTR Counted** - For cases included in line 35, columns (2) and (3), the carrier reports the number where it included the **OTR** count on a previous report. In column (4), it reports the number of cases included in either column (2) or (3) that were completed within 120 days. Cases reported in line 38 are those where an OTR decision was made, and the appellant either accepted the OTR decision, did not respond timely in accordance with The Medicare Claims Processing Manual, Chapter 30, Beneficiary Correspondence and Appeals, or decided to go directly from the OTR decision to an ALJ hearing. Then, subsequent to this OTR decision "acceptance," the appellant decided that they wanted a telephone or in-person hearing. **The carrier does not include these cases in line 6.**

**Line 39. Previous OTR Not Counted** - For cases included in line 35, columns (2) and (3), the carrier reports the number where it did not include the **OTR** count on a previous report. These are cases where it made the OTR decision first and the appellant indicated in a timely fashion that they wanted a telephone or in-person hearing. In column (4), it reports the number of cases included in either column (2) or (3) that were completed within 120 days.

## 360.3 - Section B - ALJ Hearings

***(Rev.12894; 10-17-24; Effective:11-01-24; Implementation:11-01-24)***

**B3-13410.3**

Section B is intended for all requests for ALJ hearings including those expected to be dismissed for failure to meet the $500 amount in controversy requirement or for any other reason (such as a lack of a fair hearing).

The carrier counts ALJ Hearings in Columns 1 and 2 using the following two methodologies:

**Column (1) Total** - The total of all ALJ hearing requests as originally filed.

**Column (2) Dispositions** - For lines 49 and 51-53 only, the carrier *reports* the number of dispositions rendered by the ALJ(s) in cases reported as cleared for the month in Line 49. There will usually be more ALJ dispositions than cases counted in line 49. A case is not counted in line 49 until the ALJ has cleared **all of the claims** included in the request for hearing.

**EXAMPLE:** The carrier forwards one request to an ALJ involving 20 claims. The ALJ dismisses 10 claims at once. A month later, the ALJ decides to affirm the original decision on 5 others as one group. The other 5 receive separate determinations. This is counted as 7 dispositions.

**Line 40. Opening Pending** - The number of ALJ hearings reported on line 57 as closing pending on the previous month's report.

**Line 41. Adjustments to Pending** - If line 42 of the current month differs from data in line 57 of the previous month, there must be an entry in line 41 for the current month. The carrier precedes the entry by a "+" or "-", as appropriate. See definition for line 2.

**Line 42. Adjusted Opening Pending** - The result of line 40 + line 41 (taking into account the "-" sign, if any).

**Line 43. Requests Received** - The number of ALJ hearings requested during the month. (See The Medicare Claims Processing Manual, Chapter 30, Beneficiary Correspondence and Appeals.)

**Line 44. Requests Forwarded to ALJ** - The number of ALJ hearing requests forwarded to ALJs during the month. The carrier considers the case forwarded when all necessary material has been mailed to the ALJ.

**Line 45. No. of Claims Involved** - The number of claims involved in the ALJ hearing requests forwarded to ALJs as reported on line 44. (See MCM-3, §§3000-3000.2 for definition of claim.)

**Line 46**. **No. Forwarded in 1-7 Days** - The number of ALJ hearing requests forwarded to ALJs within 7 calendar days from receipt of the request to mailing of the necessary information. The carrier shows data for all cases mailed during the month. The number must be less than, or equal to, the number shown in line 44.

**Line 47. No. Forwarded in 1-14 Days** - The number of ALJ hearing requests forwarded to ALJs within 14 days from receipt of the request to mailing of the necessary information. The carrier shows data for all cases mailed during the month. The number must be less than, or equal to, the number shown in line 44.

**Line 48. Average Time to Forward** - The average number of calendar days from receipt of the ALJ request to the mailing date of the necessary information. The carrier the same methodology for counting as discussed in §360.2 for line 13.

**Line 49. ALJ Hearings Completed** - The number of ALJ hearing requests completed during the month. The carrier considers a case completed when it receives the completed decision from the ALJ for all parts of the case.

**Line 50. Amount in Controversy** - For ALJ hearings reported as affirmed (line 51) or reversed (line 53), during the month, the carrier shows the total dollar amount remaining in controversy according to the initial ALJ hearing request. This should be the amount remaining after previous appeal decisions. (See The

Medicare Claims Processing Manual, Chapter 30, Beneficiary Correspondence and Appeals on how to determine the amount in controversy.) **It rounds results to the nearest dollar.**

**Line 51. Affirmations** - The carrier *reports* number of completed ALJ hearings in which the previous determination was completely upheld i.e., no change was made. All parts of all claims in a case must be upheld in order for the case to be counted as an affirmation. See line 53 for partial affirmations. (The carrier does not include partial affirmations on this line.)

If the prior determination is upheld, but payment is made under limitation of liability, the carrier counts the ALJ hearing determination as an affirmation. It reports the appropriate information in lines 55 and 56.

**Line 52**. **Dismissals/Withdrawals** - The e number of completed ALJ hearings that were withdrawn by the appellant or dismissed (before determination) by the ALJ. The carrier reports an appeal that was requested and withdrawn or dismissed within the same month here and in lines 43, 44, and 49.

**Line 53**. **Reversals (Full or Part)** - The total number of completed ALJ hearings in which at least part of the prior determination was reversed i.e., a change was made and some or all of the new determination was in favor of the appellant. For example, if an ALJ hearing involves several claims, and the initial determinations for some of the claims are affirmed and some are reversed, the carrier considers the decision a reversal.

**Line 54**. **Amount Awarded** - For cases included in line 53, the carrier shows the amount of allowed charges for services where the determination was reversed. It shows charges after reasonable charge reductions, but prior to application of deductible and coinsurance amounts. (If the appeal involved a reasonable charge reduction, it shows the additional amount allowed.) It rounds results to the nearest dollar.

**Line 55. Waived - Ben. and Prov** - The number of claims involved in requests for ALJ hearings where limitation of liability was granted to both the beneficiary and provider in an assigned claim (see The Medicare Claims Processing Manual, Chapter X, Limitation on Liability), or where the provider's liability was limited in an unassigned claim(see 3 The Medicare Claims Processing Manual, Chapter X, Limitation on Liability).

**Line 56. Amount Awarded** - For cases included in line 55, the carrier shows the amount of allowed charges for services (including the noncovered services) where the liability of the beneficiary and provider were limited. It shows charges after reasonable charge reductions, but prior to application of deductible and coinsurance amounts, rounding results to the nearest dollar.

**Line 57. Closing Pending** - The total number of ALJ hearing requests that were not completed by the end of the reporting month. The carrier considers a case transferred to an ALJ as pending until it has received the complete decision from the ALJ for all parts of the case.

**Line 58. Effectuation of ALJ Decisions** - The number of ALJ hearing decisions for which it initiated effectuation during the month. The carrier considers effectuation of a decision to be initiated when it completes the following:

- Submission of claim to CWF if payment can be made without further development; or

- Initiation of development e.g., when it must ascertain whether or not the provider has refunded payment to the beneficiary.

**Line 59. Number 1-7 Days** - The number of cases where the carrier effectuated the decision within 7 days, inclusive, of receipt of the decision in its corporate mailroom.

**Line 60. Number 8-15 Days** - The number of cases where the carrier effectuated the decision within 8-15 days, inclusive, of receipt of the decision in its corporate mailroom.

**Line 61. Number 16-30 Days** - The number of cases where the carrier effectuated the decision within 16-30 days, inclusive, of receipt of the decision in its corporate mailroom.

**Line 62. Number Over 30 Days** - The number of cases where the carrier effectuated the decision in more than 30 days, inclusive, of receipt of the decision in its corporate mailroom.

## 360.5 - Section D - Limitation of Liability (Claim Counts)

***(Rev.12894; 10-17-24; Effective:11-01-24; Implementation:11-01-24)***
**B3-13410.5**

ASSIGNED CASES

To include an assigned claim in lines 68-71, the carrier must have originally denied it or reduced it as "not reasonable and necessary" under §1862(a)(1) of the Act. (see The Medicare Claims Processing Manual, Chapter X, Limitation on Liability)

Lines 69-71 are mutually exclusive i.e., a claim meeting the above condition may be counted on only one of the three lines. Therefore, the carrier ensures that the sum of the number of claims recorded on each of these lines equals the total number of assigned claims considered for limitation of liability during the period reported on line 68.

The counts in lines 69-71 reflect counts of **claims** at the initial claim (column 1), review (column 2), and hearing levels (column 3) (as defined in MCM-3, §§3000-3000.2), not review or hearing requests. The carrier reports cases corresponding to the claims counted here in Section A also, as appropriate. If a claim is considered for limitation of liability at the initial claim level, the carrier does not count it at the or hearing level unless it changes the limitation of liability decision.

It categorizes claims for columns shown in Section D according to the adjudication level at which limitation of liability is considered or granted. If it makes several different limitation of liability decisions on the same claim, it uses the highest numbered line on the report that applies to that claim. It counts the claim only once. For instance, if it waives liability for both the beneficiary and provider liability on any part of the claim, it counts the claim only on line 71.

**Line 68. Total Number Considered** - The carrier *reports*, under the appropriate columns, the number of assigned claims meeting the conditions above for which limitation of liability was considered during the month.

**Line 69. Considered - Not Waived** - The carrier *reports* under the appropriate columns the number of assigned claims meeting the conditions above on which limitation of liability was considered but was not granted to the beneficiary.

**Line 70. Waived - Bene. Only** - The carrier shows, under the appropriate columns, the number of assigned claims meeting the conditions above on which it granted limitation of liability to only the beneficiary.
**Line 71. Waived - Bene. and Prov.** - The carrier *reports*, under the appropriate columns, the numbers of assigned claims where it granted limitation of liability during the reporting month to both the beneficiary and provider.

**Line 72. Amount Awarded** - For cases included in line 71, the carrier shows the amount of allowed charges for services (including noncovered services) where limitation of liability is granted to the beneficiary and provider. It shows charges after reasonable charge reductions, but prior to application of deductible and coinsurance amounts, rounding results to the nearest dollar.

UNASSIGNED CASES

This section applies to claims where waiver of a provider's liability to make refund to the beneficiary on unassigned claims for those services found to be not reasonable or necessary is considered under "Limitation on Liability". See The Medicare Claims Processing Manual, Chapter X, Limitation on Liability.

**Line 73. Total Number Considered** - The carrier *reports*, under the appropriate columns, the number of unassigned claims that meet the conditions of §7330 for which limitation of liability was considered during the month.

**Line 74. Phys. Refund Waived** - The carrier *reports*, under the appropriate columns, the number of unassigned claims that meet the requirements of §7330 on which it waived the liability of the provider to refund to the beneficiary the amount disallowed as not reasonable and necessary.

**Line 75. Phys. Refund Upheld** - The carrier *reports*, under the appropriate columns, the number of unassigned claims that meet the requirements of The Medicare Claims Processing Manual, Chapter X, Limitation on Liability chapter, on which it required the physician to refund the amount disallowed.

## 390.2 - Due Date

***(Rev.12894; 10-17-24; Effective:11-01-24; Implementation:11-01-24)***

The carrier/A/B MAC transmits data about the Participating Physician/Supplier Program to CO via PC or terminal. It uses instructions in the CROWD User Guide *available via the CMS Enterprise Portal*.

The report is due 45 days after the end of the enrollment period. It includes updated data as of the end of the most recent enrollment period.

The carrier/A/B MAC does not submit hard copies of the report.

## 400.1 - Heading

***(Rev.12894; 10-17-24; Effective:11-01-24; Implementation:11-01-24)***
**B3-13422.1**

This report is referenced as Form F *for* CROWD. The carrier *submits* the appropriate information *for the reporting period for each office assigned a separate contractor number and BSI*.

## 400.4 - Physician/Limited License Physician Specialty Codes

***(Rev.12894; 10-17-24; Effective:11-01-24; Implementation:11-01-24)***

The following list of codes and narrative describe the kind of medicine physicians practice.

| Code | Physician/Limited License Physician (LLP) Specialty Codes |
|---|---|
| 01 | General Practice |
| 02 | General Surgery |
| 03 | Allergy/Immunology |
| 04 | Otolaryngology |
| 05 | Anesthesiology |
| 06 | Cardiology |
| 07 | Dermatology |
| 08 | Family Practice |
| 09 | Interventional Pain Management |
| 10 | Gastroenterology |
| 11 | Internal Medicine |
| 12 | Osteopathic Manipulative Medicine |
| 13 | Neurology |
| 14 | Neurosurgery |

| Code | Physician/Limited License Physician (LLP) Specialty Codes |
|---|---|
| 16 | Obstetrics/Gynecology |
| 17 | Hospice and Palliative Care |
| 18 | Ophthalmology |
| 19 | Oral Surgery (Dentists only) (LLP) |
| 20 | Orthopedic Surgery |
| 21 | Cardiac Electrophysiology |
| 22 | Pathology |
| 23 | Sports Medicine |
| 24 | Plastic and Reconstructive Surgery |
| 25 | Physical Medicine and Rehabilitation |
| 26 | Psychiatry |
| 27 | Geriatric Psychiatry |
| 28 | Colorectal Surgery (formerly Proctology) |
| 29 | Pulmonary Disease |
| 30 | Diagnostic Radiology |
| 33 | Thoracic Surgery |
| 34 | Urology |
| 35 | Chiropractic (LLP) |
| 36 | Nuclear Medicine |
| 37 | Pediatric Medicine |
| 38 | Geriatric Medicine |
| 39 | Nephrology |
| 40 | Hand Surgery |
| 41 | Optometry (LLP) |
| 44 | Infectious Disease |
| 46 | Endocrinology |
| 48 | Podiatry (LLP) |
| 66 | Rheumatology |
| 70 | Single or Multispecialty Clinic or Group Practice |
| 72 | Pain Management |
| 76 | Peripheral Vascular Disease |
| 77 | Vascular Surgery |
| 78 | Cardiac Surgery |
| 79 | Addiction Medicine |
| 81 | Critical Care (Intensivist) |
| 82 | Hematology |
| 83 | Hematology/Oncology |
| 84 | Preventive Medicine |
| 85 | Maxillofacial Surgery (LLP) |
| 86 | Neuropsychiatry |
| 90 | Medical Oncology |
| 91 | Surgical Oncology |
| 92 | Radiation Oncology |
| 93 | Emergency Medicine |
| 94 | Interventional Radiology |
| 98 | Gynecological Oncology |
| 99 | Unknown Physician Specialty |
| C0 | Sleep Medicine |
| C3 | Interventional Cardiology |
| C5 | Dentist |
| C6 | Hospitalist |
| C7 | Advanced Heart Failure and Transplant Cardiology |

| Code | Physician/Limited License Physician (LLP) Specialty Codes |
|---|---|
| C8 | Medical Toxicology |
| C9 | Hematopoietic Cell Transplantation and Cellular Therapy |
| D3 | Medical Genetics and Genomics |
| D4 | Undersea and Hyperbaric Medicine |
| D7 | Micrographic Dermatologic Surgery |
| D8 | Adult Congenital Heart Disease |
| E1 | Marriage and Family Therapist |
| E2 | Mental Health Counselors |
| E3 | Dental Anesthesiology |
| E4 | Dental Public Health |
| E5 | Endodontics |
| E6 | Oral and Maxillofacial Pathology |
| E7 | Oral and Maxillofacial Radiology |
| E9 | Oral Medicine |
| F1 | Orofacial Pain |
| F2 | Orthodontics and Dentofacial Orthopedics |
| F3 | Pediatric Dentistry |
| F4 | Periodontics |
| F5 | Prosthodontics |
| F6 | Epileptologists |

**NOTE:** Specialty Code Use for Service in an Independent Laboratory. For services performed in an independent laboratory, show the specialty code of the physician ordering the x-rays and requesting payment. If the independent laboratory requests payment, use supplier code "69".

## 400.5 - Non-Physician Practitioner/Supplier Specialty Codes

*(Rev.12894; 10-17-24; Effective:11-01-24; Implementation:11-01-24)*

**The following list of codes and narrative describe the kind of medicine non-physician practitioners or other healthcare providers/suppliers practice.**

| Code | Non-Physician Practitioner/Supplier Specialty Codes |
|---|---|
| 15 | Speech Language Pathologist in Private Practice |
| 31 | Intensive Cardiac Rehabilitation (ICR) |
| 32 | Anesthesiologist Assistant |
| 42 | Certified Nurse Midwife (effective July 1, 1988) |
| 43 | Certified Registered Nurse Anesthetist (CRNA) |
| 45 | Mammography Screening Center |
| 47 | Independent Diagnostic Testing Facility (IDTF) |
| 49 | Ambulatory Surgical Center |
| 50 | Nurse Practitioner |
| 59 | Ambulance Service Supplier, e.g., private ambulance companies, funeral homes |
| 60 | Public Health or Welfare Agencies (Federal, State, and local) |
| 61 | Voluntary Health or Charitable Agencies (e.g., National Cancer Society, National Heart Association, Catholic Charities) |
| 62 | Psychologist (Billing Independently) |
| 63 | Portable X-Ray Supplier (Billing Independently) |
| 64 | Audiologist (Billing Independently) |
| 65 | Physical Therapist in Private Practice |
| 67 | Occupational Therapist in Private Practice |

| | |
|---|---|
| 68 | Clinical Psychologist |
| 69 | Clinical Laboratory (Billing Independently) |
| 71 | Registered Dietitian/Nutrition Professional |
| 73 | Mass Immunization Roster Biller (Mass Immunizers have to roster bill assigned claims and can only bill for immunizations) |
| 74 | Radiation Therapy Centers |
| 75 | Slide Preparation Facilities |
| 80 | Licensed Clinical Social Worker |
| 88 | Unknown Provider |
| 89 | Certified Clinical Nurse Specialist |
| 95 | Unknown Supplier |
| 97 | Physician Assistant |
| A5 | Pharmacy |
| C1 | Centralized Flu |
| C2 | Indirect Payment Procedure |
| C4 | Restricted Use |
| D1 | Medicare Diabetes Prevention Program |
| D2 | Restricted Use |
| D5 | Opioid Treatment Program |
| D6 | Home Infusion Therapy Services |

**Note: Specialty Code Use for Service in an Independent Laboratory. For services performed in an independent laboratory, show the specialty code of the physician ordering the x-rays and requesting payment. If the independent laboratory requests payment, use supplier code "69".**

## 420 - Exhibit

*(Rev.12894; 10-17-24; Effective:11-01-24; Implementation:11-01-24)*

**Exhibit - Participating Physician/Supplier Report - Screen 1**

**PARTICIPATING PHYSICIAN/SUPPLIER REPORT**
**SPECIALTY CODES**

01 General Practice
02 General Surgery
03 Allergy/Immunology
04 Otolaryngology
05 Anesthesiology
06 Cardiology
07 Dermatology
08 Family Practice
09 Interventional Pain Management
10 Gastroenterology
11 Internal Medicine

| | Participants | | | Non-Participants | | Par Drop-Out Current (6) | Non-Par Sign-Up Current (7) | Par Disenrolls (8) |
|---|---|---|---|---|---|---|---|---|
| SPECIALTY CODE/GROUP | Prior (1) | Current (2) | Contin. (3) | Prior (4) | Current (5) | | | |
| 01-PHY | | | | | | | | |
| 02-PHY | | | | | | | | |
| 03-PHY | | | | | | | | |
| 04-PHY | | | | | | | | |
| 05-PHY | | | | | | | | |
| 06-PHY | | | | | | | | |
| 07-PHY | | | | | | | | |
| 08-PHY | | | | | | | | |
| 09-PHY | | | | | | | | |
| 10-PHY | | | | | | | | |
| 11-PHY | | | | | | | | |

**Exhibit 1 - Participating Physician/Supplier Report - Screen 2**

**PARTICIPATING PHYSICIAN/SUPPLIER REPORT**
**SPECIALTY CODES**

12 Osteopathic Manipulative Medicine
13 Neurology
14 Neurosurgery
15 Speech Language Pathologist in Private Practice
16 Obstetrics/Gynecology
17 Hospice and Palliative Care
18 Ophthalmology
19 Oral Surgery (Dentists only)
20 Orthopedic Surgery
21 Cardiac Electrophysiology
22 Pathology
23 Sports Medicine
24 Plastic and Reconstructive Surgery

| SPECIALTY CODE/GROUP | Participants | | | Non-Participants | | Par Drop-Out Current (6) | Non-Par Sign-Up Current (7) | Par Disenrolls (8) |
|---|---|---|---|---|---|---|---|---|
| | Prior (1) | Current (2) | Contin. (3) | Prior (4) | Current (5) | | | |
| 12-PHY | | | | | | | | |
| 13-PHY | | | | | | | | |
| 14-PHY | | | | | | | | |
| 15-NPP | | | | | | | | |
| 16-PHY | | | | | | | | |
| 17-PHY | | | | | | | | |
| 18-PHY | | | | | | | | |
| 19-LLP | | | | | | | | |
| 20-PHY | | | | | | | | |
| 21-PHY | | | | | | | | |
| 22-PHY | | | | | | | | |
| 23-PHY | | | | | | | | |
| 24-PHY | | | | | | | | |

**Exhibit 1 - Participating Physician/Supplier Report - Screen 3**

**PARTICIPATING PHYSICIAN/SUPPLIER REPORT**
**SPECIALTY CODES**

25 Physical Medicine and Rehabilitation
26 Psychiatry
27 Geriatric Psychiatry
28 Colorectal Surgery (formerly Proctology)
29 Pulmonary Disease
30 Diagnostic Radiology
31 Intensive Cardiac Rehabilitation (ICR)
32 Anesthesiologist Assistant
33 Thoracic Surgery
34 Urology
35 Chiropractic
36 Nuclear Medicine
37 Pediatric Medicine

| SPECIALTY CODE/GROUP | Participants | | | Non-Participants | | Par Drop-Out Current (6) | Non-Par Sign-Up Current (7) | Par Disenrolls (8) |
|---|---|---|---|---|---|---|---|---|
| | Prior (1) | Current (2) | Contin. (3) | Prior (4) | Current (5) | | | |
| 25-PHY | | | | | | | | |
| 26-PHY | | | | | | | | |
| 27-PHY | | | | | | | | |
| 28-PHY | | | | | | | | |
| 29-PHY | | | | | | | | |
| 30-PHY | | | | | | | | |
| 31-SUP | | | | | | | | |
| 32-NPP | | | | | | | | |
| 33-PHY | | | | | | | | |
| 34-PHY | | | | | | | | |
| 35-LLP | | | | | | | | |
| 36-PHY | | | | | | | | |
| 37-PHY | | | | | | | | |

**Exhibit 1 - Participating Physician/Supplier Report - Screen 4**

**PARTICIPATING PHYSICIAN/SUPPLIER REPORT**
**SPECIALTY CODES**

38 Geriatric Medicine
39 Nephrology
40 Hand Surgery
41 Optometry
42 Certified Nurse Midwife
43 Certified Registered Nurse Anesthetist (CRNA)
44 Infectious Disease
45 Mammography Screening Center
46 Endocrinology
47 Independent Diagnostic Testing Facility (*IDTF*)
48 Podiatry
49 Ambulatory Surgical Center
50 Nurse Practitioner

| SPECIALTY CODE/GROUP | Participants | | | Non-Participants | | Par Drop-Out Current (6) | Non-Par Sign-Up Current (7) | Par Disenrolls (8) |
|---|---|---|---|---|---|---|---|---|
| | Prior (1) | Current (2) | Contin. (3) | Prior (4) | Current (5) | | | |
| 38-PHY | | | | | | | | |
| 39-PHY | | | | | | | | |
| 40-PHY | | | | | | | | |
| 41-LLP | | | | | | | | |
| 42-NPP | | | | | | | | |
| 43-NPP | | | | | | | | |
| 44-PHY | | | | | | | | |
| 45-SUP | | | | | | | | |
| 46-PHY | | | | | | | | |
| 47-SUP | | | | | | | | |
| 48-LLP | | | | | | | | |
| 49-SUP | | | | | | | | |
| 50-NPP | | | | | | | | |

**Exhibit 1 - Participating Physician/Supplier Report - Screen 5**

**PARTICIPATING PHYSICIAN/SUPPLIER REPORT**
**SPECIALTY CODES**

59 Ambulance Service Supplier
60 Public Health/Welfare Agency
61 Volunteer Health/Charitable Agency
62 Psychologist (Billing Independently)
63 Portable X-Ray Supplier (Billing Independently)
64 Audiologist (Billing Independently)
65 Physical Therapist in Private Practice
66 Rheumatology
67 Occupational Therapist in Private Practice
68 Clinical Psychologist
69 Clinical Laboratory (Billing Independently.)
70 Single or Multispecialty Clinic or Group Practice
71 Registered Dietitian/Nutrition Professional

| SPECIALTY CODE/GROUP | Participants | | | Non-Participants | | Par Drop-Out Current (6) | Non-Par Sign-Up Current (7) | Par Disenrolls (8) |
|---|---|---|---|---|---|---|---|---|
| | Prior (1) | Current (2) | Contin. (3) | Prior (4) | Current (5) | | | |
| 59-SUP | | | | | | | | |
| 60-SUP | | | | | | | | |
| 61-SUP | | | | | | | | |
| 62-NPP | | | | | | | | |
| 63-SUP | | | | | | | | |
| 64-NPP | | | | | | | | |
| 65-NPP | | | | | | | | |
| 66-PHY | | | | | | | | |
| 67-NPP | | | | | | | | |
| 68-NPP | | | | | | | | |
| 69-SUP | | | | | | | | |
| 70-PHY | | | | | | | | |
| 71-NPP | | | | | | | | |

**Exhibit 1 - Participating Physician/Supplier Report - Screen 6**

## PARTICIPATING PHYSICIAN/SUPPLIER REPORT
## SPECIALTY CODES

72 Pain Management
73 Mass Immunization Roster Biller
74 Radiation Therapy Centers
75 Slide Preparation Facilities
76 Peripheral Vascular Disease
77 Vascular Surgery
78 Cardiac Surgery
79 Addiction Medicine
80 Licensed Clinical Social Worker
81 Critical Care (Intensivist)
82 Hematology
83 Hematology/Oncology
84 Preventative Medicine

| SPECIALTY CODE/GROUP | Participants | | | Non-Participants | | Par Drop-Out Current (6) | Non-Par Sign-Up Current (7) | Par Disenrolls (8) |
|---|---|---|---|---|---|---|---|---|
| | Prior (1) | Current (2) | Contin. (3) | Prior (4) | Current (5) | | | |
| 72-PHY | | | | | | | | |
| 73-SUP | | | | | | | | |
| 74-SUP | | | | | | | | |
| 75-SUP | | | | | | | | |
| 76-PHY | | | | | | | | |
| 77-PHY | | | | | | | | |
| 78-PHY | | | | | | | | |
| 79-PHY | | | | | | | | |
| 80-NPP | | | | | | | | |
| 81-PHY | | | | | | | | |
| 82-PHY | | | | | | | | |
| 83-PHY | | | | | | | | |
| 84-PHY | | | | | | | | |

**Exhibit 1 - Participating Physician/Supplier Report - Screen 7**

**PARTICIPATING PHYSICIAN/SUPPLIER REPORT**
**SPECIALTY CODES**

85 Maxillofacial Surgery
86 Neuropsychiatry
88 Unknown Provider
89 Certified Clinical Nurse Specialist
90 Medical Oncology
91 Surgical Oncology
92 Radiation Oncology
93 Emergency Medicine
94 Interventional Radiology
95 Unknown Supplier
97 Physician Assistant
98 Gynecological Oncology
99 Unknown Physician Specialty

| SPECIALTY CODE/GROUP | Participants | | | Non-Participants | | Par Drop-Out Current (6) | Non-Par Sign-Up Current (7) | Par Disenrolls (8) |
|---|---|---|---|---|---|---|---|---|
| | Prior (1) | Current (2) | Contin. (3) | Prior (4) | Current (5) | | | |
| 85-LLP | | | | | | | | |
| 86-PHY | | | | | | | | |
| 88-NPP | | | | | | | | |
| 89-NPP | | | | | | | | |
| 90-PHY | | | | | | | | |
| 91-PHY | | | | | | | | |
| 92-PHY | | | | | | | | |
| 93-PHY | | | | | | | | |
| 94-PHY | | | | | | | | |
| 95-SUP | | | | | | | | |
| 97-NPP | | | | | | | | |
| 98-PHY | | | | | | | | |
| 99-PHY | | | | | | | | |

**Exhibit 1 - Participating Physician/Supplier Report - Screen 8**

**PARTICIPATING PHYSICIAN/SUPPLIER REPORT**
**SPECIALTY CODES**

A5 Pharmacy
C0 Sleep Medicine
C1 Centralized Flu
C2 Indirect Payment Procedure
C3 Interventional Cardiology
C4 Restricted Use
C5 General Dentist
C6 Hospitalist
C7 Advanced Heart Failure and Transplant Cardiology
C8 Medical Toxicology
C9 Hematopoietic Cell Transplantation and Cellular Therapy
D1 Medicare Diabetes Prevention Program
D2 Restricted Use
D3 Medical Genetics and Genomics
D4 Undersea and Hyperbaric Medicine
D5 Opioid Treatment Program
D6 Home Infusion Therapy Services
D7 Micrographic Dermatologic Surgery
D8 Adult Congenital Heart Disease
E1 Marriage and Family Therapist
E2 Mental Health Counselors
E3 Dental Anesthesiology
E4 Dental Public Health
E5 Endodontics
E6 Oral and Maxillofacial Pathology
E7 Oral and Maxillofacial Radiology
E9 Oral Medicine
F1 Orofacial Pain
F2 Orthodontics and Dentofacial Orthopedics
F3 Pediatric Dentistry
F4 Periodontics
F5 Prosthodontics
F6 Epileptologists

| SPECIALTY CODE/GROUP | Participants | | | Non-Participants | | Par Drop-Out Current (6) | Non-Par Sign-Up Current (7) | Par Disenrolls (8) |
|---|---|---|---|---|---|---|---|---|
| | Prior (1) | Current (2) | Contin. (3) | Prior (4) | Current (5) | | | |
| A5-SUP | | | | | | | | |
| C0-PHY | | | | | | | | |
| C1-NPP | | | | | | | | |
| C2-NPP | | | | | | | | |
| C3-PHY | | | | | | | | |
| C4-RES | | | | | | | | |
| C5-PHY | | | | | | | | |
| C6-PHY | | | | | | | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| C7-PHY | | | | | | | | |
| C8-PHY | | | | | | | | |
| C9-PHY | | | | | | | | |
| D1-SUP | | | | | | | | |
| D2-RES | | | | | | | | |
| D3-PHY | | | | | | | | |
| D4-PHY | | | | | | | | |
| D5-SUP | | | | | | | | |
| D6-SUP | | | | | | | | |
| D7-PHY | | | | | | | | |
| D8-PHY | | | | | | | | |
| E1-PHY | | | | | | | | |
| E2-PHY | | | | | | | | |
| E3-PHY | | | | | | | | |
| E4-PHY | | | | | | | | |
| E5-PHY | | | | | | | | |
| E6-PHY | | | | | | | | |
| E7-PHY | | | | | | | | |
| E9-PHY | | | | | | | | |
| F1-PHY | | | | | | | | |
| F2-PHY | | | | | | | | |
| F3-PHY | | | | | | | | |
| F4-PHY | | | | | | | | |
| F5-PHY | | | | | | | | |
| F6-PHY | | | | | | | | |

**Exhibit 1 - Participating Physician/Supplier Report - Screen 9**

**PARTICIPATING PHYSICIAN/SUPPLIER REPORT**
**SPECIALTY CODES**

Total Physicians - The contractor *reports* in the appropriate column the total of all specialty codes applicable to physicians.

Total LLPs - The contractor *reports* in the appropriate column the total of all specialty codes applicable to limited license physicians.

Total NPPs - The contractor *reports* in the appropriate column the total of all specialty codes applicable to non-physician practitioners.

Total Physicians/LLPs/NPPs - The contractor *reports* in the appropriate column the sum of all physicians, LLPs and NPPs.

Total Suppliers - The contractor *reports* in the appropriate column the total of all specialty codes applicable to suppliers.

| SPECIALTY CODE/GROUP | Participants | | | Non-Participants | | Par Drop-Out Current (6) | Non-Par Sign-Up Current (7) | Par Disenrolls (8) |
|---|---|---|---|---|---|---|---|---|
| | Prior (1) | Current (2) | Contin. (3) | Prior (4) | Current (5) | | | |
| | | | | | | | | |
| TOTALs | | | | | | | | |
| | | | | | | | | |
| PHYs* | | | | | | | | |
| LLPs* | | | | | | | | |
| NPPs* | | | | | | | | |
| PHYs/LLPS/NPPs* | | | | | | | | |
| | | | | | | | | |
| SUPs* | | | | | | | | |

* These lines do not represent specific specialty codes. They are the totals of the specialty sub-groups.

## 460.1 – General

***(Rev.12894; 10-17-24; Effective:11-01-24; Implementation:11-01-24)***

At the end of each month, the contractor prepares and transmits to CMS a report summarizing monthly activity on redeterminations processed by A/B and DME MACs, as well as those actions associated with reconsiderations, and Administrative Law Judge (ALJ) hearings and Part A and Part B Medicare Appeals Council effectuations that are processed by A/B and DME MACs. Contractors shall complete separate reports for each office where a separate A/B or DME MAC Jurisdictional identification number has been assigned.

**NOTE:** The report is NOT designed to be completed by the Qualified Independent Contractor (QIC) or the Administrative Qualified Independent Contractor (AdQIC). All data shall be entered by the contractor except for those lines that are indicated as “Not Applicable” (e.g., Medicare Approved Amount). The data in the “Not Applicable” lines are not required. Contractors shall continue to use the CMS-2591 and CMS-2590 reports to capture data on appeal workloads received prior to the implementation date of the CMS-2592 report. The CMS-2591 and 2590 reports will be used to record appeals related data received prior to

the implementation of the CMS-2592 report until all pending appeals workloads have been completed. If a case was received prior to the implementation of the CMS-2592, and as such is captured on the CMS-2591 or CMS-2590, tracking for the case remains on the CMS-2591 or CMS-2590 until all levels of appeal for the case have been completed.

**Note:** The CMS-2591 and 2590 reports will continue to be used to capture reopenings data that is not clerical in nature, and as such, is not captured on the CMS-2592 report.

Form CMS-2592 is subject to the Paperwork Reduction Act and requires approval by the Office of Management and Budget (OMB). OMB approval has been requested.

**Purpose and Scope**--The CMS-2592 enables CMS to tabulate data for administrative purposes on the following information.

- The number of redeterminations, reconsiderations, and ALJ hearings requested, completed, and pending;
- The number of redeterminations resulting in affirmations or reversals of previous determinations;
- Timeliness Data (including processing, forwarding and effectuation data at various levels of appeal); and,
- Clerical Error Reopenings Data

Unless specifically indicated, data on the CMS-2592 Report is captured in cases. Where noted, information is also requested in claims. Information on decisions is also requested, as applicable.

**Due Date** -Transmit the CMS-2592 to CO via PC or terminal. Use instructions in the CROWD User Guide *available via the CMS Enterprise Portal*.

The report is due as soon as possible after the end of the reporting month but no later than the 15th of the month following the end of the reporting month.

**COMPLETION OF ITEMS ON FORM CMS-2592**

**Heading –** This *report* is referenced as *F*orm 7 *for* CROWD. *It submits* the appropriate information *for the reporting period for each office assigned a separate contractor number and BSI*.

**General Information – Completing the Report**

Refer to the information below when determining how to count and categorize data for reporting purposes.

**Controlling Receipt of Cases -** In order to ensure that cases are processed timely, cases shall be date stamped or controlled in some way upon receipt. The date of receipt in all cases is the day the processing contractor received the request in its corporate mailroom. The days elapsed for an individual request are calculated using the number of days starting from the Julian date of case receipt through the Julian date of completion. Include the time required for the response to be mailed to the appellant. For example, a case that is received and processed on January 7 is considered to require1 day to clear. A case received on January 7 and cleared on January 8 is considered to require 2 days to clear. Consider the day of receipt to be Day 1.

Cases that are not received in the mailroom (for example, requests from the QIC for case files received by fax or telephone) shall be controlled in some way to ensure that timeliness requirements are met.

**Counting Cases --** If an appellant submits one request involving several different claims (and several different beneficiaries), count it as one case. If the contractor receives one envelope with multiple request forms and supporting documentation, count 1 case per request received. For example, if the envelope contains 10 separate request forms with supporting documentation, count as 10 cases.

**Counting Part A, B of A and Part B Claims -** If an appellant submits one request involving 5 different claims, count as 5 claims. If an appellant submits one request involving 1 claim, count as 1 claim. If the appellant submits two cases in the same envelope, of which one case has 3 claims and the other 4 claims, count as 2 cases with 7 claims. If an appellant submits a case containing 7 claims, of which 5 are requests for an appeal and the remaining 2 are determined to be reopenings, count the 5 appeal claims among the appeals workload. The remaining 2 claims shall not be counted among the appeals workload, but shall be counted as reopenings (see Line 1 of the Reopenings Section).

**Counting Part A, B of A and Part B Cases Involving Appeals and Reopenings –** If you receive a case involving multiple claims and some claims are subject to appeal but others must be handled as a reopening, count the case as an appeal. **Note**: Reopenings data is captured by claims only. Because of this, no case count is recorded for reopenings.

**Additional Evidence Submitted After Request is Received --** If you receive a case for which additional documentation is submitted for some but not all of the claims, count the case among those recorded on Line 7 (Cleared - Evidence Submitted After Request).

**When to Consider a Case Reversed --** Consider a case reversed when the initial determination is changed upon appeal, (e.g., the claim was denied at the initial determination level but is reversed when the case is appealed).

**When to Consider a Case Completed –** Consider a case to be completed when you complete the action that sets in motion correct payment of the claim **and** you mail the decision letter to the appellant. All redeterminations shall be processed **and <u>mailed</u>** by the 60th day (unless additional evidence is submitted by the party after the request is received, in which case the contractor has up to 14 additional days for each submission to process and mail the decision letter to the parties.

See Line 6.1 for additional guidance.

**When to Consider a Case Effectuated** – Consider effectuation of a decision to be completed when payment is issued to the appellant based on a fully favorable or partially favorable decision. If you enter the adjustment in the month of July, but payment is not issued to the appellant until August, the case is considered to be effectuated in August.

**Note:** Considering a case to be completed is different from determining when a case is effectuated. Note the distinctions in the previous paragraphs. It is possible for some overlap of completion and effectuation timeframes to occur.

## 460.2 - Section I – Redeterminations

***(Rev.12894; 10-17-24; Effective:11-01-24; Implementation:11-01-24)***

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

This section concerns data from Part A and Part B of A appeals processed by A/B MACs (A) as well as Part B appeals processed by A/B MACs (B) and DME MACs.

**Redeterminations**. The number of redeterminations requested (received), completed, and pending reflects the status of the workload as of the last day of the reporting month. Base data on actual counts of each activity and not on sampling or other estimating techniques.

A redetermination is the first level of appeal following an initial determination of a Part A claim or Part B claim. It is a re-evaluation of the facts and findings of a claim to determine whether the initial decision was correct. (See the Medicare Claims Processing Manual, Publication 100-04, Chapter 29, Section 310.)

Do not count duplicate redetermination requests or redetermination requests received before you have made an initial determination on a claim. Do not count inquiries. Count one redetermination per request received. With the exception of those lines for which claims counts are specifically requested in the report, count only cases. Do not count a duplicate request for appeal as a processed appeal. Duplicate requests can be reflected in Line 2 (Adjustment to Pending) of the CMS-2592 Report for the subsequent month.

Redeterminations fall into the following categories:

**Column (1)** Part A Cases- Use Column 1 to report information on Part A services processed by the A/B MAC (A).

**Column (2)** Part B of A Cases- Use Column 2 to report information on Part B services processed by the A/B MAC (A).

**Column (3)** Part B Cases- Use Column 3 to report information on Part B services processed by the A/B MAC (B) or DME MAC.

**Line 1. Opening Pending** - Show under columns 1-3, the number of redetermination cases reported on Line 21 as the closing pending redetermination cases on the previous month's report.

**Line 2. Adjustments to Pending** - CMS understands that it is often necessary to revise the categorization of data from the original categorization given when a case was initially received at the contractor. Likewise, it is often necessary to move data from one line to another in order to maintain accuracy. Prior to the submission of the monthly 2592 report to CMS, contractors are permitted to make changes to data during the reporting month to ensure that appeal workloads are accurately reflected.

Once the monthly 2592 report has been submitted to CMS, any changes to the closing pending figure of the report must be reflected in the Adjustments to Pending line of the subsequent month's report. If it is necessary to revise the pending figure for the close of the **previous** month's report because of inventories or reporting errors, enter the adjustment. If some cases were not counted in the proper month's receipts, count them as adjustments to the opening pending count in the subsequent month. Examples include any instances where something originally categorized as an appeal was determined not to be an appeal, or vice-versa. Duplicate requests for redetermination are also reflected here. If the contractor receives a request for appeal near the end of the reporting month but the case arrives too late to be reflected as a receipt in the CMS-2592 report for that month, count the case in the Adjustment to Pending line of the subsequent month's report. The purpose of the Adjustments to Pending line is to allow the contractor to modify Opening Pending counts, thereby correcting errors resulting from inventory or reporting problems that were identified after the submission of the CMS-2592 previous month's report to CMS.

Do not make adjustments to the Pending line or other lines of the 2592 report once the report has been submitted to CMS. If there is an entry for Line 2, it should be preceded by a "+" or "-", as appropriate.

**Line 3. Adjusted Pending** - Enter the result of Line 1 + Line 2 (taking into account the "-" sign, if any).

**Line 4. Requests Received** - Show, under the appropriate columns, the number of requests for redeterminations received during the reporting month. Include requests transferred to you by other A/B or DME MACs or remanded by the Qualified Independent Contractor (QIC).

**NOTE:** See the "Note" under Line 6 (Requests Cleared) regarding the handling of Medicare Secondary Payer (MSP) cases.

**Line 4.a. Adjusted Requests Received** - As a result of actions taken by the A/B and DME MACs to process appeals during the reporting month, show on this line the number of receipts that have actually been validated by the MAC to be a redetermination. This line should include both RAC and non-RAC redeterminations.

**NOTE:** See the "Note" under Line 6 (Requests Cleared) regarding the handling of Medicare Secondary Payer (MSP) cases.

**Line 4.1. Number of Claims Received –** Show the total number of redetermination claims involved in Line 4.a.

**Line 4.2. Recovery Audit Contractor (RAC) Requests Received -** Of the redetermination requests reported in Line 4.a, show the number that are Recovery Audit related. Line 4.2 is a subset of Line 4.a and should contain only RAC redeterminations.

**Line 4.2.1. Number of RAC Claims Received –** Show the number of redetermination claims involved in Line 4.2.

**Line 5. Misrouted Requests Forwarded to Another Contractor** - Show under columns 1 through 3 the number of redetermination requests the contractor forwarded to other contractors, because they were misrouted to you and you did not process the original claim(s). For columns 1-3, if you have reported a redetermination as forwarded, do not report any information regarding it on Lines 6-29. The forwarding of the misrouted request is the final action.

**NOTE:** This line is not intended for QIC reconsideration requests that were misrouted.

**Line 6. Requests Cleared -** Show, under the appropriate columns, the total number of redeterminations completed during the month. Report all completed redeterminations, regardless if the final outcome was an affirmation, reversal, withdrawal, or dismissal. Do not count cases that were transferred to another contractor because they were misrouted.

**NOTE:** A/B MACs (A) should count received and completed MSP redetermination cases in Columns 1 of Lines 4 and 6, as appropriate, regardless of whether claims involved are Part A, Part B or a combination. Do not count or report claims involved in MSP cases. MSP cases should be counted in Lines 4, 6, 7, 8, 9, 10 and 11. Do not count MSP claims on Lines 4.1, 6.1, 7.1, 8.1, 9.1, 10.1 and 11.1.

A/B MACs (B) that handle MSP cases should count them in Column 3.

**Line 6.1. Number of Claims Cleared –** Show the total number of claims involved in Line 6.

**NOTE:** For Lines 6.1 through 11.1 (letters a through i), enter the number and type of claim processed. If no claims from a certain claim type are processed, *report zero (0)*. Refer to instructions for the CMS-1565 and 1566, as well as appropriate sections of the Claims Processing Manual for guidance on determining the categories and types of claims processed by A/B MACs and DME MACs.

Line 6.1a – Report the number of SNF claims included in Line 6.1. Line 6.1b – Report the number of Home Health claims included in Line 6.1. Line 6.1c – Report the number of Inpatient Hospital claims included in Line 6.1. Line 6.1d – Report the number of Outpatient claims included in Line 6.1. Line 6.1e – Report the number of Lab claims included in Line 6.1. Line 6.1f – Report the number of Ambulance claims included in Line 6.1. Line 6.1g – Report the number of DME claims included in Line 6.1. Line 6.1h – Report the

number of Physician claims reported in Line 6.1. Line 6.1i – Report the number of Other claims or claims where the provider type cannot be determined based on the information on the claim included in Line 6.1.

Consider a redetermination cleared when:

- For affirmations, when all claims of the case are included in the decision and the decision letter is mailed to the parties

- For full and partial reversals:

(1) all claims within the case are included in the decision and the decision letter is mailed to the parties, and

(2) the contractor completes the action that sets in motion correct payment of the claim.

- For withdrawals and dismissals, the dismissal notice is mailed to the parties.

Note that sending a letter to the mailroom does not constitute mailing the letter. Letters must be mailed to the appellant on or before the 60th day in order for the requirement to be met.

**NOTE:** Considering a case to be completed is different from determining when a case is effectuated. Please note the distinctions in the previous paragraphs.

**Line 6.2. Recovery Audit Contractor (RAC) Redeterminations Cleared -** Of the cases reported in Line 6, how many are RAC related?

**Line 6.2.1. Number of RAC Claims Involved –** Show the number of claims involved in Line 6.2.

**Line 7. Cleared -- Evidence Submitted After Request -** Of the cases reported in Line 6, show under the appropriate columns, the total number of redetermination cases for which additional documentation was submitted by the party on his or her own or when the documentation was requested by the contractor after the request was received.

**Line 7.1. Number of Claims Involved –** Show the total number of claims involved in Line 6.1 for which evidence was submitted after the request was received.

Lines 7.1a through 7.1i are Not Applicable. Line 7.1a – Report the number of SNF claims included in Line 7.1. Line 7.1b – Report the number of Home Health claims included in Line 7.1. Line 7.1c – Report the number of Inpatient Hospital claims included in Line 7.1. Line 7.1d – Report the number of Outpatient claims included in Line 7.1. Line 7.1e – Report the number of Lab claims included in Line 7.1. Line 7.1f – Report the number of Ambulance claims included in Line 7.1. Line 7.1g – Report the number of DME claims included in Line 7.1. Line 7.1h – Report the number of Physician claims reported in Line 7.1. Line 7.1i - Report the number of Other claims or claims where the provider type cannot be determined based on the information on the claim included in Line 7.1.

**Line 7.2. RAC Redeterminations Cleared With Additional Documentation -** Of the cases reported in Line 7, how many are RAC related?

**Line 7.2.1. Number of RAC Claims Involved –** Show the number of claims involved in Line 7.2.

**Note about Lines 8-11:**

Count the cases in the following manner:

- If a case has multiple claims and all are affirmed, count the case as an affirmation.

- If a case has multiple claims, some of which are affirmed and others are partially reversed, count the case as a partial reversal. Consider a case reversed when the initial determination is changed upon appeal, irrespective of a change in payment.

- If a case has multiple claims, some of which are partially reversed and others are fully reversed, count the case as a partial reversal. Consider a case reversed when the initial determination is changed upon appeal, irrespective of a change in payment.

- If a case has multiple claims, all of which are fully reversed, count the case as a full reversal.

- If a case has multiple claims, some of which are fully reversed and the others are dismissed or withdrawn, count the case as a full reversal.

- If a case has multiple claims, one of which is affirmed, one of which is a partial reversal and one of which is dismissed, count the case as a partial reversal.

- If a case has multiple claims which are fully reversed, affirmations and withdrawals/dismissals, count the case as a partial reversal.

- If a case has two claims, one of which is affirmed and the other is dismissed, count the case as an affirmation.

| Full | Partial | Affirmation | Dismissal/ Withdrawal | = | Report As |
|---|---|---|---|---|---|
| X | | | | | Full |
| | X | | | | Partial |
| | | X | | | Affirmation |
| | | | X | | Dismissal/ Withdrawal |
| X | X | | | | Partial |
| X | | X | | | Partial |
| X | | | X | | Full |
| X | X | X | | | Partial |
| X | X | X | X | | Partial |
| | X | X | | | Partial |
| | X | | X | | Partial |
| | | X | X | | Affirmation |
| | X | X | X | | Partial |

**Line 8. Affirmations** - Under the appropriate columns, show the number of completed redeterminations from Line 6 in which the previous determinations were completely upheld; i.e., no change was made. All claims in a case must be upheld in order for the case to be counted as an affirmation. In instances where claims some are affirmed, but all others are dismissed or withdrawn, count the case as an affirmation. (Do not include partial reversals in this line. See Line 9 for partial reversals). Include those instances where the decision was affirmed, but a change in liability was noted.

**Line 8a. Waiver of Liability Amount Paid (Not Applicable) -** Show the amount paid under waiver of liability, on the basis that the party did not know that the service wasn't payable under Medicare.

**Line 8.1. Number of Claims Affirmed –** Show the number of claims involved in Line 6.1 for which the decision was affirmed.

**NOTE --** The following example is counted as an affirmation: A claim is denied at the initial determination level and a redetermination is requested. At the redetermination level, the denial is upheld but the denial is for a reason other than was determined to be applicable at the initial determination level. Count the claim as an affirmation.

Line 8.1a – Report the number of SNF claims included in Line 8.1. Line 8.1b – Report the number of Home Health claims included in Line 8.1. Line 8.1c – Report the number of Inpatient Hospital claims included in Line 8.1. Line 8.1d – Report the number of Outpatient claims included in Line 8.1. Line 8.1e – Report the number of Lab claims included in Line 8.1. Line 8.1f – Report the number of Ambulance claims included in Line 8.1. Line 8.1g – Report the number of DME claims included in Line 8.1. Line 8.1h – Report the number of Physician claims reported in Line 8.1. Line 8.1i – Report the number of Other claims or claims where the provider type cannot be determined based on the information on the claim included in Line 8.1.

**Line 8.2. RAC Redeterminations Affirmed-** Of the affirmation cases reported in Line 8, how many are RAC related?

**Line 8.2.1. Number of RAC Claims Involved –** Show the number of claims involved in Line 8.2.

**Line 9**. **Partial Reversals** - Under the appropriate columns, show the number of completed redeterminations, from Line 6 in which part of the prior determination decision of the appealed lines was reversed. That is, a change was made and some part of the new determination was in favor of the appellant. **NOTE:** Consider a case reversed when the initial determination is changed upon appeal, irrespective of a change in payment.

**Line 9.1. Number of Claims Partially Reversed –** Show the number of claims involved in Line 6.1 for which the decision is partially reversed. Note: It is possible to have zero claims in Line 9.1, even when cases are recorded in Line 9.

Line 9.1a – Report the number of SNF claims included in Line 9.1. Line 9.1b – Report the number of Home Health claims included in Line 9.1. Line 9.1c – Report the number of Inpatient Hospital claims included in Line 9.1. Line 9.1d – Report the number of Outpatient claims included in Line 9.1. Line 9.1e – Report the number of Lab claims included in Line 9.1. Line 9.1f – Report the number of Ambulance claims included in Line 9.1. Line 9.1g – Report the number of DME claims included in Line 9.1. Line 9.1h – Report the number of Physician claims reported in Line 9.1. Line 9.1i – Report the number of Other claims or claims where the provider type cannot be determined based on the information on the claim included in Line 9.1.

**Line 9.2. RAC Redeterminations Partially Reversed–** Of the partially reversed cases reported in Line 9, how many are RAC related?

**Line 9.2.1 Number of RAC Claims Involved –** Show the number of claims involved in Line 9.2.

**Line 10. Full Reversals** - Under the appropriate columns, show the total number of completed redeterminations from Line 6 in which the previous determination decision of the appealed lines was completely reversed. **NOTE:** Consider a case reversed when the initial determination is changed upon appeal, irrespective of a change in payment.

**Line 10.1. Number of Claims Fully Reversed –** Show the number of claims involved in Line 6.1 for which the decision is fully reversed.

Line 10.1a – Report the number of SNF claims included in Line 10.1. Line 10.1b – Report the number of Home Health claims included in Line 10.1. Line 10.1c – Report the number of Inpatient Hospital claims included in Line 10.1. Line 10.1d – Report the number of Outpatient claims included in Line 10.1. Line 10.1e – Report the number of Lab claims included in Line 10.1. Line 10.1f – Report the number of Ambulance claims included in Line 10.1. Line 10.1g – Report the number of DME claims included in Line 10.1. Line 10.1h – Report the number of Physician claims reported in Line 10.1. Line 10.1i – Report the

number of Other claims or claims where the provider type cannot be determined based on the information on the claim included in Line 10.1.

**Line 10.2 RAC Redeterminations Fully Reversed –** Of the fully reversed cases reported in Line 10, how many are RAC related?

**Line 10.2.1 Number of RAC Claims Involved –** Show the number of claims involved in Line 10.2.

**Line 11. Dismissals/Withdrawals** - Report, under the appropriate column, the number of cases from Line 6 that were withdrawn by the appellant or dismissed (before determination) by you. In order for a case to be recorded in Line 11, all claims in the case must be dismissed or withdrawn.

**NOTE: Do not count** cases that were dismissed because they were determined to be incomplete in Line 11. Cases that were dismissed because they were determined to be incomplete should only be counted in Line 12.

**Line 11.1. Number of Claims Dismissed or Withdrawn –** Show the number of claims involved in Line 6.1 which were dismissed or withdrawn.

Line 11.1a – Report the number of SNF claims included in Line 11.1. Line 11.1b – Report the number of Home Health claims included in Line 11.1. Line 11.1c – Report the number of Inpatient Hospital claims included in Line 11.1. Line 11.1d – Report the number of Outpatient claims included in Line 11.1. Line 11.1e – Report the number of Lab claims included in Line 11.1. Line 11.1f – Report the number of Ambulance claims included in Line 11.1. Line 11.1g – Report the number of DME claims included in Line 11.1. Line 11.1h – Report the number of Physician claims reported in Line 11.1. Line 11.1i – Report the number of Other claims or claims where the provider type cannot be determined based on the information on the claim included in Line 11.1.

**Notes:**

Misrouted correspondence and duplicate requests are not dismissals.

**Line 11.2. RAC Redeterminations Dismissed or Withdrawn -** Of the dismissed or withdrawn cases reported in Line 11, how many are RAC related?

**Line 11.2.1. Number of RAC Claims Involved –** Show the number of claims involved in Line 11.2.

**Line 12. Number of Incomplete Redetermination Requests Dismissed -** Enter the number of cases that were dismissed because the request was incomplete. Report incomplete cases in Line 12 only if ALL the claims from the case are incomplete. For information on what constitutes an incomplete request, refer to the Medicare Claims Processing Manual, Publication 100-04; Chapter 29; Section 310.1

> **NOTE:** If one redetermination request contains multiple claims and or line items and is split, report the case according to the overall disposition of the individual claims and/or line items. (In many instances, split cases will be reported as partially reversed).
>
> **Example:** A supplier submits a redetermination request that contains one request with 50 claims involving different beneficiaries. The request contains a name and signature of the appellant/supplier, and the supporting documentation identifies individual claims of the beneficiaries, pertinent Medicare beneficiary identifier and the dates of service. However, for some of the claims, the supplier does not identify the specific services (among the several line items on the claim) that are disputed. The contractor should not dismiss the entire redetermination request. Rather, in this situation, the contractor issues dismissals (incomplete requests) with respect to the individual claims for which the requisite information is incomplete, and issues favorable and/or unfavorable decisions for the remaining claims, as appropriate. For the purposes of reporting, the case is reported

according to the overall disposition of the individual claims and/or line items. If the case contains some affirmations, reversals and dismissals, count the case as partially reversed in Line 9.

**Example:** A supplier submits a redetermination request that contains one request with 50 claims involving different beneficiaries. The request is missing the signature of the appellant/supplier, but identifies the individual claims of the beneficiaries, pertinent names and Medicare beneficiary identifiers, dates of service and the items or services disputed. Since the signature is missing, the entire request would be dismissed as incomplete, and counted in Line 12 of the CMS-2592.

Do not count cases that were dismissed for reasons other than being incomplete on Line 12. Only count those instances for which the entire request is dismissed on Line 12.

**Line 13. Medicare Approved Amount (Not Applicable)** - For cases included in Lines 9 and 10, show the Medicare Approved Amount for services where the initial determination was reversed at the redetermination level, either fully (Line 10) or partially (Line 9). Show charges prior to application of the deductible and coinsurance. Round results to the nearest dollar.

**Processing and Pending Times - This deals with processing and pending times for Part A and Part B appeals.**

**Computing Time to Process Redeterminations for (Lines 6 through 25)**

For Lines 6-25, use the matrix below to determine the number of days from receipt to completion of redeterminations. The date of receipt in all cases is the day the processing contractor received the request in its corporate mailroom. In order to ensure that cases are processed timely, cases should also be date stamped or controlled in some way in the mailroom.

| Situation | Date Completed |
|---|---|
| o The appellant withdraws the request. | The date the dismissal letter is mailed to the party. |
| o The contractor dismisses the request | The date the dismissal letter is mailed to the party. |
| o The contractor reverses the initial determination. | For both full and partial reversals, when the contractor completes the action that sets in motion correct payment of the claim and the contractor mails the decision letter to the party. |
| o The contractor affirms the initial determination | The date the decision letter is mailed to the party. |

**REDETERMINATIONS**

**PROCESSING TIME: REDETERMINATIONS WITH DOCUMENTATION SUBMITTED TIMELY (Lines 14-16)**

**Line 14. Redetermination Processing Time – Average –** Report, under the appropriate columns, the average number of days from receipt of the redetermination in the corporate mailroom to the date of completion. Do not include redeterminations where documentation is submitted after the request (i.e., a redetermination cannot be counted in both Line 14 and Line 17).

To compute the average number of days from request to completion, divide the total days elapsed for all requests (where the documentation was submitted timely) cleared in the month by the number of requests cleared. Round results to the nearest day. The days elapsed for an individual request are calculated using the number of days from the Julian date of case receipt through the Julian date of completion. Include the time required for the response to be mailed to the appellant. If the request is cleared in the year following the year of receipt, add 365 or 366 to the result, as appropriate. (Otherwise, you will get a negative number). If a case is cleared the same day it is received, consider it to require one day. For example, a case that is received and processed on January 7 is considered to require one day to clear. A case received on January 7 and cleared on January 8 is considered to require 2 days to clear.

Include all cases cleared, regardless of whether they were affirmed, reversed, dismissed, or withdrawn.

**Line 15. Redeterminations Completed in 1-60 Days** - Show the number of redeterminations that required 1-60 calendar days to complete (based on the date of receipt of the request in the corporate mailroom). Do not include redeterminations reported in Lines 18-20.

**Line 15a. RAC Redeterminations Completed in 1-60 Days –** Of the total number of appeals reported in Line 15, show the number that are RAC related.

**Line 16. Redeterminations Completed in over 60 Days -** Show the number of redeterminations that required more than 60 calendar days to complete (based on the date of receipt of the request in the corporate mailroom). Do not include redeterminations reported in Lines 18-20.

**Line 16a. RAC Redeterminations Completed in Over 60 Days –** Of the number of appeals reported in Line 16, show the number that are RAC related.

**PROCESSING TIME: Redeterminations with DOCUMENTATION SUBMITTED AFTER REQUEST WAS RECEIVED (Lines 17-20)**

**NOTE:** This section captures information in instances where the party submits additional documentation at the redetermination level (including those instances when the contractor requests the additional documentation) after the initial request for redetermination is received. The contractor must receive the documentation before the 60 day timeframe is up in order for data to be entered into Lines 17-20.

**Line 17**. **Redeterminations Processing Time - Average (Documentation Submitted Later)** – For redeterminations where documentation/evidence is submitted after the request is received, report under the appropriate columns, the average number of days from receipt of the redetermination to the date of completion. Using redeterminations where documentation was submitted later as the basis, follow instructions in Line 14 to calculate the average processing time.

**Line 18. Redeterminations Completed in 1-60 Days (Documentation Submitted Later)** - Show the number of redeterminations from Line 6 where documentation/evidence is submitted after the request is received, and 1-60 calendar days were required to complete the case.

**Line 18a. RAC Redeterminations Completed in 1-60 Days (Documentation Submitted Later) –** Of the number of appeals reported in Line 18, show the number that are RAC related.

**Line 19. Redeterminations Completed in 61-74 Days (Documentation Submitted Later)** - Show the number of redeterminations from Line 6 where documentation/evidence is submitted after the request is received, and 61-74 calendar days were required to complete the case.

**Line 19a. RAC Redeterminations Completed in 61-74 Days (Documentation Submitted Later) –** Of the number of appeals reported in Line 19, show the number that are RAC related.

**Line 20. Redeterminations Completed in over 74 Days (Documentation Submitted Later)** - Show the number of redeterminations from Line 6 where documentation/evidence is submitted after the request is received, and more than 74 calendar days were required to complete the case.

**Line 20a. RAC Redeterminations Completed in over 74 Days (Documentation Submitted Later) –** Of the number of appeals reported in Line 20, show the number that are RAC related.

**Pending Time Frames**

**Line 21. Closing Pending Redeterminations -** Show, under the appropriate columns, the total number of redeterminations that have not been completed by the end of the reporting month. Note: Do not include pending effectuations in this line.

**Line 22. Redeterminations Pending 1-30 Days** – Show the number of redeterminations included in Line 21 that have been pending for 1-30 days, inclusive, at the end of the reporting month.

**Line 23. Redeterminations Pending 31-60 Days** - Show the number of redeterminations included in Line 21 that have been pending 31-60 days, inclusive, at the end of the reporting month.

**Line 24. Redeterminations Pending 61-74 Days -** Show the number of redeterminations included in Line 21 which have been pending 61-74 days, inclusive at the end of the reporting month.

**Line 25. Redeterminations Pending Over 74 Days -** Show the number of redeterminations included in Line 21 which have been pending more than 74 days at the end of the reporting month.

**EFFECTUATION OF REDETERMINATION DECISIONS**

**Line 26. Total Effectuations** - Show the number of redetermination cases for which you effectuated a decision during the month. Consider effectuation of a decision to be completed when you issue payment to the appellant based on a fully favorable or partially favorable decision. Include effectuation of affirmations where changes in liability are at issue. Do not include cases for which no effectuation is required.

**Notes:** Considering a case to be completed is different from determining when a case is effectuated. Please refer to the distinctions in the introductory sections of the2592 report ("When to Consider a Case Completed" and "When to Consider a Case Effectuated").

**Line 26a. Number of Claims Involved –** Show the number of claims involved in Line 26.

**Line 27. Number Effectuated 1-30 Days -** Show the number of claims from Line 26a where you effectuated the decision within 30 calendar days of the date of the decision.

**Line 28. Number Effectuated 31-60 Days** - Show the number of claims from Line 26a where you effectuated the decision within 31- 60 calendar days of the date of the decision.

**Line 29. Number Effectuated Over 60 Days -** Show the number of claims from Line 26a where you effectuated the decision in more than 60 calendar days of the date of the decision.

## 480.1 - Heading

***(Rev.12894; 10-17-24; Effective:11-01-24; Implementation:11-01-24)***

This report, referenced as Form Y *for* CROWD, is used only when program requirements compel CMS to collect data on an interim basis before the data elements can be incorporated into one of the regular forms. The Medicare contractor submit*s* the *appropriate information for the reporting period for each office assigned a separate contractor number and BSI* no later than the 10th day of the following month *using instructions in the CROWD User Guide available via the CMS Enterprise Portal*.