CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-06 Medicare Financial Management	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 126	**Date: JULY 13, 2007**
	Change Request 5642

SUBJECT: Manual Revision Re: MSN Workload Reporting

I. SUMMARY OF CHANGES: This CR manualizes information previously shown in the paper manuals that was never transferred into the IOM. This information pertained to the CMS-1565 and CMS-1566 and instructed contractors to enter the number of MSNs mailed to beneficiaries during the month.

NEW / REVISED MATERIAL
EFFECTIVE DATE: *January 1, 2008
IMPLEMENTATION DATE: January 7, 2008

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	6/20.4/Body of Report
R	6/30.7/Body of Report
R	6/130.4/Part C - Miscellaneous Claims Data
R	6/200/Exhibits

III. FUNDING:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2008 operating budgets.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

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

Attachment - Business Requirements

Pub. 100-06	Transmittal: 126	Date: July 13, 2007	Change Request: 5642

SUBJECT: Manual Revision Re: MSN Workload Reporting

EFFECTIVE DATE: January 1, 2008

IMPLEMENTATION DATE: January 7, 2008

I. GENERAL INFORMATION

A. Background: This CR manualizes information previously shown in the paper manuals that was never transferred into the IOM.

B. Policy: This information pertained to the CMS-1565 and CMS-1566 which instructed contractors to enter the number of MSNs mailed to beneficiaries during the month.

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5642.1	Contractors shall enter the number of MSNs mailed to beneficiaries during the month into the CMS-1565 or CMS-1566 as applicable.	X	X	X	X	X	X		X			

III. PROVIDER EDUCATION TABLE

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

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
	N/A

B. For all other recommendations and supporting information, use this space:

V. CONTACTS

Pre-Implementation Contact(s): Ken Frank (410.786.5659) kenneth.frank@cms.hhs.gov

Post-Implementation Contact(s): Ken Frank (410.786.5659) kenneth.frank@cms.hhs.gov

VI. FUNDING

A. *For Fiscal Intermediaries, Carriers, and the Durable Medical Equipment Regional Carrier (DMERC),* use only one of the following statements:

No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2008 operating budgets.

B. *For Medicare Administrative Contractors (MAC),* use the following statement:

The contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the Statement of Work (SOW). The contractor is not obligated to incur costs in excess of the amounts alloted 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.

20.4 - Body of Report

(Rev. 126; Issued: 07-13-07; Effective: 01-01-08; Implementation: 01-07-08)

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 a carrier or another intermediary;
- HHA bills where no utilization is chargeable and no payment has been made, but which it has requested only to facilitate record keeping processes (There is no CMS requirement for HHAs to submit no payment non-utilization chargeable bills.); and
- Bills paid by an HMO and processed by the intermediary.
- Claims submitted by HHAs under the HH PPS with three-digit classification 3-2-9 or 3-3-9 are processed as adjustments to a previously submitted RAP record. However, the intermediary counts both HHPPS RAPs and claims as initial bills for this report. It does not exempt HH PPS claims as adjustments.

Opening Pending

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

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

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

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

Receipts

Line 4 - Received During Month - The intermediary enters the total number of bills received for initial processing during the month.
It counts all bills immediately upon receipt regardless of whether or not they are put into the processing operation with the exception of those discussed below.

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

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

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

Clearances

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

Line 7 - Payment Approved (CWF) - The intermediary enters the number of initial bills for which **it approved some payment** and for which the CWF host responded accepting the intermediary determination. It includes bills for which it approved payment in full or in part as a result of a determination that both the beneficiary and the provider were without fault (liability waiver). (See The Medicare Claims Processing Manual, Chapter 10, Limitation on Liability.) The intermediary reports here those fully adjudicated,

approved-for-payment bills for which it has received a response from the host and are holding only due to the payment floor.

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

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

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

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

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

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

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

The intermediary reports HMO bills it paid on line 12 and on pages 2-12. It does <u>not</u> 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 <u>not</u> report as pending those bills that it has moved to a processed location after being accepted by the

host and is holding only due to the payment floor. It reports such bills as processed on line 12.

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

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

Bill Investigations

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

SECTION B: ADJUSTMENT BILLS

This section includes data on the number of adjustment bills processed and pending for the reporting month, including those generated by providers, PROs, or as a result of MSP or other activity. In reporting adjustment bills, the intermediary counts only the number of original bills requiring adjustment, not both the debit and credit. The total PRO adjustment bills reported as processed on lines 18 and 23 must equal the number reported as processed on CROWD Form Z, Monthly PRO Adjustment Bill Report.

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

Clearances

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

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

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

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

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

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

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

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

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

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

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

Pending

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

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

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

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

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

SECTION C: MEDICAID CROSSOVER BILLS

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

Clearances

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

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

SECTION D: MISCELLANEOUS DATA
INQUIRIES

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 followup or analysis, or from recontacts by the beneficiary, are separate inquiries. Beneficiary inquiries include those made by anyone on behalf of the beneficiary, **except** by a provider.

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

It includes or excludes beneficiary and provider inquiries as follows:

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

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

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

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

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

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

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

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

- It does not count inquiries that are, in fact, explicit or implicit requests for reconsiderations or hearing. See Medicare Claims Processing Manual, Chapter 30, Beneficiary Correspondence and Appeals. for specifics on what is a request for reconsideration or review.

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

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

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

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

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

OPTICAL CHARACTER RECOGNITION BILLS

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

BILLS PAID BY HMOs

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

MEDICARE SUMMARY NOTICES (MSNs)

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

30.7 - Body of Report

(Rev. 126; Issued: 07-13-07; Effective: 01-01-08; Implementation: 01-07-08)

SECTION F: INTEREST PAYMENT DATA

The intermediary reports on Page 22 of the CMS-1566 data on the bills on which it paid interest because it paid the bills after the required payment date per §9311 of the Omnibus Budget Reconciliation Act of 1986. Counts of bills processed reflect their status as of the last workday of the reporting calendar month. The intermediary bases data shown on reliable counts of all bill processing activity and not on estimates. It reports data on initial bills only. Note that HH PPS RAPs with three-digit classification code 3-2-2 or 3-3-2 with dates of service 10/01/2000 and greater are not subject to interest payment and should be excluded from this section. The intermediary includes all bills requiring interest payments in the month. It reports bills in the month the scheduled date of payment falls. See The Medicare Claims Processing Manual, Chapter 1, General Billing Requirements for a discussion of interest payments and the definition of scheduled payment date.

It the report for each column as follows:

- **Column 1 - Total** - It includes data for all bills for which interest payments were made in the reporting month.

- **Column 2 - Hospital** - Of the bills reported in column 1, it shows in column 2 data for CMS-1450s submitted by hospitals for **inpatient or outpatient** services with the following two-digit classification codes in Form Locator 4:

  1-1 (inpatient hospital)
  1-2 (inpatient hospital - Part B benefits)
  1-3 (outpatient hospital)
  1-4 (hospital - other Part B benefits)
  4-1 (Religious Nonmedical Health Care Hospital - inpatient)
  4-2 (Religious Nonmedical Health Care Hospital - inpatient Part B benefits)
  4-3 (Religious Nonmedical Health Care Hospital - outpatient)
  4-4 (Religious Nonmedical Health Care Hospital - inpatient other)
  8-3 (Outpatient hospital surgical procedures - ASC)

- **Column 3 - SNF**--Of the bills reported in column 1, it shows in column 3 data for CMS- 1450s submitted with the following two-digit classification codes in Form Locator 4:

  1-8 (hospital swing-bed)
  2-1 (SNF - inpatient)
  2-2 (SNF - inpatient Part B benefits)
  2-3 (SNF - outpatient)

2-4 (SNF - other Part B benefits)
2-8 (SNF-swing-bed)
5-1 (Religious Nonmedical Health Care SNF - inpatient)
5-2 (Religious Nonmedical Health Care SNF - inpatient Part B benefits)
5-3 (Religious Nonmedical Health Care SNF - outpatient)
5-4 (Religious Nonmedical Health Care SNF - inpatient other)

- **Column 4 - HHA** - Of the bills reported in column 1, it shows in column 4 data for CMS-1450s with the following two digit classification codes in Form Locator 4: 3-2, 3-3, and 3-4.

- **Column 5 - Hospice** - Of the bills reported in column 1, it shows in column 5 data for CMS-1450s with the following two-digit classification codes in Form Locator 4: 8-1 and 8-2.

- **Column 6 - Remainder** - Of the bills reported in column 1 it shows in column 6 data for all CMS-1450s not included in columns 2-5 (including provider and independent RHCs).

On line 1, it shows the number of claims on which it paid interest in the reporting month. It reports on line 2 the number of claims included in line 1 for which it made payment one day after the required payment date (e.g., the required payment date is 25 days in FY 1999). Data for lines 3-10 are similar to those for line 2. It calculates the number of days late by subtracting the Julian date of receipt of the bill from the Julian scheduled payment date and then subtracting the required payment date (i.e., 25 in FY 1999). If the bill is paid in the year following the year of receipt, it adds 365 or 366 (if the year of receipt is a leap year) to the result, as appropriate.

On line 11, it shows the amount paid in interest on the bills reported in line 1. See The Medicare Claims Processing Manual, Chapter 1, General Billing Requirements on how to calculate interest payments. On lines 12-20 it shows the amounts paid in interest for bills reported in lines 2-10, respectively. It shows payment amounts on lines 11-20 to the nearest penny, including the decimal point.

EXHIBIT 1

Form CMS 1566 - Medicare Program Intermediary Workload Report, Page 1

Intermediary Name:	Reporting Period:
Intermediary Number:	Number of Working Days:

SECTION A: INITIAL BILL PROCESSING	TOTAL **(1)**	**INPATIENT** **(2)**	OUTPATIENT **(3)**	SNF **(4)**	HHA **(5)**	OTHER **(6)**
Opening Pending						
1. Opening Pending						
2. Adjustments (+ or -)						
3. Adj Opening Pending						
Receipts						
4. Received during Month						
5. Electronic Media						
Clearances						
6. Total CWF Bills						
7. Payment Approved						
8. No Payment Approved						
9. Total Non-CWF Bills						
10. Payment Approved						
11. No Payment Approved						
12. Total Processed						
Closing Pending						
13. Pending End of Month						
14. Longer than 1 Month						
15. Longer than 2 Months						

Exhibit 1 (Cont.)

Form CMS 1566 - Medicare Program Intermediary Workload Report, Page 1

Intermediary Name:	Reporting Period:
Intermediary Number:	Number of Working Days:

SECTION A: INITIAL BILL PROCESSING	TOTAL **(1)**	**INPATIENT (2)**	OUTPATIENT **(3)**	SNF **(4)**	HHA **(5)**	OTHER **(6)**
Bill Investigations						
16. Investigations Init						
SECTION B: ADJUSTMENT BILLS						
CWF Clearances						
17. Total CWF Processed						
18. PRO Generated						
19. Provider Generated						
20. MSP						
21. Other						
Non-CWF Clearances						
22. Total Non-CWF Prcsd						
23. PRO Generated						
24. Provider Generated						
25. MSP						
26. Other						

Exhibit 1 (Cont.)

Form CMS 1566 - Medicare Program Intermediary Workload Report, Page 1

Intermediary Name:		Reporting Period:				
Intermediary Number:		Number of Working Days:				
SECTION B: ADJUSTMENT BILLS	TOTAL **(1)**	**INPATIENT (2)**	OUT PATIENT **(3)**	SNF **(4)**	HHA **(5)**	OTHER **(6)**
Pending						
27. Total Pending						
28. PRO Generated						
29. Provider Generated						
30. MSP						
31. Other						
SECTION C: MEDICAID CROSSOVER BILLS						
Clearances						
32. Trans to St Agencies						
33. Trans Electronically						
SECTION D:						
MISCELLANEOUS DATA	TOTAL	BENEFICIARY	PROVIDER			
Inquiries						
34. Total Inquiries						
35. Telephone						
36. Walk-In						
37. Written						

Exhibit 1 (Cont.)

Form CMS 1566 - Medicare Program Intermediary Workload Report, Page 1

Intermediary Name:	Reporting Period:
Intermediary Number:	Number of Working Days:

SECTION D: MISCELLANEOUS DATA	TOTAL **(1)**	**INPATIENT (2)**	OUTPATIENT **(3)**	SNF **(4)**	HHA **(5)**	OTHER **(6)**
OCR Bills						
38. Total Received						
Bills Paid by HMOs						
39. Total Processed						
Medicare Summary Notices						
40. Total MSNs Mailed						

EXHIBIT 2

SECTION E(1): CLAIMS PROCESSING TIMELINESS - ALL CLAIMS

Form CMS 1566 - Medicare Program Intermediary Workload Report, Pages 2-11

Intermediary Number:			Bill Type:			Report Month:		
		******	********	**PAID**	********	***NOT PAID***		
		Non-PIP		***PIP****				
DAYS TO PROCESS	TOTAL (1)	CLEAN (2)	OTHER (3)	CLEAN (4)	OTHER (5)	CLEAN (6)	OTHER (7)	EMC (8)
1.1								
2. 2								
3. 3								
4. 4								
5. 5								
6. 6								
7. 7								
8. 8								
9. 9								
10. 10								
11. 11								
12. 12								

Exhibit 2 (Cont.)

SECTION E(1): CLAIMS PROCESSING TIMELINESS--ALL CLAIMS

Form CMS 1566 - Medicare Program Intermediary Workload Report, Pages 2-11

Intermediary Number:			Bill Type:			Report Month:		
		*******	*******	***PAID***		NOT PAID		
		Non-PIP		****PIP****				
DAYS TO PROCESS	TOTAL (1)	CLEAN (2)	OTHER (3)	CLEAN (4)	OTHER (5)	CLEAN (6)	OTHER (7)	EMC (8)
13. 13								
14. 14								
15. 15								
16. 16								
17. 17								
18. 18								
19. 19								
20. 20								
21. 21								
22. 22								
23. 23								

Exhibit 2 (Cont.)

SECTION E(1): CLAIMS PROCESSING TIMELINESS--ALL CLAIMS

Form CMS 1566 - Medicare Program Intermediary Workload Report, Pages 2-11

Intermediary Number:			Bill Type:			Report Month:		
		********	*******	**PAID**		*NOT PAID*		
		Non-PIP		****PIP****				
DAYS TO PROCESS	TOTAL (1)	CLEAN (2)	OTHER (3)	CLEAN (4)	OTHER (5)	CLEAN (6)	OTHER (7)	EMC (8)
24. 24								
25. 25								
26. 26								
27. 27								
28. 28								
29. 29								
30. 30								
31. 31								
32. 32								
33. 33								

Exhibit 2 (Cont.)

SECTION E(1): CLAIMS PROCESSING TIMELINESS--ALL CLAIMS

Form CMS 1566 - Medicare Program Intermediary Workload Report, Pages 2-11

Intermediary Number:			Bill Type:			Report Month:		
		*******	******	**PAID**		**NOT PAID**		
		Non-PIP		****PIP****				
DAYS TO PROCESS	TOTAL (1)	CLEAN (2)	OTHER (3)	CLEAN (4)	OTHER (5)	CLEAN (6)	OTHER (7)	EMC (8)
34. 34-45								
35. 46-60								
36. 61-90								
37. 91+								
38. Total								
39. Mean PT								

CMS-1566, Page

Page number and bill type to be reported as follows:

Page 2 - Inpatient Hospital (INP)
Page 3 - Outpatient (OUT)
Page 4 - SNF (SNF)
Page 5 - HHA (HHA)
Page 6 - Hospice (HPC)
Page 7 - CORF (COR)
Page 8 - ESRD (ERD)
Page 9 - Lab (LAB)
Page 10 - Other (OTH)
Page 11 - Total (TOT)

EXHIBIT 4

SECTION F: INTEREST PAYMENT DATA

Form CMS 1566 - Medicare Program Intermediary Workload Report, Page 22

Intermediary Number:			Report Month:			
BILLS/PAYMENTS DAYS LATE	**TOTAL (1)**	**HOSPITAL (2)**	**SNF (3)**	**HHA (4)**	**HOSPICE (5)**	**REMAINDER (6)**
1. Total Bills						
2. 1						
3. 2						
4. 3						
5. 4						
6. 5						
7. 6-15						
8. 16-30						
9. 31-60						
10. 61+						
11. Total Paid						
12. 1						
13. 2						
14. 3						
15. 4						

Exhibit 4 (Cont.)

SECTION F: INTEREST PAYMENT DATA

Form CMS 1566 - Medicare Program Intermediary Workload Report, Page 22

Intermediary Number:			Report Month:			
BILLS/PAYMENTS DAYS LATE	**TOTAL (1)**	**HOSPITAL (2)**	**SNF (3)**	**HHA (4)**	**HOSPICE (5)**	**REMAINDER (6)**
16. 5						
17. 6-15						
18. 16-30						
19. 31-60						
20. 61+						

130.4 - Part C - Miscellaneous Claims Data

(Rev. 126; Issued: 07-13-07; Effective: 01-01-08; Implementation: 01-07-08)

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 enters 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 enters 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 enters 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 enters the number of MSNs mailed to beneficiaries during the reporting month.

200 - Exhibits

(Rev. 126; Issued: 07-13-07; Effective: 01-01-08; Implementation: 01-07-08)

Exhibit 1 - Medicare Program Carrier Performance Report- Page 1

MEDICARE PROGRAM CARRIER PERFORMANCE REPORT- Page 1			
Carrier	Number	Report Period (Month/Yr)	Working Days
	Number and Type of Claim		
Reporting Item	Total (1)	Assigned (2)	Unassigned (3)
A. Monthly Workload Operations			
OPENING PENDING			
1. Claims Pndg End of Last Mo.			
2. Adjustments (Show + or -)			
3. Adjusted Opening Pending			
RECEIPTS			
4. Tot. Clms. Rcvd. During Mo.			
5. Transferred to Other Carrier			
6. Net Number of Claims Received			
7. Electronic Media Claims Recvd.			
CLAIMS PROCESSED			
8. Total CWF Claims			
9. Claims Paid			
10. Claims Applied To Deductible			
11. Claims Denied			
12. Total Non-CWF Claims			
13. Claims Approved			
14. Claims Denied			
15. Total Claims Processed			
16. Replicate Claims Processed			

Exhibit 1 (Cont.)

MEDICARE PROGRAM CARRIER PERFORMANCE REPORT- Page 1 (cont)			
Carrier	Number	Report Period (Month/Yr)	Working Days
	Number and Type of Claim		
Reporting Item	Total **(1)**	Assigned **(2)**	Unassigned **(3)**
CLOSING PENDING			
17. Claims Pending at End of Month			
DISTRIBUTION OF DAYS ELAPSED SINCE RECEIPT			
18. 1 - 15 Days			
19. 16 - 30 Days			
20. 31 - 60 Days			
21. 61 - 90 Days			
22. Over 90 Days			
CLAIMS INVESTIGATIONS			
23. No. of Clms. Invest. During Mo.			
B. INQUIRIES	TOTAL	BENEFICIARY	PROVIDER
24. Tot. No. Processed During Mo.			
25. Telephone			
26. Walk-In Contact			
27. Written			
C. MISCELLANEOUS CLAIMS DATA			

MEDICAID CROSSOVER CLAIMS			
28. No. Transferred to St. Agencies			
29. No. Transferred Electronically			

Exhibit 1 (Cont.)

MEDICARE PROGRAM CARRIER PERFORMANCE REPORT- Page 1 (cont)			
Carrier	Number	Report Period (Month/Yr)	Working Days
	Number and Type of Claim		
Reporting Item	Total (1)	Assigned (2)	Unassigned (3)
OPTICAL CHARACTER RECOGNITION CLMS.			
30. Total Claims			
MEDICARE SUMMARY NOTICES			
31. Total MSNs Mailed			

Form CMS-1565

Exhibit 2 - Medicare Program Carrier Performance Report - Form CMS-1565, Pages 2-9

MEDICARE PROGRAM CARRIER PERFORMANCE REPORT -
FORM CMS-1565, Pages 2-9

CARRIER WORKLOAD REPORT - PAGE __*__

PART - D (1) CLAIMS PROCESSING TIMELINESS - ALL CLAIMS

CARRIER ID_____ TYPE OF CLAIM_____*_____ REPORT MO.___

		PAID		NOT PAID		
LINE NO./DAYS	TOTAL (1)	CLEAN (2)	OTHER (3)	CLEAN (4)	OTHER (5)	EMC (6)
1 1						
2 2						
3 3						
4 4						
5 5						
6 6						
7 7						
8 8						
9 9						
10 10						
11 11						
12 12						
13 13						
14 14						
15 15						
16 16						

17 17						
18 18						
19 19						
20 20						
21 21						
22 22						
23 23						
24 24						
25 25						
26 26						
27 27						
28 28						
29 29						

Exhibit 2 (Cont.)

		PAID		NOT PAID		
LINE NO./DAYS	TOTAL (1)	CLEAN (2)	OTHER (3)	CLEAN (4)	OTHER (5)	EMC (6)
30 30						
31 31						
32 32						
33 33						
34 34-45						
35 46-60						
36 61-90						
37 91+						
38 Tot 1-37						
39 Mean Pt						

CMS-1565 Page _*_

* PAGE NUMBER AND TYPE OF CLAIM ARE TO BE REPORTED AS FOLLOWS:

Page 2-Assigned Physician
Page 3-Assigned DME
Page 4-Assigned Lab
Page 5-Assigned Ambulance
Page 6-Assigned Other
Page 7-Unassigned
Page 8-Participating Physician
Page 9-All Claim

Exhibit 3 - Adjustments for CPEP CPT

			EMC PAID		EMC NOT PAID	
ADJUSTMENTS FOR CPEP CPT						
LINE NO./DAYS			CLEAN (1)	OTHER (2)	CLEAN (3)	CALCULATIONS:
1		1				CWF Claims which were beyond carrier control due to CWF.
2		2				
3		3				
4		4				
5		5				A. EMC clean claims Processed beyond EMC
6		6				
7		7				
8		8				B. Paper clean claims Processed beyond Paper ceiling
9		9				
10		10				
11		11				C. All claims processed Beyond 60 days ____
12		12				
13		13				**WAIVER** Claims paid under the floor For which the carrier had a waiver from CMS.
14		14				
15		15				
16		16				
17		17				D. EMC clean claims Paid under EMC floor _____
18		18				
19		19				
20		20				E. Paper clean claims Paid under paper floor _____
21		21				
22		22				
23		23				F. All EMC claims paid under EMC floor and all paper claims paid under paper floor _____
24		24				
25		25				
26		26				
27		27				
28		28				
29		29				
30		30				
31		31				
32		32				
33		33				

Exhibit 3 (Cont.)

			EMC PAID		EMC NOT PAID	
LINE NO./DAYS			CLEAN (1)	OTHER (2)	CLEAN (3)	CALCULATIONS:
34		34-45				
35		46-60				
36		61-90				
37		91+				
38		Tot 1-37				
39		Mean Pt				

CMS-1565 Page _*_

* PAGE NUMBER AND TYPE OF CLAIM ARE TO BE REPORTED AS FOLLOWS:
Page 10-Participating Physician (PAR)
Page 11-Total (TOT)

Exhibit 4 - Carrier Workload Report - Part-E - Interest Payment Data
CARRIER WORKLOAD REPORT - PAGE __*__
PART-E - INTEREST PAYMENT DATA

CARRIER ID
REPORT MONTH

LINE NO CLAIM/PAYMENT LATE DAYS	TOTAL (1)	ASTD PHYS (2)	ASTD DME (3)	ASTD LAB (4)	ASTD AMB (5)	ASTD OTHER (6)	UNASTD (7)	PARTIC. PHYS (8)
1. No. of Claims								
2. 1 Day late								
3. 2 Days Late								
4. 3 Days Late								
5. 4 Days Late								
6. 5 Days Late								
7. 6-15 A Late								
8. 16-30 A Late								
9. 31-60 A Late								
10. 61+ A Late								
11. Amount paid								
12. 1 Day late								
13. 2 Days Late								
14. 3 Days Late								
15. 4 Days Late								
16. 5 Days Late								
17. 6-15 A Late								
18. 16-30 A Late								
19. 31-60 A Late								
20. 61+ A Late								

Exhibit 5 - Carrier Workload Report - Part F - All Trunks Busy (ATB)

CARRIER WORKLOAD REPORT
PART F - ALL TRUNKS BUSY (ATB)

ALL TRUNKS BUSY
CARRIER ID_____ REPORT MONTH_____

	LOCAL CALLS (1)	TOLL FREE CALLS (2)
1. PERCENT OF ATB		
2. NUMBER OF BENEFICIARY CALLS ANSWERED IN 120 SECONDS		
3. TOTAL NUMBER OF BENEFICIARY CALLS RECEIVED		
4. % OF BENEFICIARY CALLS ANSWERED IN 120 SECONDS		
EXPLANATION FOR FAILURES:		