CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-06 Medicare Financial Management	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 175	**Date: October 28, 2010**
	Change Request 7093

SUBJECT: Change the Name of Physician Specialty Code 12 from Osteopathic Manipulative Therapy to Osteopathic Manipulative Medicine

I. SUMMARY OF CHANGES: This CR updates Publication 100-06 Chapter 6 Section 420 - Exhibits, in response to CR 6890 (Effective January 1, 2011) which changes the name of Physician Specialty Code 12 from Osteopathic Manipulative Therapy to Osteopathic Manipulative Medicine.

In addition, Sections 480, 480.1 and 480.2 were added. References to paper manuals were deleted. Obsolete headings located above sections 40, 50, 70.17, 80, 210, 220, 310 and 390 were deleted from the manual and the Table of Contents. Inactive sections were identified,

EFFECTIVE DATE: April 1, 2011
IMPLEMENTATION DATE: April 4, 2011

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 (TOC)
R	6/20.4/Body of Report
R	6/30.7/Body of Report
R	6/40/Monthly PRO Adjustment Bill Report (Inactive)
R	6/40.2/Body of Report
R	6/70.17/Completing Quarterly Report on Provider Enrollment (Inactive)
R	6/120.1/Classification of Claims for Counting
R	6/130.2/Part A - Monthly Workload Operations
R	6/130.3/Part B - Inquiries
R	6/150/Part D(1) - Claims Processing Timeliness - All Claims
R	6/170.3/Part E - Interest Payment Data
R	6/180/Completing Page Thirteen of the Carrier Performance Report (Inactive)
R	6/180.1/Instructions for Completeing the Carrier Performance Report - All Trunks Busy (ATB)
R	6/210/Monthly DMEPOS State Report - General (Inactive)
R	6/230.1/Classification of Claims for Counting
R	6/260.1/Classification of Claims for Counting
R	6/270.2/Part D - Selected Claim Data by Participation Status
R	6/400.2/Definition of Columns One Through Eight
R	6/400.3/Specialty Codes
R	6/410/Checking Reports
R	6/420 - Exhibit
R	6/430/Completing Quarterly Report on Provider Enrollment (Inactive)
N	6/480/Special Purpose Data
N	6/480.1/Heading
N	6/480.2/Exhibit

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

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

Attachment - Business Requirements

Pub. 100-06	Transmittal: 175	Date: October 28, 2010	Change Request: 7093

SUBJECT: Change the Name of Physician Specialty Code 12 from Osteopathic Manipulative Therapy to Osteopathic Manipulative Medicine

EFFECTIVE DATE: April 1, 2011

IMPLEMENTATION DATE: April 4, 2011

I. GENERAL INFORMATION

A. Background: The Centers for Medicare & Medicaid Services (CMS) will change the name of physician specialty code 12 from Osteopathic Manipulative Therapy to Osteopathic Manipulative Medicine. CR 6890 was created to update Pub 100-04 Chapter 26 Section 10.8.2. This CR is required in order to update Pub 100-06 Chapter 6 Section 420.

B. Policy: Medicare physician specialty codes describe the specific/unique types of medicine that physicians practice. Specialty codes are used by CMS for programmatic and claims processing purposes. They are used in expenditure analysis. Medicare contractors use specialty code data to develop claims processing edits to help identify potentially duplicative care provided by members of the same specialty on the same day to the same patient.

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	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7093.1	Medicare **c**ontractors shall make all necessary changes to recognize and use the physician specialty code 12 as a valid primary and/or secondary specialty code for Osteopathic Manipulative Medicine.	X			X						CROWD

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)						
		A/B	DME	FI	CAR	RHH	Shared-System Maintainers	OTHER

		MAC	MAC		RIER	I	FISS	MCS	VMS	CWF	
	None.										

IV. SUPPORTING INFORMATION

Section 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:
	None.

Section 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

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers:*

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

Section B: *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.

Medicare Financial Management Manual
Chapter 6 - Intermediary and Carrier Financial Reports

Table of Contents
(Rev.175, 10-28-10)

40 - Monthly PRO Adjustment Bill Report *(Inactive)*

70.17 - Completing Quarterly Report on Provider Enrollment *(Inactive)*

180 - Completing Page Thirteen of the Carrier Performance Report *(Inactive)*

210 - Monthly DMEPOS State Report - General *(Inactive)*

430 - Completing Quarterly Report On Provider Enrollment *(Inactive)*

480 - Special Purpose Data
480.1 - Heading
480.2 - Exhibit

20.4 - Body of Report

(Rev.175, Issued: 10-28-10, Effective: 04-01-11, Implementation: 04-04-11)

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 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 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 *30, Financial Liability Protections*.)

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 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 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

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 *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 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 *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 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.175, Issued: 10-28-10, Effective: 04-01-11, Implementation: 04-04-11)

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, 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 3

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 3 (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+						

40 - Monthly PRO Adjustment Bill Report *(Inactive)*

(Rev.175, Issued: 10-28-10, Effective: 04-01-11, Implementation: 04-04-11)

The intermediary prepares and submits to CMS, by the 10th of each month following the reporting month, a PRO Adjustment Bill Report using the CROWD system. It submits a total page showing contractor activity for all PROs in the contractor's area. In addition, it submits a separate report for each PRO/State. For example, if the intermediary handles adjustment records for a PRO involving separate States, it should submit a separate report for each State. It reports all tape adjustment requests as well as hardcopy adjustment request records which the PRO has designated XXP (where XX is a two-digit numeric identifier) in accordance with the Medicare Claims Processing Manual, Chapter 4, Outpatient Billing. If the intermediary does not have activity for a certain PRO/State combination in a month, it shall not submit a report.

40.2 - Body of Report

(Rev.175, Issued: 10-28-10, Effective: 04-01-11, Implementation: 04-04-11)

For all PRO adjustments, determine the appropriate column. Complete the report for each line as follows:

- **Line 1 - Opening Pending** - The intermediary enters the total number of adjustment request records reported as pending at the end of the previous month.

- **Line 2 - Revisions to Opening Pending** - The intermediary reports the net result of the number of request records that should not have been counted as adjustment request records pending at the end of the previous month (minus) and the number that were not counted but which should have been (plus).

- **Line 3 - Revised Opening Pending** - The intermediary enters line 1 plus line 2.

- **Line 4 - Electronic Adjustment Request Records Received** - The intermediary enters the number of electronic adjustment request records received from the PRO in the month.

- **Line 5 - Electronic Adjustment Request Records Rejected** - The intermediary enters the number of electronic adjustment request records reported on line 4 that failed contractor front end edits.

- **Line 6 - Electronic Adjustment Request Records Accepted** - The intermediary enters the difference of line 4 minus line 5.

- **Line 7 - Hard Copy Adjustment Requests Received** - The contractor shall enter the number of hard copy adjustment requests it received from its PRO(s). It shall count only hard copy requests the PRO has identified as 11P, 13P, 18P, 21P, or 83P.

- **Line 8 - Additional Bills to be Processed Due to Interim Bills**-The intermediary enters the number of interim bills to be adjusted as a result of PRO electronic or hard adjustment requests. It does not count interim bills for which no change is needed.

- **Line 9 - Total Adjustment Bills to be Processed** - The intermediary enters the total number of adjustment bills to be processed. This is the sum of lines 3, 6, 7, and 8.

- **Line 10 - Non-processable Adjustment Bills - Failed Batch/System Edits** - The intermediary enters the number of bills it could not process due to batch/system edits. It includes any requests which conflict with its history; e.g., utilization. It counts any interim bill which edits out of its system. These bills will be identified as non-processable on the Revisions to the Monthly PRO Adjustment Bill Report.

- **Line 11 - Total Adjustment Bills Processed** - The intermediary enters the total number of adjustment bills it has processed as a result of PRO adjustment requests (hard copy and electronic). It counts each bill when multiple bills are processed to satisfy one request.

- **Line 12 - Number Completed in 60 Days or Less** - The intermediary enters the number of adjustment bills processed in 60 days or less from the date it received the adjustment request record.

- **Line 13 - Number Completed in 61-90 Days** - The intermediary enters the number of adjustment bill processed in 61 to 90 days.

- **Line 14 - Number Completed in 91-120 Days** - The intermediary enters the number of adjustment bills processed in 91 to 120 days.

- **Line 15 - Number Completed Over 120 Days** - The intermediary enters the number of adjustment bills processed in 121 days or more.

- **Line 16 - Closing Pending** - The intermediary enters the total number of adjustment request records pending at the end of the report month.

70.17 - Completing Quarterly Report on Provider Enrollment *(Inactive)*

(Rev.175, Issued: 10-28-10, Effective: 04-01-11, Implementation: 04-04-11)

Each quarter, the intermediary prepares and submits to CMS a report on the number of provider enrollment applications received, processed, and pending during the quarter. Include in your counts of provider enrollment applications, any change of ownership (CHOW) notices handled by you. It submits this report via the Contractor Reporting of Operational and Workload Data (CROWD) system no later than the fifteenth day following the close of the reporting quarter.

120.1 - Classification of Claims for Counting

(Rev.175, Issued: 10-28-10, Effective: 04-01-11, Implementation: 04-04-11)

All claims data entered on page one of the performance report must represent counts of claims (real and replicate) as defined in the Medicare Claims Processing, Chapter 1, General Billing *Requirements*. The carrier includes in column (i) the following types of claims: CMS-1500s, CMS-1490s, and CMS-1491s. Of these claims forms, it reports the assigned in column (ii) and the unassigned in column (iii).

It includes any claims where processing has been suspended due to CMS directives since they are still part of its claims workload.

NOTE: It does not count assigned claims received from physicians/suppliers if they are incomplete, incorrect, or inconsistent and consequently returned for clarification. It does not have to control such claims.

Throughout its process, it includes the date material is received on all claims (real and replicate). It shows identifying numbers or codes on all replicate claims through the processing system so that they can be counted and reported separately in Part A.

The carrier reports claims as received in the month the claim is received in its mailroom with the following exceptions:

- Additional real claims resulting from a split; and
- Claims identified as replicates.

Split and replicate claims, although carrying the dates the materials were originally received, are to be counted as receipts for the month in which they are **recognized by the carrier's system** as created (i.e., split or identified as replicate) for purposes of this report.

EXAMPLE: The carrier splits a claim received in the reporting month into two claims because the total number of line items exceeds its system's line item limitation. If it can recognize this split when it occurs, it reports two claims in "Total Claims Received During Month" and in "Net Number of Claims Received" (lines 4 and 6, respectively) in Part A of the report. It reports both claims in Part A. After processing the split (replicate) claim, it reports it in Part A under "Replicate Claims Processed" (line 16), as well as under "Total Claims Processed" (line 15). If its system does not indicate when the split occurs, it counts the new claim as a receipt for the month in which the system allows it to be recognized, although the date claims materials were originally received must be carried forward and remain unchanged.

The carrier counts claims received near the end of the reporting month but placed under computer control in the following month as received in the reporting month. It obtains this count by a physical inventory or by computer count.

130.2 - Part A - Monthly Workload Operations

(Rev.175, Issued: 10-28-10, Effective: 04-01-11, Implementation: 04-04-11)

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 enters 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 enters 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 enters 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 enters the number of claims, by type, included in line 17 which are 1-15 days old.

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

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

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

Line 22. Over 90 Days - The carrier enters 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.

130.3 - Part B - Inquiries

(Rev.175, Issued: 10-28-10, Effective: 04-01-11, Implementation: 04-04-11)

The carrier reports the number of responses it processed as a result of inquiries from, or on behalf of, Medicare beneficiaries or providers during the reporting month. It reports only inquiries processed related to the Medicare program. It excludes inquiries addressing its private line of business. It bases the data on actual counts, not on estimates or samples.

The carrier counts inquiries as follows:

Beneficiary - It counts one inquiry per contact (telephone, written, walk-in), regardless of how many claims the beneficiary inquires about. For example, if a beneficiary writes it about the status of two claims, it counts the response as one beneficiary written inquiry. It counts responses to re-contacts made by that beneficiary as an additional inquiry. It counts any inquiry made by a beneficiary, or by anyone on behalf of the beneficiary, except a provider.

Provider - It counts one inquiry per contact. For example, if a provider calls or writes it regarding the status of 10 claims, it counts the response as one provider-written or phone inquiry. It counts any inquiry made by a provider, or anyone on behalf of the provider, except a beneficiary. It counts inquiries regardless of whether they relate to assigned or unassigned claims.

- It counts beneficiary and provider inquiries as follows:

- It counts Medicare inquiries directed to it for a response if they are requests for information from beneficiaries or providers (physicians/suppliers) or their representatives.

- It does not count, as inquiries, professional relations activities and contacts (i.e., its training programs for providers on new requirements).

- It counts voice inquiries captured electronically as telephone inquiries, and electronic mail inquiries as written inquiries. It does not count electronic inquiries if the provider can access the carrier system to determine claim status without its involvement.

- It does not count inquiries related specifically to the physician fee freeze or MSP. (This is to achieve comparability with the CMS-1524 budget form, where all costs related to the fee freeze and MSP are reported on separate lines.)

- It counts congressional inquiries in the appropriate category (i.e., as a beneficiary inquiry if made on behalf of a beneficiary, and as a provider inquiry if made on behalf of a provider).

- It counts inquiries made by the RO or the SSA DO in the appropriate category if the inquires are on behalf of a beneficiary or a provider and relate to a specific claim. It does not count the inquiries if they are of a general nature (i.e., ongoing liaison necessary during monitoring of day-to-day operations).

- It does not count Part A inquiries if it handles all Part A inquiries for an intermediary on a routine basis. In this case, it charges the related costs to the intermediary. It does not include the volume of work on the CMS-1565.

- It counts misdirected telephone inquiries (i.e., those that must be referred to another source for response) as processed telephone inquiries. It does not count misdirected written inquiries.

- It does not count requests for reviews or hearings as inquiries. (See The Medicare Claims Processing, Beneficiary Correspondence and Administrative Appeals, for definitions of reviews and hearings.) It reports reviews and hearings on the CMS-2590, not on the CMS-1565.

- It does not count reopenings and revisions. For example, if a claim is denied for lack of information after the appropriate suspense period, and the physician/supplier or beneficiary submits the missing information, it does not count any actions taken subsequently. (See the Medicare Claims Processing Manual, *Chapter 34, Reopening and Revision of Claim Determinations and Decisions,* for definitions of reopenings and revisions.)

It reports the number of inquiries from beneficiaries (column 2) and providers (column 3) as follows:

Line 24. Total Number Processed During Month - It enters the total number of inquiries processed during the month. It does not report the number of inquiries received.
Line 25. Telephone - It reports the number of telephone inquiries processed during the month.
Line 26. Walk-in Contact - It reports the number of walk-in inquiries processed during the month.
Line 27. Written - It reports the number of written inquiries responded to during the month.

150 - Part D(1) - Claims Processing Timeliness - All Claims

(Rev.175, Issued: 10-28-10, Effective: 04-01-11, Implementation: 04-04-11)

Pages 2-9 of the CMS-1565 include data on its activity in processing all claims to completion during the reporting period. *A claim is counted as processed to completion on the scheduled payment date, which is the date the check is mailed, deposited in the provider's account, or transferred electronically.* For non-paid claims, the date of completion is the date the *MSN* or other notice of final action on the claim is mailed. Data shown must be based on reliable counts of all claims (real and replicate) processing activity. The carrier does not estimate claim counts. It

reports 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.

"Clean" claims are defined as those that do not require investigation or development external to the carrier's operation on a prepayment basis. Claims which do not meet the definition of "clean" are "other" claims. Claims paid are those for which some payment was made (i.e., payment greater than zero). Claims not paid are those for which no payment was made (i.e., claim charges applied completely toward deductible or fully denied).

On pages 2-9, the carrier reports:

- In column 1, the total number of claims processed to completion;
- In column 2, the number of "clean" claims paid;
- In column 3, the number of "other" claims paid;
- In column 4, the number of "clean" claims not paid;
- In column 5, the number of "other" claims not paid; and
- In column 6, the number of "clean" or "other" claims processed to completion, which were received via electronic media from providers or their billing agencies and read directly into the carrier's claims processing system. The carrier does not count on this line claims that it received in hardcopy and entered using an 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.

The data in lines 1 through 37 of pages 2 through 9 represent the number of claims processed in the number of days shown on that line, counting from the date of receipt. Line 38 represents the sum of lines 1 -37. The date of receipt is defined for hard-copy and magnetic tape claims as the date of receipt in the mailroom. For EMC billed via terminal or equivalent, it is the date the claim passes all front-end edits. For split claims, whether required or replicate, the date of receipt is the date of receipt of the original claim material, not the date of the split.

To calculate the processing time for a claim, the carrier subtracts the Julian receipt date from the processed to completion Julian date. When the processed to completion date falls in the year following the year of receipt, it adds 365 to the Julian date of completion (or 366 if the year of receipt is a leap year). If a claim is processed to completion on the same day it is received, the processing time is one day. This definition applies to all lines of the report, including line 39.

On line 39, the carrier reports the mean processing time (PT) to one decimal place for each column. To calculate the mean PT, it adds the processing times for the claims shown in line 38 of that column, and divides by the number in line 38. It does not use the categories on the report to calculate the mean PT. Because of the aggregation of claims in lines 34-37, it uses the processing times for individual claims, as explained below, to make this calculation.

Mean PT Calculation for All Claims - To determine the mean PT for all claims:

- Subtract the Julian date of receipt from the Julian date of payment or equivalent action for those not paid for each claim.

- Accumulate the result to cell counter for number of days for all claims.

- Divide this result by the total number of claims.
- Round to one decimal place.

EXAMPLE:

Claim	Julian Date Receipt	Paid	Counter by Days	Counter by Claims
A	87103	87133	30	1
B	87105	87206	101	2
C	87115	87177	62	3
D	87120	87213	93	4
E	87122	87215	93	5
F	87130	87223	93	6

Total Days = 30 + 101 + 62 + 93 + 93 + 93 = 472
Mean = 472/6 = 78.6666 = 78.7
The carrier completes the report for each of the following claim types:

Page 2. **Assigned Physician** - It shows the number of **assigned** claims included on page 9 which involved services billed by physicians. Physicians are identified by specialty codes *01-14, 16-41, 44, 46, 48, 66, 70, 72, 76-79, 81-86, 90-94, 98 or 99*.

Page 3. **Assigned DME** - It shows the number of assigned claims included on page 9 which involved services billed by DME suppliers. DME suppliers are identified by specialty codes *51 - 58, 87, 88, 96, A0-A8, or B2-B4*.

Page 4. **Assigned Lab** - It shows the number of assigned claims included on page 9 which involved services billed by an independent laboratory. Independent laboratories are identified by specialty code 69.

Page 5. **Assigned Ambulance** - It shows the number of assigned claims included on page 9 which involved services billed by ambulance service suppliers. Ambulance service suppliers are identified by specialty code 59.

Page 6. **Assigned Other** - It shows the number of assigned non-physician claims included on page 9 but not represented on pages 3, 4, or 5.

Page 7. **Unassigned** - It shows the number of unassigned claims (real and replicate) included on page 9.

Page 8. **Participating Physician** - It shows the number of claims included on page 9 involving services rendered by physicians enrolled in the Medicare Physician/Supplier Participation Program. *Physicians are identified by specialty codes 01-14, 16-41, 44, 46, 48, 66, 70, 72, 76-79, 81-86, 90-94, 98 or 99.*

Page 9. **All Claims** - It shows the total number of claims (real and replicate) processed during the month.

170.3 - Part E - Interest Payment Data

(Rev.175, Issued: 10-28-10, Effective: 04-01-11, Implementation: 04-04-11)

The carrier reports on Page 12 of the CMS-1565 data on the claims on which it paid interest because it paid the claims after the required payment date per §9311 of the Omnibus Reconciliation Act of 1986 (OBRA 1986). It bases data shown on reliable counts of all claims processing activity, not on estimates. It reports data on initial claims only. It includes in the report all claims requiring interest payments in the month. It reports claims in the month the date of payment falls. (For a discussion of interest payments refer to the Medicare Claims Processing Manual, *Publication 100-04, Chapter 1, Sections 80.2.2 and 80.2.2.1).*

The carrier completes the report for each column as follows:

Column 1. Total - Data for all claims (real and replicate) for which interest payments were made during the month.

Column 2. Assigned Physician - Data for the **assigned** claims included in column 1 which involved services billed by physicians. Physicians are identified by specialty codes *01-14, 16-41, 44, 46, 48, 66, 70, 72, 76-79, 81-86, 90-94, 98 or 99*.

Column 3. Assigned DME - Data for the assigned claims included in column 1 that involved services billed by DME suppliers. DME suppliers are identified by specialty codes *51-58, 87, 88, 96, A0-A8, or B2-B4*.

Column 4. Assigned Lab - Data for the assigned claims included in column 1 that involved services billed by an independent laboratory. Independent laboratories are identified by specialty code 69.

Column 5. Assigned Ambulance - Data for the assigned claims included in column 1 that involved services billed by ambulance service suppliers. Ambulance service suppliers are identified by specialty code 59.

Column 6. Assigned Other - Data for the assigned non-physician claims included in column 1 but not represented in columns 3, 4, or 5.

Column 7. Unassigned - Data for the unassigned claims included in column 1.

Column 8. Participating Physician - Data for claims involving services rendered by physicians enrolled in the Medicare Physician/Supplier Participation Program. Physicians are identified by specialty codes *01-14, 16-41, 44, 46, 48, 66, 70, 72, 76-79, 81-86, 90-94, 98 or 99.*

On line 1, the carrier 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 17 days after receipt for participating physician claims received in FY 1992.) (See §9311 of OBRA 1986.) Data for lines 3-10 are similar to those for line 2.

The carrier calculates the number of days late by subtracting the Julian date of the required payment date from the Julian date of payment.

On line 11, it shows the amount paid in interest for claims reported in line 1. On lines 12-20, it shows the amount paid in interest for claims reported in lines 2-10, respectively. It shows dollar amounts on lines 11-20 to the nearest penny, and includes the decimal point.

180 - Completing Page Thirteen of the Carrier Performance Report *(Inactive)*

(Rev.175, Issued: 10-28-10, Effective: 04-01-11, Implementation: 04-04-11)

180.1 - Instructions for Completing the Carrier Performance Report - All Trunks Busy (ATB)

(Rev.175, Issued: 10-28-10, Effective: 04-01-11, Implementation: 04-04-11)

Each month the carrier prepares and submits to CMS Central Office (CO) page 13 of the Carrier Performance Report - ATB. This report contains the monthly data for ATB, for both local and toll free calls, the number of beneficiary calls answered in 120 seconds, and the total number of beneficiary calls received.

It reports these statistics electronically by the 15th of the month following the reporting month using the Medicare Contractor Reporting of Operational and Workload Data (CROWD) System at the CMS Data Center (CDC). It enters data on the ATB report screen for each office that has been assigned a separate carrier number.

210 - Monthly DMEPOS State Report – General *(Inactive)*

(Rev.175, Issued: 10-28-10, Effective: 04-01-11, Implementation: 04-04-11)

If the carrier is a Durable Medical Equipment Regional Carrier (DMERC), it prepares and submits a report each month for its region (either A, B, C, or D - see §210.3 for exhibits) to CMS summarizing its performance in processing DMEPOS claims. It transmits the DMEPOS report as soon as possible after the end of the reporting month, but no later than the 10th day of the following month using the instructions contained in the CROWD User's Guide. It is also required to submit all pages of the CMS-1565 report for its total DMEPOS workload. It must also submit data on forms CMS-2174, CMS-2590, CMS-1564, CMS-1565A, and CMS-1565C via CROWD for its total DMEPOS workload.

230.1 - Classification of Claims for Counting

(Rev.175, Issued: 10-28-10, Effective: 04-01-11, Implementation: 04-04-11)

Claims data entered on the performance report represent counts of claims (real and replicate). *(See the Medicare Claims Processing Manual, Publication 100-04, Chapter 1, Section 70.8.2, for a definition of replicate claims).* It includes in column (1) both assigned and unassigned claims. The carrier reports assigned claims in column (2) and unassigned claims in column (3).

260.1 - Classification of Claims for Counting

(Rev.175, Issued: 10-28-10, Effective: 04-01-11, Implementation: 04-04-11)

All claims data entered on the CMS-1565C must represent counts of claims (real and replicate) as defined in the *Medicare Claims Processing Manual, Publication 100-04, Chapter 1, Section 70*. The carrier classifies the claims on the report form as follows: (1) An assigned claim submitted by a non-participating physician or supplier; (2) An unassigned claim, usually submitted by a

beneficiary and accompanied by bills from one or more physicians or suppliers; or (3) A claim submitted by a participating physician or supplier.

The terms "participating" and "non-participating" refer to whether or not the physician/supplier has signed an agreement to follow the provisions of the Medicare Physician/Supplier Participation Program. The carrier classifies claims as follows:

- A claim in which all services were provided when the physician/supplier was "participating" as a participant claim, and

- A claim with a mix of participant and non-participant services (including those cases where a physician/supplier has changed status) as a participant claim.

NOTES: An exception to the above is the unassigned claim involving services by a participating physician/supplier. If the carrier denies this type of claim, it classifies it as a non-participant, unassigned claim. When the corresponding claim is submitted by the beneficiary's physician (supplier), it classifies it as a participant claim.

The above classification rules apply only to claims. Services, covered charges, and disallowed charges should be allocated according to the participation status of the physician/supplier at the time the service was provided.

The carrier makes the distinction between physician and non-physician claims and services according to the coding used for the Bill Summary Record. It classifies those entities with specialty codes of *01-14, 16-41, 44, 46, 48, 66, 70, 72, 76-79, 81-86, 90-94, 98 or 99* as physicians. It considers all others to be non-physicians.

270.2 - Part D - Selected Claim Data by Participation Status

(Rev.175, Issued: 10-28-10, Effective: 04-01-11, Implementation: 04-04-11)

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 enters 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.

400.2 - Definitions of Columns One Through Eight

(Rev.175, Issued: 10-28-10, Effective: 04-01-11, Implementation: 04-04-11)

Column 1 - Participating Physicians/*LLPs/*NPPs/Suppliers - Prior - A count of the number of physicians, *limited license physicians (LLPs)*, non-physician practitioners (NPPs), and suppliers participating prior to the beginning of the latest enrollment period.

> **Note:** The carrier *or A/B MAC* adjusts this data if there are changes from the information submitted in column 2 on the previous enrollment period.

Examples of possible reasons for changes to the data include:

- Addition of new physicians to the Medicare file;
- Reclassification of physicians, *LLPs,* NPPs, and suppliers between specialty designations;
- Deletion of deceased or retired physicians from the Medicare file; or
- Technical corrections to previously submitted data.

Column 2 - Participating Physicians/*LLPs/*NPPs/Suppliers - Current - The number of physicians, *limited license physicians*, NPPs, and suppliers who are continuing as participants from the prior participation period into the new participation period and the number who have **newly** signed participation agreements in the latest enrollment period.

Column 3 - Participating Physicians/*LLPs/*NPPs/Suppliers - Continuing - Only the number of physicians, *limited license physicians*, NPPs, and suppliers **continuing** as participants from the prior participation period into the new participation period, not including those who have newly signed participation agreements in the latest enrollment period or those who have dropped out.

Column 4 - Non-Participating Physicians/*LLPs/*NPPs/Suppliers - Prior - A count of physicians, *limited license physicians*, NPPs, and suppliers not participating at the beginning of the latest enrollment period.

> **Note:** The carrier *or A/B MAC* adjusts this data if the information is different from that submitted in column 5 on the previous enrollment period. (See column 1 for further information.)

Column 5 - Non-Participating Physicians/*LLPs/*NPPs/Suppliers - Current - A count of physicians, *limited license physicians*, NPPs, and suppliers not participating after the latest enrollment period, including those who were not participating at the beginning of the latest enrollment period and chose not to enroll and those who disenrolled during the latest period.

Column 6 - Participating Drop-Out - Current – Physicians*/LLPs/*NPPs, and suppliers who, prior to this enrollment period, were participating in the program and have now decided to drop out.

Column 7 - Non-Participating Sign-Up - Current – Physicians*/LLPs/*NPPs, and suppliers who were non-participating prior to the latest enrollment period and who enrolled in the program during the latest enrollment period.

Column 8 – Participating Disenrolls - Only the number of participants who disenrolled from the Medicare program during an authorized disenrollment period held during the past 12 months. This is blank unless CMS declares an authorized disenrollment period.

400.3 - Specialty Codes

(Rev.175, Issued: 10-28-10, Effective: 04-01-11, Implementation: 04-04-11)

For the list of physician, limited license physician, non-physician practitioner and supplier specialty codes, *see the Medicare Claims Processing Manual, Publication 100-04, Chapter 26, Sections 10.8.2 and 10.8.3.*

The contractor counts individual participants by specialty. It does not count an individual more than once, even if the individual practices in more than one setting.

NOTE: Refer to the pre-April 2010 version for DMERC activity (Calendar Years 1993-2007)

410 - Checking Reports

(Rev.175, Issued: 10-28-10, Effective: 04-01-11, Implementation: 04-04-11)

Before submitting Form F, the Medicare contractor checks for completeness and arithmetical accuracy using the following checklist:

- Column 3 must be = to or < column 1
- Column 3 must be = to or < column 2
- Column 6 = column 1 - column 3
- Column 7 = column 2 - column 3
- *Total Physicians = sum of Group PHY for all columns.*
- *Total LLPs = sum of Group LLP for all columns.*
- *Total NPPs = sum of Group NPP for all columns.*
- *Total Suppliers = sum of Group SUP for all columns*.

420 - Exhibits

(Rev.175, Issued: 10-28-10, Effective: 04-01-11, Implementation: 04-04-11)

Exhibit 1 - 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
16 Obstetrics/Gynecology
17 Hospice and Palliative Care
18 Ophthalmology
19 Oral Surgery
20 Orthopedic Surgery
21 Reserved
22 Pathology
23 Reserved
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-PHY								
20-PHY								
21-RES								
22-PHY								
23-RES								
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
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-PHY								
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 (DTL)
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-PHY								
42-NPP								
43-NPP								
44-PHY								
45-SUP								
46-PHY								
47-SUP								
48-PHY								
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 Clinical Psychologist (Ind.)
63 Portable X-Ray Supplier
64 Audiologist (Ind.)
65 Physical Therapist (Ind.)
66 Rheumatology
67 Occupational Therapist (Ind.)
68 Clinical Psychologist
69 Clinical Laboratory (Ind.)
70 Single or Multi-Specialty 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 Supplier/Provider
89 Certified Clinical Nurse Specialist
90 Medical Oncology
91 Surgical Oncology
92 Radiation Oncology
93 Emergency Medicine
94 Interventional Radiology
95 Reserved
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-PHY								
86-PHY								
88-SUP								
89-NPP								
90-PHY								
91-PHY								
92-PHY								
93-PHY								
94-PHY								
95-RES								
97-NPP								
98-PHY								
99-PHY								

Exhibit 1 - Participating Physician/Supplier Report - Screen 8

PARTICIPATING PHYSICIAN/SUPPLIER REPORT
SPECIALTY CODES

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

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

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

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

Total Suppliers - The contractor enters 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.

430 - Completing Quarterly Report on Provider Enrollment *(Inactive)*

(Rev.175, Issued: 10-28-10, Effective: 04-01-11, Implementation: 04-04-11)

Each quarter, the carrier prepares and submits to CMS a report on the number of provider enrollment applications received, processed, and pending during the quarter. It submits this report via the Contractor Reporting of Operational and Workload Data (CROWD) system no later than the fifteenth day following the close of the reporting quarter.

480 - Special Purpose Data

(Rev.175, Issued: 10-28-10, Effective: 04-01-11, Implementation: 04-04-11)

480.1 - Heading

(Rev.175, Issued: 10-28-10, Effective: 04-01-11, Implementation: 04-04-11)

This report, referenced as Form Y in the CROWD system, 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 will submit the form via the CROWD system no later than the 10th day of the following month.

480.2 - Exhibit

(Rev.175, Issued: 10-28-10, Effective: 04-01-11, Implementation: 04-04-11)

Exhibit - Special Purpose Data

SPECIAL PURPOSE DATA

CONTRACTOR	*NUMBER*					
DESCRIPTION	*CODE*	*COL 1*	*COL 2*	*COL 3*	*COL 4*	*COL 5*
	0000	*0*	*0*	*0*	*0*	*0*
	0000	*0*	*0*	*0*	*0*	*0*
	0000	*0*	*0*	*0*	*0*	*0*