CMS Manual System

Pub. 100-06 Medicare Financial Management

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 36 **Date: MARCH 12, 2004**

CHANGE REQUEST 2249 & 2547

This manualizes transmittal number B-02-079 dated November 1, 2002, and transmittal number A-03-037 dated May 2, 2003.

I. SUMMARY OF CHANGES: A new Contractor Reporting of Operational and Workload Data (CROWD) system reporting form (Form 5) was created which requires that intermediaries and carriers submit monthly reports. This change revises the Table of Contents and adds a new manual section incorporating the instructions for the form.

MANUALIZATION - EFFECTIVE DATE: Not Applicable
***IMPLEMENTATION DATE: Not Applicable**

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

II. CHANGES IN MANUAL INSTRUCTIONS:
(R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	6/Table of Contents
N	6/450/Medicare Contractor Transaction Report (Form CMS-5)
N	6/450.1/Due Date
N	6/450.2/Heading
N	6/450.3/Body of Report
N	6/450.4/Exhibit 1

***III. FUNDING:**

These instructions shall be implemented within your current operating budget.

IV. ATTACHMENTS:

	Business Requirements
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

***Medicare contractors only**

Medicare Financial Management Manual
Chapter 6 - Workload Reporting

Table of Contents

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450 – Medicare Contractor Transaction Report (Form CMS-5)
- *450.1 – Due Date*
- *450.2 - Heading*
- *450.3 – Body of Report*
- *450.4 – Exhibit 1*

450 –Medicare Contractor Transaction Report (Form CMS-5)

(Rev. 36, 03-12-04)

Intermediaries and carriers must prepare and submit to CMS each month the Medicare Contractor Transaction Report (CMS Form 5) showing their Electronic Data Interchange (EDI) and manual transactions workload under the health insurance program. A separate report is required for each office assigned a separate contractor number.

450.1 – Due Date

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The report is transmitted to central office via PC or terminal as soon as possible after the end of the month being reported but no later than the 15th of the following month. Use instructions in the Contractor Reporting of Operational and Workload Data (CROWD) System User's Guide.

450.2 - Heading

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The report is referenced as Form 5 in the CROWD system. The intermediary or carrier completes the ADD/UDATE/DELETE criteria screen with the appropriate information to bring the reporting format to its screen.

450.3 – Body of Report

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The intermediary or carrier completes the report for each column as follows:

- *For column 1 data, include data on electronic transactions, batch or online interactive real time, and all formats (e.g., NSF, ASCX12N) and magnetic tape. Do not include Direct Data Entry (DDE).*

- *For column 2 data, include statistics on manual processes such as paper, E-mail, fax, diskette, and fax/optical character recognition (except where shaded). Continue with the current requirement for counting and reporting manual inquiry responses as cited in Pub. 100-06 Financial Management Manual - Workload Reporting.*

Line 1 – Response to Claim Status Inquiry - Report on the number of responses to claims status. Do not report on the number of inquiries. Count each occurrence of the unique trace or reference number as assigned by the provider (e.g., in the 276/277use TRN02).

Line 2 – Response to Eligibility Status Inquiry – Report on the number of responses to inquiries. Do not report on the number of inquiries. Count each unique occurrence of an individual beneficiary HIC number.

Line 3 – Outgoing Coordination of Benefit (COB) Claims Processed (includes Medigap, does not include NCPDP) – Count each unique occurrence of the patient control number as assigned by the provider (e.g., in the 837, use CLM01). Alternately, the intermediary or carrier may count each unique occurrence of the patient's HIC number.

NOTE: *Lines 4, 5 and 6 are to be completed by DMERC carriers only.*

Line 4 – Prior Authorization Requests (Durable Medical Equipment Regional Carriers or Advance Determination of Medicare Coverage) – Count each unique occurrence of an individual beneficiary HIC number in a valid response.

Line 5 – National Council of Prescription Drug Plans (NCPDP) for Retail Pharmacy Drug Claims Processed – Count each unique occurrence of an individual beneficiary HIC number in the claim.

Line 6 – Outgoing COB NCPDP for Retail Pharmacy Drug Claims Processed (including NCPDP Medigap) – Count each unique occurrence of an individual beneficiary HIC number.

Line 7 – Remittance Advices-Number Sent – For X12 electronic remittance advice, count as "1" each occurrence of the ST through SE segments on the remittance advice for paid and no paid claims. For carrier NSF, count the number of remittance advices sent to each provider. If a provider is sent both an electronic and a paper remittance advice for the same set of claims, count this as two advices, not one.

Line 8 – Number of Payments to Providers or Suppliers – report on the number of electronic fund transfers and paper checks issued to providers' bank accounts, not on the number of claims.

Line 9 – Dollar Amounts Associated with Payments (Dollar Amounts Reflected with Payments) – Report on the dollar amounts associated with those payments reported in line 8.

450.4 – Exhibit 1

(Rev. 36, 03-12-04)

MEDICARE CONTRACTOR TRANSACTIONS
(CROWD FORM 5)

CONTRACTOR NUMBER____________ REPORT PERIOD______________

TYPE OF TRANSACTION	*ELECTRONIC (1)*	*NON-ELECTRONIC (MANUAL PROCESSES) (2)*
1. REPSONSES TO CLAIMS STATUS INQUIRY		
2. RESPONSES TO ELIGIBILITY STATUS INQUIRY		
3. OUTGOING COB CLAIMS PROCESSED (INCLUDE MEDIGAP, NOT NCPDP)		
DMERC ONLY:		
4. PRIOR AUTHORIZATION REQUESTS OR ADVANCED DETERMINATION OF MEDICARE COVERAGE		
5. NCPDP FOR RETAIL PHAR. DRUG CLAIMS PROCESSED		
6. OUTGOING COB NCPDP FOR RETAIL PHARMACY DRUG CLAIMS PROCESSED (INCLUDING NCPDP MEDIGAP)		
7. REMITTANCE ADVICES—NUMBER SENT		
8. # OF PAYMENTS TO PROVIDERS OR SUPPLIERS		
9. DOLLAR AMOUNTS ASSOCIATED W/ PAYMENTS (DOLLAR AMOUNTS REFLECTED W/ PAYMENTS)		