CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-09 Medicare Contract Beneficiary and Provider Communications	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 18	**Date: SEPTEMBER 8, 2006**
	Change Request 5277

Subject: Provider Customer Service Program

I. SUMMARY OF CHANGES: Chapters 3 and 6 are being revised to reflect: changes in contractor requirements for handling provider inquiries included in the FY 2006 BPRs and FY 2007 BPRs, updates to the provider inquiry standardization categories and report submission, contractor assistance to CMS in implementing provider satisfaction surveys and miscellaneous clarifications and corrections. Additionally, Chapter 6 is being revised to include revisions to provider outreach and education requirements, including FY 06 and 07 BPR changes and provider education resulting from medical review referrals. Also, Chapter 6 is being reorganized into a more logical arrangement.

Effective 10/1/2006, Chapter 4 is being deleted in its entirety. Contractors shall adhere to the requirements in IOM 100-9, Chapter 6, for provider outreach and education requirements (sections 20, 40.1, 50.2, 50.3 and 60.1.)

New / Revised Material
Effective Date: October 1, 2006
Implementation Date: October 2, 2006

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	3/10/Introduction
R	3/20.1/Guidelines for Telephone Service
R	3/20.1.1/Toll Free Network Services
R	3/20.1.3/Call Handling Requirements
R	3/20.1.4/Customer Service Assessment and Management System (CSAMS) Reporting Requirements
R	3/20.1.6/Staff Development and Training

R	3/20.1.7/Quality Call Monitoring (QCM)
R	3/20.1.9/Provider Contact Center User Group (PCUG)
R	3/20.2/Written Inquiries
R	3/20.2.1 Contractor Guidelines for High Quality Responses to Written Inquiries
R	3/20.2.2.2/QWCM Calibration
R	3/20.2.2.3/QWCM Performance Standards
N	3/20.4.1/Customer Service Operations Surveys
N	3/20.4.2/Provider Satisfaction Surveys
N	3/20.4.2.1/Contractor Activities Related to the Medicare Contractor Provider Satisfaction Survey (MCPSS)
R	3/20.5/Provider Inquiry Standardized Categories
D	4/Provider Communications (entire chapter, all sections)
R	6/10/Introduction to Provider Customer Service Program (PCSP)
R	6/20/Provider Outreach and Education (POE)
R	6/20.1/POE Goals
R	6/20.1.1/Internal Development of Provider Issues
R	6/20.1.2/Partnering with External Entities
D	6/20.1.3/POE Advisory Groups
D	6/20.1.4/"Ask-the-Contractor" Teleconferences (ACT)
D	6/20.1.5/Provider Bulletins/Newsletters
D	6/20.1.6/Education and Training Events
D	6/20.1.7/Training for New Medicare Providers
D	6/20.1.8/Training Tailored for Small Providers
D	60/20.1.9/Provider Information and Education Materials
D	6/20.1.10/Partnering with External Entities
D	6/20.1.11/Remittance Advice Messaging
D	6/20.1.12/Internal Development of Provider Issues
D	6/20.1.13/Training of Provider Education Staff
R	6/20.2/Data Analysis
R	6/20.2.1/CERT Data
R	6/20.2.2/Inquiry Analysis
R	6/20.2.3/Claims Submission Errors

R	6/20.2.4/Referrals from Medical Review
D	6/20.2.5/Quarterly Provider Update
R	6/20.3/Provider Education
R	6/20.3.1/Provider Bulletins/Newsletters
R	6/20.3.2/Training for New Medicare Providers
R	6/20.3.3/Training Tailored for Small Providers
D	6/20.3.3.1/No Charge
D	6/20.3.3.2/Fair and Reasonable Fees
D	6/20.3.3.3/Considerations and Record Keeping for Fee Collection
D	6/20.3.3.4/Excess Revenues from Participant Fees
D	6/20.3.3.5/Refunds/Credits for Cancellation of Events
D	6/20.3.3.6/Mixed Training Events
D	6/20.3.3.7/Recording of Training Events
N	6/20.3.4/Educational Topics
N	6/20.3.4.1/Local Coverage Determinations
N	6/20.3.4.2/Education Resulting from Medical Review Referrals
N	6/20.3.4.3/Medicare Preventive Service Benefits
N	6/20.3.4.4/Electronic Claims Submissions
N	6/20.3.4.5/Remittance Advice
N	6/20.3.4.6/"Ask-the-Contractor" Teleconferences (ACT)
N	6/20.4/POE Advisory Groups
N	6/20.5/POE Reporting
N	6/20.5.1/Provider Service Plan (PSP)
N	6/20.5.2/Education Activity Report (EAR)
N	6/20.5.3/Error Rate Reduction Plan (ERRP)
N	6/20.6/Charging Fees to Providers for Medicare Education and Training Activities
N	6/20.6.1/No Charge
N	6/20.6.2/Fair and Reasonable Fees
N	6/20.6.3/Considerations and Record Keeping for Fee Collection
N	6/20.6.4/Excess Revenues from Participant Fees
N	6/20.6.5/Refunds/Credits for Cancellation of Events
N	6/20.6.6/Recording of Training Events

R	6/30/Provider Contact Center (PCC)
R	6/30.1/Inquiry Triage Process
D	6/30.1.1/Provider Inquiry Reporting Standardization
D	6/30.1.1.1/Required Training
D	6/30.1.1.2/Updates to Chart
R	6/30.2/Telephone Services
N	6/30.2.1/Inbound Calls
N	6/30.2.2/Troubleshooting Problems
N	6/30.2.3/Availability Requirements
N	6/30.2.3.1/Providing Busy Signals
N	6/30.2.3.2/Queue Message
N	6/30.2.3.3/General Inquiries Lines
N	6/30.2.4/CSR Requirements
N	6/30.2.4.1/CSR Equipment Requirements
N	6/30.2.4.2/Sign-in Policy
N	6/30.2.4.3/CSR Identification to Callers
N	6/30.2.5/Remote Monitoring Access
N	6/30.2.6/Disaster Recovery
N	6/30.2.7/Contractor Guidelines for High Quality Response to Telephone Inquiries
N	6/30.2.7.1/Quality Call Monitoring (QCM)
N	6/30.2.7.2/QCM Calibration
R	6/30.3/Contractor Guidelines for Written Inquiries
R	6/30.3.1/Controlling Written Inquiries
R	6/30.3.2/Written Inquiry Storage
R	6/30.3.3/Telephone Responses
R	6/30.3.4/E-mail and Fax Responses
D	6/30.3.4.1/Providing Busy Signals
D	6/30.3.4.2/Queue Message
D	6/30.3.4.3/General Inquiries Lines
R	6/30.3.5/Check Off Letters
R	6/30.3.6/Contractor Guidelines for Response to Written Inquiries

R	6/30.3.6.1/Quality Written Correspondence Monitoring (QWCM)
N	6/30.3.6.2/QWCM Calibration
D	6/30.3.7/Calibration
R	6/30.4/Walk-In Inquiries
R	6/30.4.1/Guidelines for Walk-In Service
D	6/30.4.2/Forwarding Misdirected Inquiries
D	6/30.4.3/Timeliness
D	6/30.4.3.1/Responding to Written Inquiries by Telephone
D	6/30.4.3.2/E-Mail Responses
D	6/30.4.3.3/Check Off Letters
D	6/30.4.3.4/Contractor guidelines for Response to Written Inquiries
D	6/30.4.3.4.1/Quality Written correspondence Monitoring (QWCM)
D	6/30.4.3.4.2/Calibration
R	6/30.5 Provider Relations Research Specialists (PRRS)
R	6/30.5.1/Complex Provider Inquiries
N	6/30.5.2/Complex Beneficiary Inquiries
R	6/30.6/Inquiry Tracking
R	30.6.1/Updates to Chart
D	6/30.6.2/Complex Beneficiary Inquiries
R	6/30.7/Provider Contact Center User Group (PCUG)
N	6/30.9.1/Customer Service Operations Surveys
N	6/30.9.2/Provider Satisfaction Surveys
N	6/30.9.2.1/Contractor Activities Related to the Medicare Contractor Provider Satisfaction Survey (MCPSS)
R	6/40/PCSP Staff Development and Education
R	6/40.1/POE Staff Training
D	6/40.1.1/General Requirements
D	6/40.1.2/Provider Contact Centers Training Program
D	6/40.1.3/Closure Determination
D	6/40.1.4/Provider Complaints
D	6/40.1.5/Training Schedule
D	6/40.1.6/Training closures of More than Four Hours

D	6/40.1.7/Provider Notifications
D	6/40.1.8/CSR Feedback
D	6/40.1.9/Reports
D	6/40.1.10/CMS Monitoring
R	6/40.2/PCC Staff Development and Training
N	6/40.2.1/General Requirements
N	6/40.2.2/Provider Contact Centers Training Program
N	6/40.2.3/Closure Determination
N	6/40.2.4/Provider Complaints
N	6/40.2.5/Training Schedule
N	6/40.2.6/Training Closures of More than Four Hours
N	6/40.2.7/Provider Notifications
N	6/40.2.8/CSR Feedback
N	6/40.2.9/Reports
N	6/40.2.10/CMS Monitoring
N	6/40.3/PRRS Staff Training
R	6/50/Provider Self-Service Technology
R	6/50.1/Interactive Voice Response system (IVR)
R	6/50.2/Provider Web Site
R	6/50.2.1/General Requirements and Content
R	6/50.2.2/Webmaster and Attestation Requirements
R	6/50.2.3/Feedback Mechanism
R	6/50.2.4/Contents
R	6/50.2.4.1/Information from CMS
R	6/50.2.4.2/FAQs
R	6/50.2.4.3/Quarterly Provider Update (QPU)
N	6/50.2.4.4/Internet-based Provider Educational Offerings
R	6/50.3/Electronic Mailing List/Listserv
R	6/50.3.1/Targeted Electronic Mailing Lists/Listservs
R	6/50.3.2/Listserv Promotion
R	6/60/PCSP Performance Management
R	6/60.1/POE – Listserv Membership
D	6/60.1.1/Call Completion

D	6/60.1.2/CSR Identification to Callers
D	6/60.1.3/Sign-in Policy
D	6/60.1.4/Equipment Requirements
D	6/60.1.5/Remote Monitoring Access
D	6/60.1.6/Call Acknowledgment
D	6/60.1.7/Average Speed of Answer (ASA)
D	6/60.1.8/Callbacks
D	6/60.1.9/QCM Performance Standards
R	6/60.2/Telephone Inquiries
N	6/60.2.1/Initial Call Resolution
D	6/60.2.1.1/PRRS
N	6/60.2.2/Call Completion
N	6/60.2.3/Call Acknowledgment
N	6/60.2.4/Average Speed of Answer (ASA)
N	6/60.2.5/Callbacks
N	6/60.2.6/QCM Performance Standards
N	6/60.3/Written Inquiries
N	6/60.3.1/QWCM Performance Standards
N	6/60.3.2/General Inquiries Timeliness
N	6/60.4/PRRS Timeliness
R	6/70.1/Definition of Contact Center for CSAMS
R	6/70.2/Data to Be Reported Monthly
R	6/90/Provider Inquiry Standardized Categories

III. FUNDING:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2007 operating budgets.

IV. ATTACHMENTS:
Manual Instruction
Business Requirements

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

Attachment - Business Requirements

Pub. 100-09	Transmittal: 18	Date: September 8, 2006	Change Request 5277

SUBJECT: Provider Customer Service Program

I. GENERAL INFORMATION

A. Background: Chapter 3 is being revised to: include changes made to the FY 2006 Budget and Performance Requirements (BPRs) for provider inquiries (20.1, 20.1.3, 20.1.4), clarify that contractors require providers to use the Interactive Voice Response (IVR) system to check beneficiary eligibility and claim status (20.1), update hyperlinks to CMS' redesigned web site (20.1.1, 20.1.4, 20.1.6), reflect a name change for the Network Service Provider from MCI to Verizon (20.1.1, 20.1.4), require contractors to train customer service representatives to use the CMS web site and the contractor's provider education web site to assist providers (20.1.6), clarify how contractors are to submit instructions to access the contractor's call center so that CMS may perform remote monitoring (20.1.7), clarify date stamping for emails and faxes (20.2), reinsert language concerning timeliness of written responses incorrectly deleted in CR4137 (20.2.1), include how inquiries received via fax are to be handled (20.2.1), include information about contractor responsibilities for provider satisfaction surveys (20.4), include changes to the inquiry standardization chart and a requirement to submit an inquiry tracking report (20.5), include changes made to provider inquiries as a result of the FY07 BPRs (20.1.3, 20.2.2.3) and provide miscellaneous clarifications (10, 20.1, 20.1.1, 20.1.3, 20.1.7, 20.1.9, 20.2.2.2, 20.4.)

Chapter 4 is being deleted. Contractors shall follow the requirements in IOM 100-9, Chapter 6 for Provider Outreach and Education activities (all sections in 20, 40.1, 50.2, 50.3 and 60.1.)

Chapter 6 is being revised to: include changes made to provider inquiries (30.2.4, 30.2.3.2, 30.2.7.2, 30.3, 30.5, 30.6, 60.2, 60.3, 60.4), update hyperlinks to CMS' redesigned web site (20.3, 20.3.4.5, 20.5.1, 20.5.2, 30.2, 30.2.7, 30.6, 30.7, 40.2, 40.2.1, 40.2.5, 50.2.2, 50.2.4, 50.3.1), reflect a name change for the Network Service Provider from MCI to Verizon (30.2, 70.2), require contractors to train customer service representatives to use the CMS web site and the contractor's provider education web site to assist providers (50.2), clarify how email and fax inquiries are to be handled (30.3.4), include information about contractor responsibilities for provider satisfaction surveys (30.9), include changes to the inquiry standardization chart and a requirement to submit an inquiry tracking report (30.6, 90), clarify contractor responsibilities for data analysis (20.2), require contractors to educate using medical review referrals (20.3.4.2), clarify contractor responsibilities regarding the Education Activity Report (20.5.2) and provide miscellaneous clarifications throughout the document.

Chapter 6 is also being reorganized to present the information in a more logical arrangement.

B. Policy: These changes reflect Addendum 2 to the FY 2006 BPRs issued February 1, 2006 as well as needed clarifications and corrections. Additionally, the changes reflect the FY 07 BPRs effective October 1, 2006. All contractors shall follow § 20, 40.1, 50.2, 50.3 and 60.1 of Chapter 6. All contractors funded for CR 3376 and all Medicare Administrative Contractors (MACs) shall follow

Chapter 6 in its entirety. Those contractors not funded for 3376 shall continue to follow IOM Pub.100-9, Chapter 3, for their provider inquiries work.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5277.1	Contractors shall implement the revised requirements in IOM 100-9, Chapter 3, section 20.1, concerning provider call center hours of operation, reporting unplanned call center closures, and use of the IVR to check beneficiary eligibility and claim status.	x	x		x					RRB carrier
5277.2	Contractors shall implement the revised requirements in IOM 100-9, Chapter 3, section 20.1.3, concerning the provider call center queue message, average speed of answer, service level indicator, call completion rate and Quality Call Monitoring performance standards.	x	x		x					RRB carrier
5277.3	Contractors shall refer providers with questions about interpretation of procedural and diagnostic coding to the entities identified in IOM 100-9, Chapter 3, section 20.1.3.E.	x	x		x					RRB carrier
5277.4	Contractors shall implement the revised requirements in IOM 100-9, Chapter 3, section 20.1.4, concerning the days allowed for callback.	x	x		x					RRB carrier
5277.5	Contractors shall implement the revised requirements in IOM 100-9, Chapter 3, section 20.1.6, concerning CSR training on the CMS and contractor provider education web sites.	x	x		x					RRB carrier
5277.6	Contractors shall implement the revised requirements in IOM 100-9, Chapter 3, section 20.1.7, concerning the submission of remote monitoring access instructions.	x	x		x					RRB carrier

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5277.7	Contractors shall implement the requirements in IOM 100-9, Chapter 3, section 20.2, to date stamp faxes and emails received after the close of business with the next business day's date.	x	x		x					RRB carrier
5277.8	Contractors shall implement the requirements in IOM 100-9, Chapter 3, section 20.2.1, concerning interim responses for written inquiries.	x	x		x					RRB carrier
5277.9	Contractors shall respond to inquiries received via fax in a similar fashion as those received via email according to IOM 100-9, Chapter 3, section 20.2.1.E.	x	x		x					RRB carrier
5277.10	Contractors shall implement the revised requirements in IOM 100-9, Chapter 3, section 20.2.2.3, concerning Quality Written Correspondence Monitoring performance standards.	x	x		x					RRB carrier
5277.11	Contractors shall implement the requirements in IOM 100-9, Chapter 3, section 20.4, to assist CMS with implementing provider satisfaction surveys.	x	x		x					RRB carrier
5277.12	Contractors shall implement the changes in the inquiry standardization chart and submit an inquiry tracking report as instructed in IOM 100-9, Chapter 3, section 20.5.	x	x		x					RRB carrier
5277.13	Beginning October 1, 2006, contractors previously following the requirements in IOM 100-9, Chapter 4, concerning provider communications, shall follow the requirements in IOM 100-9, Chapter 6, sections 20, 40.1, 50.2, 50.3 and 60.1. Effective October 1, 2006, Chapter 4 is deleted.	x	x		x					RRB carrier
5277.14	Contractors funded for the requirements in CR 3376 shall be in compliance with the instructions in IOM 100-09, Medicare Contractor Beneficiary and Provider Communications Manual, Chapter 6.	x	x	x						DME MAC, A/B MAC

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5277.15	Contractors shall implement a provider education strategy based on the analysis of error rate data, inquiries, claim submission errors, and referrals from medical review as required by IOM 100-9, Chapter 6, sections 20.2, 20.2.1, 20.2.2, 20.2.3, and 20.2.4.	x	x	x						DME MAC, A/B MAC
5277.16	The contractor shall develop a method of effective communication with medical review regarding the disposition of medical review cases referred to Provider Outreach and Education for potential educational intervention as required in IOM 100-9, Chapter 6, section 20.2.4.	x	x	x						DME MAC, A/B MAC
5277.17	Contractors shall educate the provider community on new or significantly revised Local Coverage Determinations as required in IOM 100-9, Chapter 6, section 20.3.4.1	x	x	x						DME MAC, A/B MAC
5277.18	Contractors shall provide education as a result of medical review referrals when requested by the provider as required in IOM 100-9, Chapter 6, section 20.3.4.2.	x	x	x						DME MAC, A/B MAC
5277.19	Contractors shall prepare and submit twice per contract year an Education Activity Report as required in IOM 100-9, Chapter 6, section 20.5.2.	x	x	x						DME MAC, A/B MAC
5277.20	Contractors shall implement the requirements in IOM 100-9, Chapter 6, section 20.5.3 concerning the Error Rate Reduction Plan.	x	x	x						DME MAC, A/B MAC
5277.21	Contractors shall comply with IOM 100-9, Chapter 6, section 20.6.1 and offer education at no charge to providers attending an education event as a result of receiving a medical review referral to Provider Outreach and Education.	x	x	x						DME MAC, A/B MAC

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5277.22	Contractors shall implement the revised requirements in IOM 100-9, Chapter 6, section 20.6.4, concerning excess revenues from participant fees at education events.	x	x	x						DME MAC, A/B MAC
5277.23	Contractors shall meet the requirements in IOM 100-9, Chapter 6, section 60.2.2, concerning call completion rates.	x	x	x						DME MAC, A/B MAC
5277.24	Contractors shall implement the revised requirements in IOM 100-9, Chapter 6, section 30.2.3, concerning hours of operation.	x	x	x						DME MAC, A/B MAC
5277.25	Contractors shall implement the revised requirements in IOM 100-9, Chapter 6, section 30.2.3.2., concerning the queue message for provider contact centers.	x	x	x						DME MAC, A/B MAC
5277.26	Contractors shall submit remote monitoring access instructions to CMS as instructed in IOM 100-9, Chapter 6, section 30.2.5.	x	x	x						DME MAC, A/B MAC
5277.27	Contractors shall implement the requirements in IOM 100-9, Chapter 6, section 30.3.4, to date stamp faxes and emails received after the close of business with the next business day's date.	x	x	x						DME MAC, A/B MAC
5277.28	The contractor's PRRS staff shall provide clear, accurate, and complete written answers within 25 business days for at least 75 percent of cases referred by the telephone CSRs, and 45 business days for 100% of all cases referred by telephone CSRs or from the general written inquiries area as required by IOM 100-9, Chapter 6, § 60.4.	x	x	x						DME MAC, A/B MAC
5277.29	Contractors shall implement the changes in the inquiry standardization chart and submit an inquiry tracking report as instructed in IOM 100-9, Chapter 6, sections 30.6 and 90.	x	x	x						DME MAC, A/B MAC

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5277.30	Contractors shall implement the requirements in IOM 100-9, Chapter 6, section 30.9.2.1, to assist CMS with implementing the Medicare Contractor Provider Satisfaction Survey.	x	x	x						DME MAC, A/B MAC
5277.31	Contractors shall implement the revised requirements in IOM 100-9, Chapter 6, section 50.1, concerning Interactive Voice Response systems.	x	x	x						DME MAC, A/B MAC
5277.32	Contractors shall implement the revised requirements in IOM 100-9, Chapter 6, section 50.2.4.2, concerning Frequently Asked Questions.	x	x	x						DME MAC, A/B MAC
5277.33	Contractors shall meet the requirements in IOM 100-9, Chapter 6, section 60.1, concerning provider participation in contractor listservs.	x	x	x						DME MAC, A/B MAC
5277.34	Contractors shall meet the requirements in IOM 100-9, Chapter 6, section 60.2.4, concerning average speed of answer.	x	x	x						DME MAC, A/B MAC
5277.35	Contractors shall meet the revised requirements in IOM 100-9, Chapter 6, section 60.2.5, concerning callbacks.	x	x	x						DME MAC, A/B MAC
5277.36	Contractors shall meet the Quality Call Monitoring performance standards in IOM 100-9, Chapter 6, section 60.2.6.	x	x	x						DME MAC, A/B MAC
5277.37	Contractors shall meet the Quality Written Correspondence Monitoring performance standards in IOM 100-9, Chapter 6, section 60.3.1.	x	x	x						DME MAC, A/B MAC
5277.38	Contractors shall refer providers with questions about interpretation of procedural and diagnostic coding to the entities identified in IOM 100-9, Chapter 6, section 30.1.	x	x	x						DME MAC, A/B MAC

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5277.39	Contractors shall implement the requirements in IOM 100-9, Chapter 3, section 20.4.2.1, to assist CMS with implementing the Medicare Contractor Provider Satisfaction Survey.	x	x		x					RRB carrier
5277.40	Contractors who are not Medicare Administrative Contractors (MACs) shall follow the fiscal year as the contract year.	x	x	x	x					RRB carrier

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	None. .									

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions:

X-Ref Requirement #	Instructions
N/A	

B. Design Considerations:

X-Ref Requirement #	Recommendation for Medicare System Requirements
N/A	

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: While not a new workload for contractors, the reporting requirements for provider education as a result of medical review referrals will shift from Local Provider Education and Training to Provider Outreach and Education.

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: October 1, 2006 **Implementation Date:** October 2, 2006 **Pre-Implementation Contact(s):** Lynne Lockard, 410-786-2174, lynne.lockard@cms.hhs.gov Charlie Riesz, 410-786-8127, charles.riesz@cms.hhs.gov Shana Olshan, 410-786-3122, shana.olshan@cms.hhs.gov **Post-Implementation Contact(s):** Appropriate Regional Office contact.	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.**

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

Medicare Contractor Beneficiary and Provider Communications Manual
Chapter 3 - Provider Inquiries

Table of Contents

(Rev. 18, 09-08-06)

10 - Introduction

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

NOTE: Those contractors not funded for the requirements in CR 3376 shall follow the instructions in this chapter. Contractors funded for CR 3376 shall follow the instructions in Chapter 6 of IOM Pub. 100-09.

This chapter contains general instructions and requirements for Medicare carriers, including DMERCs and intermediaries for processing provider inquiries (telephone, written and walk-in.) Normally, the term "contractor" is used in this manual to mean any or all of these. If an instruction should apply to only one type of contractor, it will be specified.

In this chapter, the term provider applies to all Medicare provider and supplier types.

20.1 - Guidelines for Telephone Service

(Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06)

The guidelines established below apply to contractors' general provider inquiry telephone numbers. The standards shall not apply to those inquiries handled by other units within the contractor (e.g., appeals, fraud, MSP). To ensure all inquiries are handled as expeditiously as possible, inbound provider inquiry numbers (and the lines) shall be separate from beneficiary inquiry numbers. Providers shall not use numbers established for beneficiary inquiries.

A. Availability of Telephone Service

1. Contractors shall make CSR telephone service available to callers continuously during normal business hours, including lunch and breaks.

2. Normal business hours for live telephone service are defined as 8:00 a.m. through *4:00* p.m. for all time zones of the geographical area serviced, Monday through Friday. *Where provider call volume supports it, the normal business hours may be shifted to 8:30 a.m. – 4:30 p.m. for all time zones. Contractors adopting these hours shall notify CMS by sending an e-mail to Service Reports (servicereports@cms.hhs.gov) no later than the first day of the contract year (October 1) or one month in advance of an anticipated change within a contract year.*

3. Planned closures during normal business hours must be approved by CMS CO. Contractors shall notify CMS via the service reports mailbox (servicereports@cms.hhs.gov) by October 31st of each year about any planned call center closures. This list shall also be sent to the appropriate RO. Call centers shall notify the provider community of the approved closure at least two weeks in advance of closure.

4. On Federal holidays, in lieu of answering telephone inquiries, contractors may choose to perform other appropriate call center work, e.g., provide CSR training. Contractors shall notify CMS via the service reports mailbox (servicereports@cms.hhs.gov) by October 31st of each year about any planned call center closures. This list shall also be sent to the appropriate RO. Call centers shall notify the provider community of the planned closure at least two weeks in advance of closure*, including Federal holiday closures*.

5. *Contractors shall notify CMS via the service reports mailbox (servicereports@cms.hhs.gov) of any unplanned closures (those not submitted by October 31st) at least three weeks before the planned date of closure. If CMS CO grants approval of the closure the contractor shall notify the provider community of the approved closure at least two weeks in advance of the closure.*

6. Call center staffing shall be based on the pattern of incoming calls per hour and day of the week, ensuring that adequate coverage of incoming calls throughout each workday is maintained.

In accordance with Section 508 of the Rehabilitation Act of 1973 and the Workforce Investment Act of 1998, all call centers shall provide the ability for deaf, hard of hearing or speech-impaired providers to communicate via TeleTYpewriter (TTY) equipment. A

TTY is a special device permitting, hard of hearing, or speech-impaired individuals to use the telephone, by allowing them to type messages back and forth to one another instead of talking and listening. (A TTY is required at both ends of the conversation in order to communicate.) Contractors shall publicize the TTY line on their websites.

B - Automated Services-Interactive Voice Response (IVR)

1. Although the provider shall have the ability to speak to a CSR during normal call center operating hours, automated "self-help" tools, such as IVRs, shall also be used by all contractors to assist with handling inquiries. IVR service is intended to assist providers in obtaining answers to various Medicare questions, including those listed below:

- Contractor hours of operation for CSR service
- General Medicare program information. (Contractors shall target *individual* message duration to be under 30 seconds. Contractor shall have the technical capability to either require callers to listen or to allow them to bypass the message as determined by CMS. In cases where CMS makes no determination the contractor shall use their own discretion.)
- Specific information about claims in process and claims completed. For claims status inquiries handled in the IVR, all call centers shall adhere to the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule *by authenticating callers as required in section 30 of this chapter.*
- *Official d*efinitions for the 100 most frequently used Remittance Codes as determined by each contractor. Contractors are not limited to 100 definitions and may add more if their system has the capability to handle the information. This requirement may be satisfied by providing *official* Remittance Code definitions for specific provider IVR claim status inquiries.

NOTE: *Providers shall be required to use IVRs to access claims status and beneficiary eligibility information.* IVRs shall be updated to address areas of provider confusion as determined by contractors' inquiry analysis staff and CMS best practices at least once every six months.

2. The IVR shall be available to providers 24 hours a day with allowances for normal claims processing and system mainframe availability, as well as normal IVR and system maintenance. When information is not available, contractors shall put a message alerting providers *on the IVR*. Waivers shall be granted as needed to allow for normal IVR and system maintenance.

NOTE: IVRs shall be programmed to provide callers with an after-hours message indicating normal business hours. (It is not necessary to duplicate this message if the caller is informed of the normal business hours via the telephone system prior to being delivered to the IVR.)

3. Contractors shall print and distribute a clear IVR operating guide to providers upon request. The guide shall also be posted on the contractor's Web site.

Contractors who are able to provide claims status information through their IVR shall require providers to use the IVR to obtain this information.

20.1.1 - Toll Free Network Services

(Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06)

A. Inbound Services

The CMS will use the General Services Administration's FTS 2001 contract *or its successor* for its toll-free network. All inbound provider telephone service will be handled over the toll-free FTS network, with the designated Network Service Provider (NSP), currently *Verizon*. Any new toll-free numbers and the associated network circuits used to carry these calls shall be acquired via the FTS 2001 network. Contractors shall not maintain their own local inbound lines.

B. Processes for Ordering More Lines, Changing Configurations, or Disconnecting Lines

1. The ongoing management of the entire provider toll free system requires a process for making changes, which may be initiated by either the contractor or CMS. All change requests associated with the FTS 2001 network (e.g., adding or removing channels or T1s, office moves, routing changes), shall be processed through the Provider Telecommunications Technical Support Contractor (TSC). *Contact information for the TSC is located at http://www.cms.hhs.gov/ProviderInquiryOp/.* Any CMS-initiated changes (i.e., adding lines, removing lines, reconfiguring trunk groups) will be based upon an analysis of Customer Service Assessment and Management System (CSAMS) data and traffic reports. *CMS reserves the right to initiate changes based on this information.*

2. If a contractor is requesting changes they shall provide an analysis of their current telephone environment (including a detailed traffic report) specific to the service being requested that shows the need for changes to their phone system (i.e., additional lines, trunk group reconfiguration). This information shall be gathered at the contractor site through the contractor's switch and through the *Verizon Business* Customer Center reports. This information should be sent to CO and the appropriate RO. Based on technical merit and availability of funds, CO will review the recommendation and make a determination. In cases where the request is approved, CO will forward approved requests to the designated agency representative (DAR) for order issuance.

C. Troubleshooting

To report and monitor a problem, contractors shall follow these steps:

Step 1

Isolate the problem and determine whether it is caused by internal customer premise equipment or the toll-free network service.

- Internal Problem - The contractor's local telecommunications personnel shall resolve, but report per steps below.
- Toll-Free Network Service Problem - Contractor reports the problem to *Verizon* by calling 1-888-387-7821.

Step 2

Involve personnel from the Provider TSC, if needed, to answer technical questions or to facilitate discussions with the *Verizon* Help Desk. *Contact information for the TSC is located at http://www.cms.hhs.gov/ProviderInquiryOp/.*

Step 3

File an incident report with the provider TSC for major interruptions of service. The TSC will notify the appropriate CMS staff. Major interruption of service is defined as any incident with a trouble ticket opened for more than 24 hours or a total loss of service. The contractor shall send an email to service reports that summarizes the problem and the steps taken to restore full service. The contractor shall send a follow-up email to service reports when the problem has been resolved.

Step 4

Use *Verizon's Business* Customer Service Center to review documentation, track trouble tickets, or to close a trouble ticket online.

Step 5

File a monthly report with CMS at servicereports@cms.hhs.gov about interruption of service - including both *Verizon* related and in-house and send a copy to the contractor's RO.

D. Disaster Recovery

1. When a call center is faced with a situation that results in a major disruption of service, the call center shall take the necessary action to ensure that callers are made aware of the situation. This service is intended to supplement the contractor's existing disaster recovery or contingency plans. Whenever possible, the call center is responsible for activating its own emergency messages or re-routing calls. However, when this is not possible and providers are unable to reach the call center switch, the call center shall contact the TSC. *Contact information for the TSC is located at http://www.cms.hhs.gov/ProviderInquiryOp/.* The contractor shall also send an email to servicereports@cms.hhs.gov *reporting the problem*. For all other FTS 2001 support requests, provider call centers shall follow their normal procedures.

By December 31st of each year, call centers shall *submit to CMS* their *current* written contingency plan describing how the Medicare provider telecommunications operations will be maintained or continued in the event of manmade or natural disasters. The plan shall cover partial loss of telecommunications capabilities due to equipment or network failures through the total loss of a call center. The plan may include arrangements with one or more other contractors to assist in telephone workload management during the time the call center is unable to receive provider phone calls. *Contractors shall submit these p*lans to the service reports mailbox at servicereports@cms.hhs.gov or via postal mail, with a copy to the RO. Contractors may choose to submit the portion of their contingency plan *that deals with telecommunications developed in relation to the Centers for Medicare & Medicaid Services (CMS) Business Partners Systems Security Manual.*

E. Inbound Service Costs

The CMS will pay for the rental of inbound T-1/PRI lines and all connect time charges for FTS-2001 toll-free service. The costs associated with the installation and monthly

fees for this toll-free service will be paid centrally by CMS and shall not be considered by contractors in their budget requests. However, contractors shall still be responsible for all other internal telecommunications costs and devices such as agent consoles, handsets, internal wiring and equipment (ACD, IVR, PBX, etc.) and any local or outbound telephone services and line charges. Since these costs are not specifically identified in any cost reports, contractors shall maintain records for all costs associated with providing telephone service to providers (e.g., costs for headsets) and shall provide this information upon request by RO or CO.

20.1.3 - Call Handling Requirements

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

A. Call Acknowledgement

Contractors shall program all systems related to inbound provider calls to the center to acknowledge each call within 20 seconds before a CSR, IVR or ACD prompt is reached. This measure shall be substantiated and/or reported upon request by CMS.

B. Providing Busy Signals

Call center customer premise equipment shall not be configured/programmed to return, "soft busies." Contractor call centers shall only provide "hard" busy signals to the FTS network. At no time, shall any software, gate, vector, application, IVR, and/or ACD/PBX accept the call by providing answer back supervision to the FTS network and then providing a busy signal to the caller and/or dropping the call. The contractor shall optimize their inbound toll-free circuits to ensure the proper ratio of circuits to existing FTEs.

C. Call Routing

When a call center routes calls to another site, CMS needs to make sure that the contractor handling the calls gets credit for the work. If a call is forwarded over a contractor's system there is no way for CMS to determine the final termination point of the call. Therefore, prior to transferring calls to another center, contractors shall notify CMS through the Service Reports mailbox at servicereports@cms.hhs.gov. Contractors shall also notify the appropriate Regional Office.

D. Queue Message

Contractors shall provide a recorded message that informs callers waiting in queue to speak with a CSR. They shall use the message to inform the provider to have certain information readily available (e.g., health insurance claim number) before speaking with the CSR. The queue message should also be used to indicate non-peak time frames for callers to call back when the call center is less busy.

Beginning October 1, 2006, the contractor's queue message shall announce to callers in queue the anticipated time until answer. The contractor shall also use the queue time to deliver educational information on issues identified by the contractor.

E. General Inquiries Line

The provider toll free numbers installed for general provider inquiry traffic shall not be used for other applications (e.g., MSP, reviews, EDI, provider enrollment, and other non-claim related provider inquiries) beyond answering general questions for each application. At a minimum, these general lines shall be used to handle questions related to billing, claims, eligibility, and payment. Complex questions (ones that might currently require an internal transfer) shall be directed to the "other" units on a different toll free number than the general inquiry number. It is not necessary for each "other" function to have its own unique toll free number, although contractors can choose this option. Other acceptable options are having a single "other" toll free number to handle all the "other" (non general inquiry) functions or a few "other" toll free numbers handling more than one

"other" function via each number. The CSRs on the general inquiry line shall not transfer callers to the "other" functional units but rather shall instruct the caller to hang up and dial the appropriate number. "Other" numbers shall not be subject to CSAMS reporting or the call performance standards that govern the general inquiries line. If contractors need toll free service for other Medicare applications currently being handled on the provider claims inquiry toll free numbers, please follow the established process for adding additional toll free numbers. We will consider all requests for additional toll free numbers.

Providers are responsible for determining the correct diagnostic and procedural coding for the services they furnish to Medicare beneficiaries. General information about coding may be found at http://www.cms.hhs.gov/MedHCPCSGenInfo/20_HCPCS_Coding_Questions.asp#TopOfPage. Customer service representatives shall not make those determinations about the proper use of codes for the provider. When providers inquire about interpretation of procedural and diagnostic coding they shall be referred to the entities that have responsibility for those coding sets. There are four places that CSRs shall refer callers that have questions about coding.

1. Current Procedural Terminology (CPT-4) are codes proprietary to the American Medical Association (AMA). As such, CPT coding questions from providers (with exception noted in 4 below) shall be referred to the AMA. The AMA offers CPT Information Services (CPT-IS). This new internet based service is a benefit to AMA members and is available as a subscription fee-based service for non-members and non-physicians. The AMA also offers CPT Assistant. Information about these resources is found at www.ama-assn.org.

2. ICD-9-CM related questions are handled by the American Hospital Association's Coding Clinic. Details about this resource are available at www.ahacentraloffice.org.

3. Level II Healthcare Common Procedure Coding System (HCPCS) codes related to Durable Medical Equipment or prosthetics, orthotics, and supplies are answered by the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) or, in the future, the Data and Analysis Coding function contractor (DAC). This contractor has a website with lots of information and a toll-free helpline.

4. The American Hospital Association's Coding Clinic for HCPCS responds to questions related to CPT-4 codes for hospital providers and Level II HCPCS codes, specifically A-codes for ambulance service and radiopharmaceuticals, C-codes, G-codes, J-codes, and Q-codes (except Q0136 through Q0181), for hospitals physicians and other health professionals who bill Medicare. Details about this resource are available at www.ahacentraloffice.org.

F. CSR Identification to Callers

The CSRs shall identify themselves when answering a call, however the use of both first and last names in the greeting is optional. In order to provide a unique identity for each CSR for accountability purposes, where a number of CSRs have the same first name, it is

suggested that the CSRs also use the initial of their surname. If the caller specifically requests that a CSR identify himself/herself, the CSR shall provide both first and last name. Where the personal safety of the CSR is an issue, *or for other security reasons,* call center management shall permit the CSR to use an alias*, such as an Operator ID or a telephone extension*. This alias shall be known for remote monitoring purposes. The CSRs shall also follow local procedures for escalating calls to supervisors or managers in situations where warranted.

G. Sign-in Policy

Contractors shall establish and follow a standard CSR sign-in policy in order for CMS to ensure that data collected for telephone performance measurement are consistent from contractor to contractor. The sign-in policy shall include the following:

- The CSRs available to answer telephone inquiries shall sign-in to the telephone system to begin data collection;
- The CSRs shall sign-off the telephone system for breaks, lunch, training, and when performing any other non-telephone inquiry workload. (Note: If the telephone system supports an additional CSR work-state or category that accumulates this non-telephone inquiry performance data so that it can be separated and not have any impact on the measurements CMS wants to collect, this work-state or category may be utilized in lieu of CSRs signing-off the system; and
- The CSRs shall sign-off the telephone system at the end of their workday.

H. Average Speed of Answer (ASA) – for provider call centers (non-blended)

Beginning October 1, 2006, the contractor shall maintain an average speed of answer of 120 seconds. This standard shall be measured quarterly and will be cumulative for the quarter.

Of all calls answered by the contractor by a customer service representative (CSR) during *February through September 2006,* the contractor shall maintain an average speed of answer of *60* seconds or less. During the quarter, no month shall have an average speed of answer greater than *80* seconds. This standard shall be measured quarterly and will be cumulative for the quarter.

The ASA standard will be applied to the speed at which the initial call is answered by a CSR. Should the caller need to be transferred to another level CSR, the time associated with that transfer shall not be included in the ASA calculation.

NOTE: Contractors with provider call centers shall continue to report 60 second Service Level Indicator (SLI) in addition to ASA.

I. Average Speed of Answer – for beneficiary/provider blended call centers

Beginning October 1, 2006, the contractor shall maintain an average speed of answer of 120 seconds. This standard shall be measured quarterly and will be cumulative for the quarter.

***NOTE:** Contractors with beneficiary/provider blended call centers shall report 120 second SLI and ASA.*

***J*. Service Level Indicator - for beneficiary/provider blended call centers**

*From October 1, 2005 through September 30, 2006, e*ach month, contractors shall answer no less than 85 percent of all callers who choose to speak to a CSR within the first 120 seconds of their delivery to the queuing system. This standard will be measured monthly.

NOTE: Contractors with beneficiary/provider blended call centers shall report 120 second SLI and ASA.

***K*. Initial Call Resolution**

Contractors shall handle no less than 90 percent of the calls to completion during the initial contact with a CSR. A call is considered resolved during the initial contact if it does not require a return call by a CSR. This standard will be measured quarterly and will be cumulative for the quarter.

***L*. Call Completion**

- *Beginning October 1, 2006, each CSR and IVR combined line shall have a completion rate of no less than 70%. From February through September 2006, e*ach CSR and IVR combined line shall have a completion rate of no less than 80%. This standard will be measured quarterly and will be cumulative for the quarter.
- *Beginning October 1, 2006, each CSR-only line shall have a completion rate of no less than 70%. From February through September 2006, e*ach CSR-only line shall have a completion rate of no less than 80%. This standard will be measured quarterly and will be cumulative for the quarter.
- *Beginning October 1, 2006, each IVR-only line shall have a completion rate of no less than 90%. From February through September 2006, e*ach IVR-only line shall have a completion rate of no less than 95%. This standard will be measured quarterly and will be cumulative for the quarter.

***M*. Callbacks**

Contractors shall only have to make three attempts to reach a provider for a callback. *The contractor may leave a message requesting a return call, including the patient's name if appropriate, but no PHI should be left on the message. If the provider does not respond after 3 callbacks, the contractor has the discretion to prepare a written response, completed within 10 business days of the original inquiry. The contractor shall not close out the inquiry without any type of response to the caller. Contractors shall not leave the response on the provider's voicemail. All callbacks shall be completed and closed out within 10 business days of the original inquiry and documented in the inquiry tracking system, discussed in section 20.5.*

***N*. Quality Call Monitoring:**

- Frequency of Monitoring: Contractors shall monitor a minimum of three calls per CSR per month. In centers where CSRs answer both beneficiary and provider calls, monitor a minimum of three calls, including at least one of each type, during the month. Any deviation from this requirement shall be requested and justified to the RO in order to determine if a waiver is warranted.

- Performance Standards for Quality:
    - *Beginning October 1, 2006, of all calls monitored for the quarter, the percent scoring as "Pass" shall be no less than 90 percent for Adherence to Privacy Act. From February through September 2006, o*f all calls monitored for the quarter, the percent scoring as "Pass" for Adherence to Privacy Act shall be no less than 93 percent. During the quarter, no month shall fall below 85 percent. This standard will be measured quarterly and will be cumulative for the quarter.
    - *Beginning October 1, 2006, of all calls monitored for the quarter, the percent scoring as "Achieves Expectations" or higher shall be no less than 90 percent for Customer Skills Assessment. From February through September 2006, o*f all calls monitored for the quarter, the percent scoring as "Achieves Expectation" or higher shall be no less than 93 percent for Customer Skills Assessment. During the quarter, no month shall fall below 85 percent. This standard will be measured quarterly and will be cumulative for the quarter.
    - *Beginning October 1, 2006, of all calls monitored for the quarter, the percent scoring as "Yes" shall be no less than 90 percent for Knowledge Skills Assessment. From February through September 2006, o*f all calls monitored for the quarter, the percent scoring as "Yes" shall be no less than 93 percent for Knowledge Skills Assessment. During the quarter, no month shall fall below 85 percent. This standard will be measured quarterly and will be cumulative for the quarter.

***O*. Equipment Requirements:**

- To ensure that inquiries receive accurate and timely handling, contractors shall provide the following equipment:
    1. Online access to a computer terminal for each CSR responsible for claims-related inquiries. Locate the computer terminal so that representatives can research data without leaving their seats.
    2. Access to the contractor's Web site and www.cms.hhs.gov.
    3. An outgoing line for callbacks.
    4. A supervisory console for monitoring CSRs.

***P*. Limiting the Number of Issues Per Call**

- Call centers may limit the number of issues discussed during one phone call, but all call centers shall respond to at least three issues before asking the provider to call back.

20.1.4 - Customer Service Assessment and Management System (CSAMS) Reporting Requirements

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

The CSAMS is an interactive Web-based software tool used by CMS to collect and display call center telephone performance data. Each call center site shall enter required telephone customer service data elements into CSAMS between the 1st and 10th of each month for the prior month. To change data after the 10th of the month, users shall inform CO via CSAMS at csams@cms.hhs.gov. In those rare situations where one or more data elements are not available by the 10th of the month, the missing data shall not prevent the call center from entering all other available data into CSAMS timely. The call center shall supply the missing data to CMS within two workdays after it becomes available to the contractor. Definitions, calculations and additional information for each of the required telephone customer service data elements as well as associated standards are posted on the CMS' telephone customer service Web site at https://bizapps.cms.hhs.gov/csams. Call centers shall use CSAMS call handling data to improve call center performance.

A. Definition of Call Center for CSAMS

All contractors shall ensure that monthly CSAMS data are being reported by individual call centers and that the data are not being consolidated. The CMS wants telephone performance data reported at the lowest possible physical location in order to address performance concerns. A call center is defined as a location where a group of CSRs *is* answering *Medicare provider calls*.

B. Data to Be Reported Monthly

Contractors shall capture and report the following data each month:

- Number of Attempts - This is the total number of calls offered to the provider call center via the FTS Toll-Free during the month. This shall be taken from reports produced by FTS toll-free service provider. The current provider is *Verizon* and the reports are available at their Web site *http://www.verizonbusiness.com/us/.*
- Number of Failed Attempts - This represents the number of calls unable to access the call center via the toll-free line. This data shall be taken from reports produced by FTS toll-free service provider. The current provider is *Verizon* and the reports are available at their Web site *http://www.verizonbusiness.com/us/.* Number of Attempts (TTY/TDD) - This is the total number of calls offered to the TTY/TDD line at the provider call center via the FTS Toll-Free during the month. This shall be taken from reports produced by FTS toll-free service provider. The current provider is *Verizon* and the reports are available at their Web site *http://www.verizonbusiness.com/us/.*
- Number of Failed Attempts (TTY/TDD) - This represents the number of calls unable to access the call center via the TTY/TDD toll-free line. This data shall be taken from reports produced by FTS toll-free service provider. The current provider is *Verizon* and the reports are available at their Web site *http://www.verizonbusiness.com/us/.*

- Number of Attempts (for those call centers with IVR-only lines) - This is the total number of calls offered to the IVR-only line at the provider call center via the FTS Toll-Free during the month. This shall be taken from reports produced by FTS toll-free service provider. The current provider is *Verizon* and the reports are available at their Web site *http://www.verizonbusiness.com/us/.*
- Number of Failed Attempts for those call centers with IVR-only lines) - This represents the number of calls unable to access the call center via the IVR-only toll-free line. This data shall be taken from reports produced by FTS toll-free service provider. The current provider is *Verizon* and the reports are available at their Web site *http://www.verizonbusiness.com/us/.*
- Call Abandonment Rate - This is the percentage of provider calls that abandon from the ACD queue. This shall be reported as calls abandoned up to and including 60 seconds.
- Average Speed of Answer - This is the amount of time that all calls waited in queue before being connected to a CSR. It includes ringing, delay recorder(s), and music. This time begins when the caller enters the CSR queue and includes both calls delayed and those answered immediately.
- Total Sign-in Time (TSIT) - This is the amount of time the CSRs were available to answer telephone inquiries. This time includes the time that CSRs were plugged-in, logged-in, handling calls, making outgoing calls, in the after call work state or in an available state.
- Number of Workdays - This is the number of calendar days for the month that the call center is open and answering telephone inquiries. For reporting purposes, a call center is considered open for the entire day even if the call center was closed for a portion of the day and/or not able to answer telephone inquiries for a portion of the day.
- Total Talk Time - This is the total amount of time that all CSRs were connected to callers and includes any time the caller is placed on hold by the CSR during the conversation.
- Available Time - Available time is the amount of time that CSRs were signed-in on the telephone system waiting for a call to be delivered (i.e., the CSR is not handling calls, making outgoing calls, or in the after call work (ACW) state).
- After Call Work Time - This includes the time that CSRs need to complete any administrative work associated with a call after the customer disconnects.
- Status of Calls Not Resolved at First Contact - Report as follows:

    1. Number of callbacks required. This number is based on calls received for the calendar month and represents the number requiring a callback as of the last workday of the month.
    2. Number of callbacks closed within *10* workdays. This number is based on calls received for the calendar month and represents the number closed within

10 workdays even if a callback is closed within the first *10* workdays of the following month.

- IVR Handle Rate - Report data needed to calculate the IVR handle rate.

  For call centers with combined CSR and IVR lines this includes:

  1. The number of calls offered to the IVR (defined as the total number of calls receiving a prompt offering the use of the IVR during or after business hours); and
  2. The number of calls handled by the IVR.

  For call centers with separate CSR and IVR lines this includes:

  1. The number of calls offered to the IVR (defined as the total number of IVR-only calls receiving a prompt offering the use of the IVR during or after business hours plus the total number of CSR completed calls); and
  2. The number of calls handled by the IVR (defined as the number of calls where the caller selected and played at least one informational message).

- Calls in CSR queue - This is the total number of calls delivered to the CSR queue.
- Calls Answered by CSRs - This represents the total number of calls answered by all CSRs for the month from the CSR queue.
- Calls Answered <= 60 Seconds - This represents the total number of calls answered by all CSRs within 60 seconds from the CSR queue.
- Calls Answered <= 120 Seconds - This represents the total number of calls answered by all CSRs within 120 seconds from the CSR queue.
- Calls Abandoned <= 120 Seconds - This represents the total number of calls abandoned before or at 120 seconds from the CSR queue.
- Quality Call Monitoring (QCM)-Number of CSRs Available for Monitoring - This is the number of CSRs (not FTEs) that take calls on a regular basis, both full-time and part-time CSRs. This number is obtained from the QCM Database.
- QCM-Number of Completed Scorecards – This is the number of scorecards that were completed and entered into the QCM database for the month. This number is obtained from the QCM Database.
- QCM-Customer Skills Assessment - This is the percent of calls monitored that scored greater than or equal to Achieves Expectations. This number is obtained from the QCM Database.
- QCM-Knowledge Skills Assessment - This is the percent of calls monitored that scored greater than or equal to Achieves Expectations. This number is obtained from the QCM Database.
- QCM-Privacy Act - This is the percentage of calls that scored as pass. This number is obtained from the QCM Database.

- Training Hours – Normal Business Days - Report the number of hours (rounded to the nearest half-hour) that the provider contact center closed for CSR training per month. This indicator is used to measure the time the provider contact center is closed during normal business hours for staff development. The number of hours used each month can not exceed 8 hours per month.
- Training Hours – Federal Holidays - Report the number of hours (rounded to the nearest half-hour) that the provider contact center closed for CSR training on a Federal holiday(s) per month. This indicator is to measure the time the contact center closed on a Federal Holiday for staff development.

20.1.6 – Staff Development and Training

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

A. General Requirements

1. Contractors shall provide training for all new CSR hires and refresher training updates for existing personnel. This training shall enable the CSRs to answer the full range of customer service inquiries. Contractors shall have a training evaluation process in place to certify that the trainee is ready to independently handle inquiries.

2. Upon receipt of CMS developed standardized CSR training materials, including job aids, contractors shall implement these materials for all CSRs on duty and those hired in the future. Since the development of these materials will be done by CMS, it is not expected that there will be any costs to the contractors to use these training materials. Standardized training materials and other training information will be posted to the following Web site: *http://www.cms.hhs.gov/ContractorLearningResources/02_Training.asp#TopofPage*. Contractors shall check this Web site monthly for updated training materials. Contractors may supplement the standard materials with their own materials as long as there is no contradiction of policy or procedures.

3. All contractors shall train their CSRs about how to find, navigate and fully use their Medicare provider education Web site and www.cms.hhs.gov. CSRs shall be connected to and able to use the contractor's Web site and the CMS Web site *to assist* providers.

4. *All contractor provider call center staff shall be trained in the use of the contractor and CMS FAQs in order to maintain consistency of the information given to Medicare providers.*

5. Contractor staff working with provider telephone and written inquiries shall be trained to log their inquiry types according to the CMS Standardized Provider Inquiry chart in the tracking system used by the contractor.

6. Contractors shall send training representatives to 2-4 national train-the-trainer conferences provided by CMS. Contractors shall be prepared to send at least one customer service/provider education representative to these training sessions. Contractors shall expect training sessions to run from 2-4 days. This representative shall be responsible for training additional contractor customer service staff. These staff members shall also be prepared to develop training programs for Medicare providers and suppliers on the various initiatives.

B. Provider Contact Centers Training Program

The CMS recognizes the need for provider Customer Service Representative training. The goal is to help CSRs improve the consistency and accuracy of their answers to provider questions, to increase their understanding of issues, and to facilitate CSRs' retention of the facts of their training by increasing its frequency. To accomplish this goal, all Medicare Provider Contact Centers may close for up to 8 hours per month for CSR training and/or staff development with the following limitations:

- The 8 hours approved by CMS for contact center closure shall be used for training time only.
- The training time shall not be used for corporate meetings. Contractors shall request permission to close in those circumstances according to Section 20.1.A of this chapter.
- Training time not used within a specific month shall not be carried over to the next month.

Time used for training on Federal holidays is in addition to the 8 hours per month allowed by CMS for CSR training closure. This 8 hour allowance is separate from any training time occurring during Federal holidays in accordance with Section 20.1.A of this chapter.

1. Closure Determination

Contractors shall perform an analysis to evaluate the appropriate time for closure to anticipate the impact on their ability to meet all CMS performance requirements as instructed in Sections 20.1.3 and 20.2.1.4 of this chapter. Contractors should consult their *POE* Advisory Group about the best hours for training closures and training topics. CMS will not view performance waivers favorably if the training time closures are the justification for poor performance.

2. Provider Complaints

Contractors shall monitor provider complaints about training time closures and take action to resolve them and decrease the volume of complaints. Reports about provider complaints and their resolution shall be kept on site and available to CMS upon request.

3. Training Schedule

Contractors shall submit to CMS a training schedule, including dates, times, topics, sub-topics and contact information by the 15th of the month prior to when the training will be performed via the Provider Services mailbox, ProviderServices@cms.hhs.gov using the subject line "Training Schedule". CMS will post training schedules and contact information submitted by all Medicare contractors at *http://www.cms.hhs.gov/ContractorLearningResources/02_Training.asp#TopofPage*. Upon receipt of the training schedule, CMS will send an acknowledgement e-mail. Contractors shall assume approval of closures of 4 hours or less unless they receive notification to the contrary.

4. Training Closures of More than Four Hours

For training of more than four hours on the same day, contractors shall request CMS approval at least a month in advance of the training date via the Provider Services mailbox, ProviderServices@cms.hhs.gov using the subject line "One Time Approval Request". CMS will provide one time authorization for training closure requests of more than four hours. CMS will evaluate this type of authorization on a case by case basis and authorize it under special circumstances within one week of receipt. If the contractor does not receive a confirmation from CMS within one week of submitting its request for training closure, the contractor can close for training under the assumption that its request was approved.

In instances where changes to previously approved training schedules are necessary, contractors shall submit all requests for changes via the Provider Services mailbox, ProviderServices@cms.hhs.gov using the subject line "Change of One Time Approval". A new CMS approval is required to proceed with changes to previously approved training schedules. Changes shall be submitted to CMS within a reasonable time, enough to allow provider notification.

5. Provider Notifications

Contractors shall notify providers about their closure time for training. At a minimum, contractors shall post a closure notification for providers on their IVRs and websites. Contractors with separate lines for IVR and CSRs shall post a closure notification for providers on both lines. See additional instructions regarding IVR posting in Section 20.1.B of this chapter. In addition to the IVR and website, contractors shall use their listserv to notify providers of CMS authorized one time only-training closure or a training closure out of the contractor's regular training schedule. Contractors shall use their listserv to notify their provider community of their closure times the first time that they implement the Training Program in their site.

Contractors shall notify providers of all training closures or changes in their training closure schedule at least two weeks in advance of the training date. For training of more than four hours approved by CMS, contractors shall notify providers at least three weeks in advance of training closure.

6. CSR Feedback

To assure that CSRs are receiving the maximum benefit of the training program, contractors should use CSRs' feedback from training, CSRs' pre-and post-training and retention results to determine improvement opportunities to their training program and for development of refresher training. Contractors should implement a process to evaluate the CSRs' progress pre- and post- training on a monthly basis. Also, contractors should implement a process to periodically evaluate the CSRs' retention of training information.

7. Reports

a. *C*ontractors shall report in CSAMS the following:

(1) the number of hours per month that the contractor closed for training, during normal business hours

(2) the number of hours used for training on Federal holidays.

b. Copies of CMS written approval, training schedule, training plan, training materials, as well as CSR attendance sheets, shall be made available upon request.

8. CMS Monitoring

For monitoring purposes, contractors' telephone systems shall allow calls from CMS or CMS's representatives to CSRs. These CMS callers will not have a provider number. *CSRs shall respond to these calls as if they were calls from the provider community.*

20.1.7 - Quality Call Monitoring (QCM)

(Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06)

Contractors shall have a monitoring program in place to ensure the quality of telephone inquiries responses. The monitoring program shall, at a minimum, follow the requirements and performance standards as set forth in the QCM program. The guidelines established apply to contractors' general provider inquiry telephone numbers. The standards shall not apply to those inquiries handled by other units within the contractor (e.g., appeals, fraud, MSP). As contractors are ultimately responsible for the quality of their responses to provider inquiries, contractors shall use the results of the QCM program to identify, and act upon, areas of needed improvement, both for the call center as a whole and for individual call center staff. Contractors shall document their monitoring efforts and corrective action plans as applicable, and provide such information to CMS upon request.

A. Process and Tools

Contractors shall be responsible for:

1. Monitoring, measuring and reporting the quality of service continuously by utilizing the CMS-developed QCM process. Contractors shall monitor all CSRs throughout the quarter, using a sampling routine. The sampling routine shall ensure that all CSRs are monitored at the beginning, middle and end of each month (ensuring that assessments are distributed throughout the week), and during morning and afternoon hours. If there is more than one auditor, contractors shall rotate the CSR monitoring assignments regularly among the auditors.

2. Recording all monitored calls on the standard scorecard, using the QCM chart as a guideline. Copies of the scorecard and chart can be obtained at QCM database Web site at https://www.qcmscores.com. Contractors shall use only the *most current* official versions of the scorecard and chart that are posted on the Web site. The QCM database, also available on the Web site, shall be used to collect monitoring results that will be reported monthly in CSAMS.

3. Training every CSR and auditor on the scorecard, chart and database and ensuring that each person has a copy of the *most current* chart for reference. Contractors shall analyze individual CSR data frequently to identify areas needing improvement, and shall document and implement corrective action plans. *Such information shall be available to CMS upon request.*

4. Analyzing QCM data to develop a plan for continuous improvement and to determine where training is indicated, whether at the individual, team, or call center level and provide such training. *Such information shall be available to CMS upon request.*

B. Frequency of Monitoring

1. Experienced CSRs – Contractors shall monitor a minimum of 3 calls per CSR per month. In centers where CSRs answer both beneficiary and provider calls, contractors shall monitor a minimum of 3 calls, including at least one of each type, during the month.

Any deviation from this requirement shall be requested and justified to the RO in order to determine if a waiver is warranted.

2. New CSRs - Contractors are encouraged to heavily monitor CSR trainees that have just completed classroom instruction before they begin to handle calls independently. Scores for these trainees will be excluded from CSAMS reporting on QCM performance for a period up to 30 days following the end of formal classroom training. The calculation will be done automatically when the CSRs are entered into the QCM database with the appropriate indicator of trainee.

C. QCM Calibration

Contractors shall participate in all national and regional QCM calibration sessions organized by CMS. (Calibration is a process to help maintain fairness, objectivity and consistency in scoring calls by staff within one or more call centers or throughout CMS.) National sessions are held *once per quarter*. *Appointments will be sent to all provider inquiry units via the PCUG listserv.* Contractors *with more than one call center* shall conduct regular calibration sessions *among the* multiple centers. Contractors with more than one reviewer shall conduct monthly calibration sessions within the call center. *Contact centers shall keep written records of their internal calibration meetings, including attendance lists. These records shall be provided to CMS upon request.*

D. Retention of Taped Calls

Contractors that tape calls for QCM purposes shall be required to maintain such tapes for an ongoing 90-day period during the year. All tapes shall be clearly identified by date and filed in a manner that will allow for easy selection of tapes for review. Contractors may reuse tapes after the 90-day period. Contractors shall dispose of tapes that are no longer used in a manner that would prohibit someone from obtaining any personally identifiable information on the tapes.

E. Remote Access

The contractor shall provide remote access to their incoming provider inquiries toll free lines. CMS personnel monitoring personnel shall have the capability to monitor entire provider calls by:

- Specific workstation (CSR)
- Next call from the network or next call from the CSR queue; or
- Specific business line

Whenever possible, CMS prefers to remotely monitor calls based upon next call in queue. This approach facilitates the monitoring process and increases the ability to monitor various CSRs.

Contractors shall submit the instructions to remotely monitor their provider inquiry toll free lines to the servicereports@cms.hhs.gov mailbox. If the contractor monitoring system requires changes in its access codes or other parts of the instructions from what was previously submitted, the contractor shall submit the revised instructions or access codes to the servicereports@cms.hhs.gov mailbox at least 3 business days before the

beginning of the affected month. CMS will take reasonable measures to ensure the security of this access (e.g., passwords will be controlled by one person.)

For those contractors whose security procedures prohibit the emailing of passwords, contractors shall send an email to the servicereports@cms.hhs.gov mail for further instructions on how to submit this information.

20.1.9 – Provider Contact Center User Group (PCUG)

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

*The Provider Contact Center User Group is a newly developed conference call that allows for information sharing and provides timely responses to questions raised by Medicare contractors. Additionally, t*he PCUG sessions provide a forum for CMS to discuss new and ongoing projects related to telephone *and written* customer service, for contractors to surface issues for CMS resolution, and *for* call centers to share best practices in telephone customer service delivery. Call centers shall participate in the monthly PCUG calls. At a minimum, the call center manager or a designated representative shall participate. Call centers may submit topics for consideration in agenda planning to the PCUG mailbox at *pcug_listserv@cms.hhs.gov. Further information about the PCUG, including schedules, can be found at: http://www.cms.hhs.gov/ProviderInquiryOp/04_ProviderContactCenterUserGroup(PCUG).asp#TopOfPage*.

20.2 - Written Inquiries

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

All general written inquiries, including letters, faxes, and e-mails, *shall* be handled consistently for accuracy and timeliness. *A general written inquiry is defined as any inquiry that is not forwarded to a specialized unit with its own CMS mandated timeliness standards, such as MSP and Appeals. All general written inquiries are subject to the 45-business day requirement, and are also subject to all provider written inquiry performance standards, as defined in section 20.2.2.3.*

Every inquiry shall receive either a telephone or written response. In cases where a duplicate inquiry is received, the contractor shall verify by telephone or letter, that the provider has received a response. For written inquiries received that could be handled by the IVR, such as claim status and eligibility (see section 20.1.B), it is strongly suggested that contractors include language in the responses to those inquiries that the information being requested is available on the IVR.

Contractors shall control all general written inquiries until they are closed by the written inquiries unit. If an inquiry is transferred to another unit that has its own reporting system and timeliness standards, such as MSP and Appeals, the inquiry shall be closed by the general written inquiries unit and responsibility for the inquiry shall be transferred to the unit to which the inquiry was referred. Documentation shall be kept in the provider inquiry tracking system to identify that the inquiry was referred and/or forwarded to another unit.

The contractor shall stamp the cover page of all written inquiries including letters, e-mails and faxes, and the top page of all attachments with the date of receipt in the corporate mailroom and control them until a final answer is sent. *E-mails and faxes received after the close of the contractor's normal business day should be date-stamped the next business day. E-mails and faxes that contain system generated date stamps are not required to receive an additional corporate date stamp.* Contractors shall not be required to keep the incoming envelope. However, if it is a contractor's normal operating procedure to keep envelopes with the incoming correspondence, the envelope, incoming letter and the top page of all attachments shall be date-stamped in the corporate mailroom.

20.2.1 - Contractor Guidelines for High Quality Responses to Written Inquiries

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

Contractors shall be in compliance with the following:

A Written Inquiry Storage

The majority of contractors currently retain all written inquiries on site. Some contractors house files at a remote location during the year due to cost and space constraints. Those contractors housing written inquiries off-site shall notify CMS within 6 weeks of the final BPR date of the exact address/location of their off site written inquiries. This information shall be sent electronically to the RO *and to the provider services mailbox at providerservices@cms.hhs.gov*. This notification is necessary in the event an onsite evaluation review is conducted. Contractors are required to allow CMS access to all written inquiries stored off site within 24 hours of notification to the contractor. All written inquiries, whether maintained on site or off-site, shall be clearly identified and filed in a manner that will allow for easy selection for review.

Identification data shall be kept that will allow electronic production of a sequential listing of the universe of written inquiries. In addition, responses shall be kept in a format that allows for easy reproduction. Only necessary and related information shall be kept for each corresponding inquiry. Examples of necessary and related information include reports of contact, screenshots, copies of the incoming inquiry, copies of response, and any research required for response. Contractors shall be able to electronically reproduce, when requested, any documents the contractor deems relevant to the resolution of the written inquiry.

B Forwarding Misdirected Inquiries

The contractor shall refer and/or forward written inquiries such as appeals, fraud and abuse, and MSP when appropriate. Documentation shall be kept in the general correspondence unit and shall identify the date the inquiry was referred and/or forwarded and the receiving unit.

C Timeliness

The 45 business day timeframe begins the day the inquiry is originally received and date-stamped by the contractor and ends the day the contractor sends the response from the mailroom. There may be instances when an inquiry is mistakenly sent to another address used by the contractor. If the contractor has done a proper job of publicizing the correct address to the provider community then the 45 business day timeframe will begin once the inquiry is received in the contractor mailroom where written inquiries are routinely sent. This does not apply to contractors who choose to have all of their mail sent to a separate location and then forwarded to the proper written inquiry unit. For these contractors, the 45 business day timeframe starts the day that the mail is received at the initial location.

Substantive action shall be taken and a final response shall be sent to all provider correspondence with 45 business days from receipt of the inquiry. In instances where a final response cannot be sent within 45 business days (e.g., inquiry shall be referred to a

specialized unit for response), the contractor shall send an interim response acknowledging receipt of the inquiry and the reason for any delay. When possible, inform the provider about how long it will be until a final response will be sent.

If the contractor is responsible for handling both Part A and Part B claims, inquiries requiring response from both of these areas share the same time frame for response (i.e., the 45 business day period starts on the same day for both responses). Therefore, the contractor shall ensure that the inquiry is provided to both responding units as quickly as possible. The response to these inquiries may be combined, or separate, depending on which procedure is most efficient for the contractor's conditions. If a contractor responds separately, each response shall refer to the fact that the other area of inquiry will be responded to separately.

See the chart below for assistance with converting calendar days to business days.

Business Days	Calendar Days
5	7
10	14
15	21
20	28
25	35
30	42
35	49
40	56
45	63

D Responding to Written Inquiries by Telephone

Every contractor shall have the flexibility to respond to provider written inquiries by phone within 45 business days. For tracking and evaluation purposes, the contractor shall develop a report of contact for each telephone response. All reports of contact shall contain the following information:

- Provider name;
- Telephone number;
- Provider number;
- Date of contact;
- Internal inquiry control number;
- Subject */ nature of inquiry*;

- Summary of discussion;
- Status *– closed / pending research / open*;
- *Follow – up a*ction required (if any); and
- Name of the correspondent who handled the inquiry.

Upon request, the contractor shall *either* send the provider a copy of the report of contact *or a letter of the* results from the phone response. *If the contractor decides to send the report of contact by letter, it must meet CMS' requirements for written responses.* The report of contact shall be retained in the same manner and time frame as the current process for written responses. The contractor shall use its discretion when identifying which written inquiries (i.e., provider correspondence that represents simple questions) can be responded to by phone. If the contractor cannot reach the provider by phone, it is acceptable to leave a message as long as the message does not contain any Protected Health Information (PHI). If after 3 attempts the contractor still has not resolved the inquiry the contractor shall develop a written response within 45 business days from the incoming inquiry. *It is not acceptable to leave a message on the provider's voicemail*.

E E-mail *and Fax* Responses

In some cases, an e-mail inquiry received can be responded to by e-mail. Since e-mail represents official correspondence with the public, it is paramount that contractors use sound e-mail practices and proper etiquette when communicating electronically. Contractors shall ensure that e-mail responses utilize the same guidelines that pertain to all written inquiries. Responses that contain financial information, HICN or protected health information shall not be sent by e-mail. If the response must contain this information, it shall be mailed in hardcopy to the provider or a telephone response must be given, rather than by e-mail. *It is not acceptable to leave a message on the provider's voicemail*.

Contractors shall treat inquiries received via fax in the same manner as e-mail inquiries. Contractors shall follow the same guidelines that pertain to all written inquiries and shall not fax any responses containing financial information, HICN or protected health information. In these situations, the contractor shall be mail the response to the provider or give a telephone response. It is not acceptable to leave a message on the provider's voicemail.

E-mails and faxes that contain system generated date stamps are not required to receive an additional corporate date stamp. E-mails and faxes received after the contractors' normal business hours should be entered as the next business day.

F Check Off Letters

Check-off letters are appropriate for routine inquiries like claims status or eligibility. Check-off letters shall not be used to address more complex inquiries. Each check-off letter shall be personalized and *will be held to the same QWCM standards as all other general written inquiry responses*.

20.2.2.2 - QWCM Calibration

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

Contractors shall participate in all QWCM national calibration sessions organized by CMS. National sessions are held *once per quarter. Appointments will be sent to all provider written inquiry units via the PCUG listserv.* Contractors with more than one reviewer shall conduct monthly calibration sessions within the written inquiries unit. Contractors with more than one written inquiries unit should conduct regular calibration sessions among the multiple units. *Contact centers shall keep written records of their internal calibration meetings, including attendance lists. These records shall be provided to CMS upon request.*

20.2.2.3 - QWCM Performance Standards

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

Contractors shall evaluate and enter into the QWCM application a minimum of 3 provider responses per correspondent per month or the entire universe available for monitoring, whichever is less, regardless of how many locations for which the correspondent is responding. Contractors shall meet the following standards:

- *Beginning October 1, 2006, of all provider written responses monitored for the quarter, the percent scoring as "Pass" shall be no less than 90 percent for Adherence to Privacy Act. From February through September 2006, o*f all written responses monitored for the *quarter, the* percent scoring as "Pass" for Adherence to Privacy Act shall be no less than 93 percent. During the quarter, no month shall fall below 85%. This standard will be measured quarterly and will be cumulative for the quarter.
- *Beginning October 1, 2006, of all provider written responses monitored for the quarter, the percent scoring as "Achieves Expectations" or higher shall be no less than 90 percent for Knowledge Skills. From February through September 2006, o*f all written responses monitored for the quarter, the percent scoring as "Achieves Expectations" or higher for Knowledge Skills shall be no less than 93 percent. During the quarter, no month shall fall below 85 percent. This standard will be measured quarterly and will be cumulative for the quarter.
- *Beginning October 1, 2006, of all provider written responses monitored for the quarter, the percent scoring as "Achieves Expectations" or higher shall be no less than 90 percent for Customer Skills. From February through September 2006, o*f all written responses monitored for the quarter, the percent scoring as "Achieves Expectations" or higher for Customer Skills Assessment shall be no less than 93 percent. During the quarter, no month shall fall below 85 percent. This standard will be measured quarterly and will be cumulative for the quarter.

20.4.1 Customer Service Operations Surveys

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

Contractors shall complete periodic surveys of customer service operations within the time frames and in areas indicated on the specific notice *as directed by CMS*. Examples include annual call center technology surveys, staffing profiles, training needs, etc.

20.4.2 Provider Satisfaction Surveys

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

The contracting reform provisions of the Medicare Modernization Act direct CMS to measure provider satisfaction with the performance of Medicare contractors. Contractors shall assist CMS in its efforts to implement this requirement. While the current survey is the Medicare Contractor Provider Satisfaction Survey, contractors shall assist CMS in implementing any provider satisfaction surveys that may be developed in the future.

20.4.2.1 - Contractor Activities Related to the Medicare Contractor Provider Satisfaction Survey (MCPSS)

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

A. Contractor Activities Related to the Medicare Contractor Provider Satisfaction Survey (MCPSS)

Contractors shall:

1. Provide data for the MCPSS--Contractors shall provide CMS with current data that may be used to:

a) determine if a provider is actively participating in the Medicare program,

b) contact active providers for the MCPSS (e.g., names, Identification Numbers (IDs), business and mailing addresses, business telephone numbers, provider types, key contact information for the appropriate respondent in each provider organization), and

c) address non-response bias in the survey (e.g., claims volume/workload, practice size, number of beneficiaries served).

2. Perform marketing and outreach for the MCPSS--Contractors shall support CMS in disseminating information about the MCPSS to providers. Contractors shall place information about the survey on listservs, newsletters, bulletins, and other provider communications channels. Contractors shall also post information about MCPSS on their Web sites and create a link to the MCPSS Study Website at www.mcpsstudy.org and CMS' MCPSS Web page at www.cms.hhs.gov/MCPSS. Contractors shall include information about the survey on their Interactive Voice Response (IVR) systems, or automatic call distributor (ACD) systems, and any other communications channel with providers. This may be part of the general program information posted to the IVR as described in 20.1.B. A media kit with sample documents to use about the survey, a project timeline and key tasks will be available at www.mcpsstudy.org.

3. Create a letter, using contractor letterhead, signed by a senior official, to be included in all survey packages. CMS will provide a template so that the same information can be shared with the provider community. The template and instructions will also be available at www.mcpsstudy.org. The Contractors shall customize the letter to reference the particular services (see #4) that the Contractor provides. The survey contractor will work closely with the Contractor and will make copies of the letter to include in the notification packet to providers. The survey contractor will be responsible for the mailing and administration of MCPSS.

4. Review and confirm the services that they offer to providers with the survey contractor at MCPSS@westat.com. The survey is customized to include ONLY those services that pertain to the Contractor's providers. A matrix of services that CMS considers apply to the Contractor will be available at www.mcpsstudy.org.

5. Appoint a MCPSS contact person. Contractors shall submit the contact name, business address, business telephone number and e-mail to CMS or designated survey contractor. CMS will provide the contact person a username and secured-password to access information relevant to the Contractor's individual survey results and/or response rates. Contractor shall send this information to MCPSS@westat.com by October 15 each year.

6. Participate in conference calls, focus groups, or in-depth interviews that will provide feedback about Contractor-Provider interaction, MCPSS, and any other related provider satisfaction survey that will enhance the MCPSS project and CMS' ability to measure provider satisfaction with Medicare Contractors. Arrangements for conference calls will be made in advance by the MCPSS administrator.

B. Contractor Use of MCPSS Results

Contractors shall use the MCPSS survey results and provider feedback to identify and implement process improvement initiatives.

C. Information for Contractors

A main objective of MCPSS is to support and assist Contractors in using provider feedback to implement process improvement initiatives. To this effect, CMS will provide detailed results of the survey on a secure Web page on the MCPSS Study Web site at www.mcpsstudy.org. This page will include:

1. *Data Collection Reports: The reports will include counts and percentages overall and by provider type for completed responses and each category of the survey sample disposition (e.g., postal non-deliverables, non-locatables, refusals and ineligibles)*
2. *Survey Results: The results of the survey will be available via an interactive online reporting system. A model of the online reporting system is currently available to provide an example of the functions and analysis capabilities of the system. Please note that the site does not include real data; the information is for illustrative purpose s only.*
3. *Study updates, fact sheets, FAQs and media messages. As the project progresses, we will continue to update the MCPSS Study Web site with new*

materials (e.g., fact sheets, frequently asked questions (FAQs), media messages). Contractors may access their secure Web page at any time to download relevant project information.

4. *CSR Script: The script is part of the media kit material that Contractors can access through the MCPSS study Website page at www.mcpsstudy.org.*

The dates when this information will be available to Contractors will also be listed in the MCPSS Project Timeline. This timeline can be found under Reference Documents tab at the MCPSS Study Web page or www.mcpsstudy.org.

20.5 Provider Inquiry Standardized *Categories*

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

Contractors shall maintain a tracking and reporting system for all provider inquiries that identifies at a minimum:

1. *The type of inquiry (telephone, letter, e-mail, fax, walk-in);*
2. *The person responsible for answering the provider inquiry (by name or other unique identifier);*
3. *Category of the inquiry (using CM-provided categories listed in the chart);*
4. *The disposition of the inquiry, including referral to other areas at the contractor (e.g., appeals, medical review, MSP); and*
5. *The timeliness of the response.*

CMS requires all contractors to track and report the nature of their inquiry types (reason *for the inquiry*) for *all provider* telephone and written inquiries using categories and subcategories listed according to definitions provided in the CMS Standardized Provider Inquiry Chart.

These categories are to be used to capture the reason for the inquiry, not the action taken. Contractors may use an additional level of detail, if necessary, to assist in identification of provider education or CSR training needs. However, inquiries reported to CMS must use categories and subcategories in the chart.

For all provider general telephone and written inquiries, contractors shall track multiple issues raised by a provider during a single call or in a piece of written correspondence.

Beginning October 1, 2006, contractors shall submit a contractor inquiry tracking report to ProviderServices@cms.hhs.gov on a quarterly basis. This report is due at the end of the month following the end of each calendar quarter (January 31, April 30 July 31, and October 31. The format for the ports shall be found at http://www.cms.hhs.gov/FFSContReptMon/

A. Required Training

Contractors' staff working with telephone and written inquiries shall be trained to log their inquiry types according to CMS Standardized Provider Inquiry Chart in the tracking system used by the contractor.

B. Updates to Chart

Contractors shall recommend changes to CMS Standardized Provider Inquiry Chart, including modifications to existing categories and subcategories and new inquiry categories and subcategories. Contractors shall submit changes or comments related to the CMS Standardized Provider Inquiry Chart via the Provider Services mailbox,

ProviderServices@cms.hhs.gov. Suggested changes shall include the following information:

- a definition of the inquiry type to be added,
- examples of questions where the inquiry type could be used, and
- information about the number of inquiries associated with it.

The chart will be updated on a quarterly basis, as needed. CMS will define categories to be tracked under the "Temporary Issues Category" and the reporting period for those subcategories through separate instructions. *Between updates, contractors may create and add contractor-specific temporary codes if their call volume requires them to do so.*

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
Adjustments	Changing the information on a submitted claim to correct an error or the correction of a claim denied in error.	*Cancellation of Claim/Return Claim/Billed in Error*	Contact is asking to cancel a claim that was submitted in error. Includes "services not rendered."
		Claim Processing Error	Contact is asking for an adjustment of an incorrect payment due to a processing error by the local or shared systems, imaging errors, interest not paid or penalties applied in error.
		Claim Information Change	Contact is asking for change or correction of information on a submitted/processed claim; for example, contact asks to add or remove modifiers or procedure codes to correct the amount of units provided, etc.
		Medical Review	Contact is asking about corrections/changes in diagnosis/treatment on processed claim.
		MSP	Contact is asking about the adjustment process for changes in the beneficiary MSP or HMO record.
Administrative Billing Issues	The mechanism and processes of how to bill for Medicare Services, which includes the explanation of CMS instructions, procedures and decision-making criteria for claim review and payment decisions. This does not include an explanation of why a particular claim was denied.	*1500/UB-92 Form*	Contact is asking how to complete the claim form and/or where to find it, including an electronic equivalent of both 1500 and UB92 Forms.
		Advance Beneficiary Notice (ABN)	Contact is asking for general information on ABN, for example, When is it appropriate to use an ABN?, What do I have to do with an ABN?

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		Claims Related Reports	Contact is asking for information about accessing and/or receiving reports produced by Medicare regarding to billing trends, history of Medicare payments, comparative billing reports, medical review reports, etc.
		Claim Documentation	Contact is asking what information is necessary to submit with a claim to allow processing and/or adjudication of the claim, for example, medical record, progress notes, physicians orders, x-rays, etc.
		Coinsurance	Contact is asking for the amount of coinsurance and/or deductible that a beneficiary must pay before Medicare begins to pay for covered services and supplies. This subcategory applies to inquiries at a general level. Use "Deductible" subcategory under "Eligibility" for inquiries on annual deductible for a specific beneficiary.
		Fraud and Abuse	Contact is reporting a fraud and abuse allegedly done by a Medicare provider. This subcategory also includes providers calling for guidelines to assure compliance of Medicare rules and regulations against fraudulent and abusive practices.
		Filing/Billing Instructions	Contact is asking for instructions on filing a claim, type of bill necessary for a type of claim, how to correct a claim (adjust a claim), mandatory submission of claims, and time filing limits. Includes inquiries on "How to meet the 72 hr rule for dx services".
		HPSA/PSA	Contact is asking for information about Health Professional Shortage Area (HPSA) and/or Physician Scarcity Area (PSA) classification. This subcategory includes questions such as how to bill based on location class as urban vs. rural area, the use of appropriate modifiers and the amount

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
			of bonus payment applicable to them.
Allowed Amount	The amount that Medicare will pay for a certain procedure code according to the Medicare payment systems, fee schedules and locality rates applicable.	*Ambulance Fee Schedule*	Contact is asking for the Ambulance Fee Schedule payment amount for a particular item or service provided to a Medicare beneficiary.
		Ambulatory Surgical Center	Contact is asking for the Ambulatory Surgical Centers payment amount for a particular item or service provided to a Medicare beneficiary.
		Anesthesia Fee Schedule	Contact is asking for the Anesthesia Fee Schedule payment amount for a particular item or service provided to a Medicare beneficiary.
		Critical Access Hospitals	Contact is asking for the Critical Access Hospitals payment amount for a particular item or service provided to a Medicare beneficiary.
		Clinical Lab Fee Schedule	Contact is asking for the Clinical Laboratory Fee Schedule payment amount for a particular item or service provided to a Medicare beneficiary.
		Drug Average Sales Price (ASP) Resource	Contact is asking about the Medicare Part B Drug Average Sales Price Resource payment amounts. This extensive listing of drugs is a guide. It may not include all drugs that could be considered for payment by Medicare.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		ESRD Composite Rate	Contact is asking for the ESRD Composite Rate payment amount for a particular item or service provided to a Medicare beneficiary.
		Home Health PPS	Contact is asking for the Home Health PPS payment amount for a particular item or service provided to a Medicare beneficiary.
		Hospital Inpatient PPS	Contact is asking for the Hospital Inpatient PPS payment amount for a particular item or service provided to a Medicare beneficiary.
		Hospital Outpatient PPS	Contact is asking for the Hospital Outpatient PPS payment amount for a particular item or service provided to a Medicare beneficiary.
		Hospice Payment System	Contact is asking for the Hospice Payment System payment amount for a particular item or service provided to a Medicare beneficiary.
		Long Term Care Hospital PPS	Contact is asking for the Long Term Care Hospital PPS payment amount for a particular item or service provided to a Medicare beneficiary.
		Physician Fee Schedule	Contact is asking for the Physician Fee Schedule payment amount for a particular item or service provided to a Medicare beneficiary.
		DMEPOS Fee Schedule	Contact is asking for the DMEPOS Fee Schedule payment amount for a particular item or service provided to a Medicare beneficiary.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		Psychiatric Hospital PPS	Contact is asking for the Psychiatric Hospital PPS payment amount for a particular item or service provided to a Medicare beneficiary.
		Rehabilitation Hospital PPS	Contact is asking for the Rehabilitation Hospital PPS payment amount for a particular item or service provided to a Medicare beneficiary.
		Skilled Nursing Facility PPS	Contact is asking for the Skilled Nursing Facility PPS payment amount for a particular item or service provided to a Medicare beneficiary.
Appeals	Action initiated by the provider due to disagreement on a Medicare's claim determination.	*Process/Rights*	Contact is asking for general appeal information, appeal process instructions and/or appeal rights.
		Status/Explanation/Resolution	Contact is asking the status of the appeal. This involves whether an appeal has been received and/or whether the time to file an appeal has expired, an explanation of Medicare's determination with respect to the submitted appeal and requests for duplicates of Medicare Redetermination Notices (MRN).
		Qualified Independent Contractor (QIC) Contractor	Contact is asking about an appeal status or information related to appeals reviewed by the QIC.
Claim Denials	Claim that has been fully adjudicated and a non-payment determination has been made based on Medicare rules and regulations.	*ABN*	Contact is asking for clarification on a particular claim denial where the use of ABN applies and the patient is not required to pay the provider for a service.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		Certification Requirements	*Contact is asking about claim(s) denied due to certification requirements not being met. This includes Hospice certifications and/or Certificates of Medical Necessity (CMNs).*
		Claim Overlap	Contact is asking about claim(s) denied due to an overlap in service dates with a previously processed claim. This may include the denial of a Part B claim for physical therapy services that conflicted with a previously processed inpatient claim with overlapping dates of service.
		Coding Errors/Modifiers	Contact is asking about a claim(s) denied due to an invalid or incorrect code. Includes the absence or incorrect use of a modifier and global surgery denials.
		Contractor Processing Errors	Contact is asking about a claim(s) denied due to a contractor error (incorrect edit, shared systems issue, etc.), when processing the claim.
		Contractual Obligation Not Met	Contact is asking about a claim(s) denied because the provider did not comply with their Medicare contractual obligation (for example, the claim was submitted with missing information, the claim was not filed timely, etc).
		CWF Rejects	Contact is asking about a claim(s) denied because information on the claim does not match the CWF beneficiary information (for example, *Managed Care/HMOs status,* discharge status, name mismatch, female patient with a male procedure claimed). Log under this sub-category CWF issues that need to be corrected through SSA because the provider submitted correct information on the claim and CWF file needs to be updated. Please note that “frequency limit” issues identified by CWF should be categorized under "frequency limitation" (See below).

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		Denial Letter Request	Contact is asking for a copy of the Medicare denial letter, establishing the reason for non payment of services in order to bill another insurer.
		DME POS Issues	Contact is asking about a claim(s) denied due to equipment, item or service not received by a beneficiary or returned to a supplier and other maintenance/services issues. *Also, includes break-in service denials.*
		Duplicate	Contact is asking about a claim(s) denied due to same date of service, claim previously processed or paid for the same date and same provider.
		EMC Filing Requirements	*Contact is asking about a claim(s) where payment was denied as not being covered unless they are submitted electronically.*
		Eligibility	Contact is asking about a claim(s) denied due to incorrect patient information submitted by the provider that does not agree with CWF (for example, incorrect suffix, transposed numbers) and affects the patient's eligibility for Medicare Benefits. Log under this sub-category, issues were there is no need to update information on CWF files.
		Evaluation & Management Services	Contact is asking about a claim(s) where payment was denied or reduced due to a changed E&M code. E&M codes explain how the physician gathered and analyzed patient information determined a condition and advised the best treatment. Includes services such as: office visits, hospital visits, consultation visits, and care plan oversight.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		Frequency / Dollar Amount Limitation	*Contact is asking about a claim(s) that was denied because the allowable number of incidences or dollar amount limit for that service in a given time period has been exhausted or exceeded due to a service that was previously billed. Also, includes inquiries related the outpatient therapy cap and to billing frequency limits for durable medical equipment and supplies (same or similar equipment denials) such as Capped Rental.*
		LCD	Contact is asking about a claim(s) that was denied or reduced based on a local coverage determination (LCD) by the contractor. Coverage determinations reflect the local contractor decision as to whether a product, service, or device is reasonable and necessary.
		Life Time Days Met	Contact is asking about claim(s) denied because a particular benefit is disallowed for a Medicare beneficiary due to the lifetime days limit exhausted.
		Medical Necessity	Contact is asking about a claim(s) denied because the information presented did not indicate services or supplies are reasonable and necessary for the diagnosis and treatment of the illness or injury.
		MSP	Contact is asking about a claim(s) denied due to other insurance existing on the beneficiary file that is primary to Medicare.
		NCD	Contact is asking about a claim(s) that was denied or reduced based on a national coverage determination (NCD) by CMS. Coverage determinations reflect national Medicare coverage policies governing specific medical service, procedure or device.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		Statutory Exclusion	Contact is asking about a claim(s) that items or services were denied by law.
Claim Status	Information about where the claim is in the process and whether it has been paid. Routine claim status questions are to be referred to the IVR.	*Additional Development Request (ADR) Letters*	Contact is asking about a Medicare letter received from the contractor that requests more information or documentation to process pending claim(s). Contact may also be providing a response to a written request.
		Applied to Deductible	Contact is asking about a processed claim where payment was not generated because the payment amount was applied to the beneficiary's annual deductible amount.
		ATP Amount/Check Information	Contact is asking for current Approved to Pay (ATP) amount, current pending claims totals and/or payment information on a claim (i.e., status of check, check number, check amount and issued date).
		Crossover	Contact is asking for information on a claim that is covered by a supplemental insurer, such as Medigap or other private insurance.
		Not on File	Contact is asking for a claim that Medicare does not have on file or that has not been received by the contractor.
		Paid in Error	Contact is asking about a claim that they believe was paid in error.
		Payment Explanation/Calculation	Contact is asking for explanation on how the claim was paid or how the payment amount was calculated. Includes "reimbursement" questions.
		Suspended	Contact is asking about the status of a claim that is pending

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
			while waiting for information needed to complete processing.
Coding	Any set of codes used to encode data elements, such as tables of terms, medical concepts, medical diagnostic codes or medical procedure codes. Includes the codes, their descriptions, and how to use them.	*CCI Edits*	Contact is asking about Correct Coding Initiative edits that identify types of inappropriate coding combinations, such as comprehensive and component code combinations and code combinations of services or procedures that could not be performed together.
		Condition Codes	Contact is asking about billing codes that indicate whether the claimant meets a condition of the service.
		Procedure Codes	Contact is asking about the numeric representation of a procedure code used to determine reimbursement for services rendered on a claim or for other medical documentation. Includes CPT-4 codes, which belong to the American Medical Association and indicate physician services, physical and occupational therapy services, radiology procedures, clinical laboratory tests, medical diagnostic services, and hearing and vision services. Also, includes HCPCS Codes Level II that determines reimbursement for equipment and medical supplies.
		Diagnosis codes	Contact is asking about the numeric representation of a disease, injury, impairment, or other health problem that providers must use to report the diagnosis for each service and /or item they provide.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		Evaluation & Management Codes (E&M)	Contact is asking about codes that explain how the physician gathered and analyzed patient information, determined a condition, and advised the best treatment. Examples are: care plan oversight, office visits, hospital visits and consultations. E&M codes are a part of the AMA's CPT-4 coding system.
		Modifiers	Contact is asking about two digit codes used in conjunction with a procedure code that provides additional information about the service. The modifier may affect the reimbursement rate of a service.
		MSP Payer/Value Codes	Contact is asking about codes used to designate that another insurer is responsible for full or partial payment where Medicare has no payment or secondary payment responsibility.
		Revenue Codes	Contact is asking about codes that identify specific accommodations or ancillary charges that are provided in a hospital, (e.g., blood, cardiology, radiology, laboratory services, etc.
		Patient Status Codes	Contact is asking about codes that indicate the patient's status as of the "Through" date of the billing period. These codes reflect the destination of the patient not the service received at the ending date. Includes also inquiries related to source of admission codes and discharge status codes.
		Place of Service Codes	Contact is asking about codes on professional claims to identify where the service was rendered.
		Specialty Codes	Contact is asking about codes used on a claim form to indicate a provider's type or medical specialty.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
Complaints	An expression of dissatisfaction with service from providers in regards to different aspects of the Medicare operation.	*Contact Center Closure*	Contact is expressing dissatisfaction due to hours of operation or call center closures for CSR training.
		Medicare Contractor Operation	Contact is expressing dissatisfaction due to contractor operational errors, procedures, policies, processes, and staff issues not addressed by other subcategories included in this section.
		Medicare Program	Contact is expressing dissatisfaction due to issues with the Medicare program. Includes provider expressions of intentions of leaving the Medicare program.
		Provider Education and Outreach	Contact is expressing dissatisfaction with educational activities, education staff performance or availability of educational resources or activities for Medicare providers.
		Self Service Technology	Contact is expressing dissatisfaction due to content, functionality, instability, formatting and processes related to Provider Self Service tools such as CMS or contractor website, online tools for eligibility inquiries or claim submissions, IVR, etc.
		Staff	Contact is expressing dissatisfaction due to CSR or Staff attitude, incorrect information given or non response to an inquiry.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
Direct Data Entry (DDE)	The Direct Data Entry system is an on-line application that allows direct on-line access to Medicare claims, such as: claim entry, error correction, eligibility inquiry, claims status, claim adjustment and roster billing.	*Connectivity/Installment/Processing Issues*	Contact is requesting assistance with the connection, installment, password resets, claim processing and adjustments through DDE.
		Orientation Package	Contact is requesting information or an orientation package related to DDE.
Electronic Data Interchange (EDI)	The system for submitting claims electronically and retrieving Electronic Remittance Advices.	*Connectivity/Installment Issues*	Contact is requesting assistance with the connection, installment and password resets through EDI.
		Front End or Vendor Editing	Contact is requesting information or assistance with errors in the transmission or status of claims submitted electronically.
		Information package/HIPAA Compliant Billing Software	Contact is requesting information or an orientation package related to EDI.
Eligibility/Entitlement	The qualification of an individual to receive Medicare, including various qualifying aspects of Medicare coverage (as described in the associated subcategories). If multiple sub-categories are discussed in the same inquiry, log main category for tracking purposes.	*Beneficiary Demographic*	Contact is asking to verify or update (within the contractor's ability) beneficiary personal information, such as HIC number, address, date of birth, date of death, etc.
		Benefit Days Available	Contact is asking for the number of days in a hospital or SNF that remain available for the beneficiary.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		Deductible	Contact is asking if the beneficiary's annual deductible amount has been met so that Medicare payment for providers' services or supplies can begin.
		DME Same or Similar Equipment	*Contact is asking if beneficiary has a DME Certificate of Medical Necessity (CMN) or DMERC Information Form (DIF) active, or if a beneficiary has same or similar equipment previously covered by Medicare on file.*
		HMO Record	Contact is asking whether the beneficiary is enrolled in an HMO, when HMO enrollment began, or for HMO contacts information.
		Hospice	Contact is asking if beneficiary has a hospice record open.
		MSP Record	Contact is asking for information related to other insurance coverage that the beneficiary might have that is primary to Medicare.
		Next Eligible Date	Contact is asking when is the next eligible date for the beneficiary to receive one or more preventive services.
		Outpatient Therapy Cap	*Contact is asking if the beneficiary's outpatient therapy cap amount has been reached.*
		Part A Entitlement	Contact is asking when the beneficiary became eligible for Part A benefits.
		Part B Entitlement	Contact is asking when the beneficiary became eligible for Part B benefits or whether the beneficiary is eligible for Part B benefits.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
Financial Information	The financial responsibility of providers and/or Medicare. These types of inquiries normally involve the information that comes from the contractor's financial department or requests that are processed by the contractor's financial department.	*Check Copies*	Contact is requesting a copy of a check.
		Cost Report	Contact is asking about the annual report that institutional providers are required to submit in order to make proper determination of amounts payable under the Medicare program; for example, How do I submit a cost report? What supporting documents are needed for an acceptable cost report? Have you received my cost report?
		Credit Balance/Account Receivable	Contact is asking about a credit balance that is due to Medicare. A credit balance is an improper or excess payment made to a provider as the result of patient billing or claims processing errors. Examples of Medicare credit balances instances are: 1) Paid twice for the same service either by Medicare or another insurer; 2) Paid for services planned but not performed or for non-covered services; 3) Overpaid because of errors made in calculating beneficiary deductible and/or coinsurance amounts; or 4) A hospital that bills and is paid for outpatient services included in a beneficiary's inpatient claim. Also, includes inquiries to confirm if a payment was applied to an open receivable.
		Do Not Forward (DNF) Initiative	Contact is requesting information about CMS initiative that entails the use of "Return Service Requested" envelopes to preclude the forwarding of Medicare checks and remittance advices to locations other than those recorded on the Medicare provider files, and the provider is not receiving its

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
			checks.
		Electronic Fund Transfer	Contact is asking about electronic transfer of Medicare payments directly to a provider's financial institution.
		Offsets	Contact is asking the reason that payment was withheld or for an explanation of the Financial Control Number (FCN#) that appeared on the Remittance Advice.
		Overpayment	Contact is asking about the notice that they have received due to Medicare funds in excess of amounts that are due and payable to them under the Medicare statute and regulation. The amount of the overpayment is a debt owed to the U.S. Government.
		Refunds	Contact is asking about a refund, such as, its status, notifying Medicare that a refund is needed, or asking about the process to request it.
		Stop Payment / Check to Be Reissued	Contact is requesting a stop payment, reissuance a check, asking how to request it or verifying the status of a previous request. Also, includes check reissue inquiries due to stale dated checks and checks sent to wrong provider.
General Information	Information that cannot be included in other categories.	*Address /Phone/Fax/Web Address*	Contact is asking for contractor's addresses including website, fax and phone numbers.
		Issue Not Identified/Incomplete Information Provided	Contact failed to explain the reason for the inquiry, or omitted a HIC number or provider number. This sub-category may apply to written correspondence only.
		Misrouted Telephone Call/Written Correspondence	Contact is asking a question that should be handled in another contractor area, by another contractor and or by another agency/program.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		Reference Resources Referral/Request	Contact is asking where to find or access information about specific topics or requesting information about resources available for provider education or self service options, such as, MEDPARD directory, online claim status availability, electronic remittance advice, IVR, etc.
		Other Issues	Contact is discussing subjects that are not classifiable into the defined categories or subcategories.
HIPAA Privacy/ Privacy Act	The statutory authorities that govern the protections for personally identifiable patient health information and the conditions of its release.	*Authorizations*	Contact is asking for a consent/authorization form or a copy of their patient's authorization, which is necessary to release the information requested.
		Release of Information Request	Contact is requesting a copy of patient history or record.
		Requirements	Contact is asking about the HIPAA Privacy or Privacy Act requirements. Also, includes inquiries related to HIPAA contingency plans and the compliance with HIPPA transaction rules.
MSP	The term used when Medicare is not responsible for paying primary on a claim that is otherwise the primary responsibility of another payer.	*COB/MSP Rules*	Contact is asking about Coordination of Benefits Rules and/or Medicare Secondary Payer Rules.
		Coordination of Benefits (COB) Contractor	Contact is asking about the COB contractor responsibilities and contact information. Includes situations that require a referral to the COB contractor.
		File Updates	Contact is asking for beneficiary MSP/COB files information

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
			or providing information for MSP/COB file update.
		Liens and Liabilities/Settlements	Contact is asking about requesting or accepting a Medicare conditional payment, for services that would otherwise be covered under Workers Compensation, No Fault Insurance, Liability and Group Health Plans (GHP). Also, includes questions about settlement information and the status of a conditional payment.
Policy/ Coverage Rules	Includes inquiries related to policy questions, coverage rules and benefits information.	*Benefits/Exclusions/ Coverage Criteria/Rules*	Contact is asking for clarification of rules and criteria used by Medicare to cover and pay for services furnished to Medicare beneficiaries by Medicare providers.
		Certifications Requirements	Contact is asking about requirements, electronic submissions and/or status, when applicable, of certifications for Medicare Benefits. This may include Hospice certifications and/or Certificate of Medical Necessity.
		Local Coverage Determination (LCD)	Contact is asking about a local coverage policy developed by the Medicare contractor to describe the circumstances for Medicare coverage for a specific medical service, procedure or device within their jurisdiction.
		National Coverage Determination (NCD)	Contact is asking about a national coverage policy developed by the Centers for Medicare & Medicaid Services to describe the circumstances for Medicare coverage for a specific medical service, procedure or device.
		Non-published Items	Contact is asking about the coverage of items with no criteria published by contractor or CMS.
		Pre-authorization	Contact is asking about or requesting a pre-authorization for providing Medicare benefits.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		Statutes and Regulations	Contact is asking about the Federal law and regulations that govern the Medicare Program and its operation.
Provider Enrollment	The forms and process by which an individual, institution or organization becomes a provider in the Medicare program, eligible to bill for their services.	*National Provider Identifier*	Contact is asking about the National Provider Identifier (NPI).
		Provider Demographic Information Changes	Contact is asking for verification of their provider demographic information or asking how to request a change/correction of its existing information.
		Provider Eligibility	Contact is asking about his or her status as a Medicare Program participant or not participant provider, and how to change it. Also, includes inquiries related to a provider alert/sanction status period.
		Provider Enrollment Requirements	Contact is asking about the requirements to become a participating provider of the Medicare Program. Also, includes inquiries from a provider not certified by Medicare, overview/orientation of the Provider Enrollment Forms (CMS 855 Form), where to find it and/or instructions on how to complete it.
Provider Outreach	The contractor's educational effort and activities with the provider community.	*Education Referrals*	Contact is requesting contact/visit from Professional Relations Staff to provide supplemental education, discuss an issue in-depth, or to request clarification of a confusing situation.
		Workshop Information	Contact is asking for information about provider outreach activities or educational opportunities for providers and their staff.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
Remittance Advice (Remit)	The paper or electronic summary statement for providers, including payment information for one or more beneficiaries.	*Duplicate Remittance Notice*	Contact is asking for a duplicate remittance notice. Includes inquiries where provider did not received his/her remittance notice, needs to send it to the patient's second insurance, needs a single line or a no pay remittance notice.
		ERA Election	Contact is asking for information about how to access and/or receive remittance notices electronically.
		How to read RA	Contact is asking for assistance in reviewing and/or understanding their remittance notice. Includes explanation of the Claim Adjustment Reason Codes and Remittance Advice Remark Codes on the Remittance Notice.
RTP/Unprocessable Claim	A claim(s) with incomplete, invalid, or missing information will be returned to the provider as unprocessable. This action cannot be appealed and the corrected claim(s) needs to be submitted as a new claim. Includes "W Status of Claim" and status of claims to be returned to provider.	*1500 / UB-92 Form Item*	Contact is asking about a claim(s) that was returned because the CMS claim form was not completed with the required information, such as, missing or invalid HICN, name, date of birth or sex. Includes the explanation of narrative of reason codes in the contractor's claims correction file, claims processing system and reports.
		Clinical Laboratory Improvement Act (CLIA)	Contact is asking about a claim(s) that was returned because the claim had a missing or incorrect CLIA number.
		Contractor Error	Contact is asking about a claim(s) that was returned to provider as unprocessable due to a contractor error.
		Contractual Obligation Not Met	Contact is asking about a claim(s) rejected because the provider did not comply with his or her Medicare contractual obligation. For example, the claim was presented with missing information (other than codes or modifiers), the

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
			billing was not timely, etc.
		Shared Systems	Contact is asking about a claim(s) that was returned because the patient information on the claim does not match information on CMS's shared systems (FISS, MCS, VMS and CWF).
		Missing/Invalid Codes	Contact is asking about a claim(s) that was returned because of a missing or invalid or changed code. Includes "Invalid CPT" inquiries.
		Place of Service	Contact is asking about a claim(s) that was returned due to invalid place of service or the place of service was not related to the procedure.
		Provider Information	Contact is asking about a claim(s) that was returned due to an incorrect or missing UPIN/NPI.
		Submitted to Incorrect Program	Contact is asking about a claim(s) that was returned because it was submitted to the incorrect program (FI, Carrier or DMERC).
		Truncated Diagnosis	Contact is asking about a claim(s) that was returned due to incorrect, invalid or missing diagnosis information.
Systems Issues	Medicare electronic systems, including the Medicare Claims Processing Systems and/or customer self-service applications (I.e. CMS website, contractor	*Medicare Claims Processing System Issues*	Contact is presenting situation related to issues with the Medicare Processing Systems; for example, issues due to an aged claim, recycling claim and release of claims, etc.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
	website, IVR, etc).		
		Website Issues	Contact is reporting problems with the functionality, stability or use of the CMS and contractor website.
		IVR Issues	Contact is reporting problems with the functionality or use of the contractor's IVR.
Temporary Issues	Includes inquiries that CMS would like to track temporarily due to special circumstances. CMS will provide specific timeframes for the monitoring of temporary issues. For contractor specific temporary issues, please follow instructions on IOM 100-9, Chapter 3, Section 20.5 or Chapter 6, Sections 30.1.1 – 30.1.1.2.	*Part D Drug Coverage*	Contact is presenting situation related to issues with the implementation of the Part D Medicare Prescription Drug Coverage.
		CD-ROM Initiative	Contact is requesting a hard-copy of the Annual Disclosure Statement, the "Dear Provider" letter and provider enrollment material in CD-ROM form, or asking for clarification of the CD-ROM content. Includes logging of CD-ROM related problems that providers encountered.
		CERT	Contact is asking information related to the Comprehensive Error Rate Testing (CERT) Program.
		Competitive Acquisition Program (CAP)	*Contact is asking general questions about the CAP.*

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		HIGLAS	Contact is presenting a situation due to the implementation of HIGLAS, the new financial accounting system. Includes inquiries about HIGLAS's training material, its impact on claim processing, recoup overpayments, demand letters, settlements and penalty withholdings, HIGLAS changes on remittance advices and checks (voided/reissued).
		Recovery Audit Contractor (RACs)	Contact is asking information about a CMS initiative using RACs to identify underpayments and overpayments and to recoup overpayments. Includes inquiries related to demand letters and records requested by RACs.

Medicare Contractor Beneficiary and Provider Communications Manual

Chapter 6 - Provider Customer Service Program

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Provider Customer Service Program

NOTE: *All contractors shall follow § 20, 40.1, 50.2, 50.3 and 60.1 of this chapter. All contractors funded for CR 3376 and all Medicare Administrative Contractors (MACs) shall follow this chapter in its entirety. Those contractors not funded for 3376 shall continue to follow IOM Pub. 100-9, Chapter 3, for their provider inquiries work.*

Deliverable dates and/or requirements in a MAC Statement of Work supersede any such dates or requirements stated in this chapter, where the two documents conflict.

In this chapter, the term provider applies to all Medicare provider and supplier types.

10 – Introduction *to Provider Customer Service Program (PCSP)*

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

CMS requires that all Medicare contractors have a Provider Customer Service Program (PCSP) to assist providers in understanding and complying with Medicare's operational processes, policies, and billing procedures. The PCSP serves to strengthen and enhance Medicare's ongoing efforts associated with provider inquiries and education. The primary principle is to continuously improve Medicare customer satisfaction through the timely delivery of accurate, accessible, and consistent information to providers in a courteous and professional manner. These practices will enable providers to understand, manage, and bill the Medicare program correctly.

The PCSP integrates *contractor* provider inquiry and provider education *activities* creating a comprehensive program. The PCSP shall be a trusted source of accurate and relevant information, staffed with personnel that have technical and customer service expertise and experience to address various provider inquiries and to develop and deliver provider education. The PCSP consists of three major components: Provider Outreach and Education (POE), Provider Contact Center (PCC), and Provider Self-Service Technology (PSS).

To receive important and timely information from CMS related to the PCSP, including CSR training materials, written and telephone provider inquiry job aids, updates to the CMS web site, provider education material and copies of proposed and final regulations, the contractor shall join the CMS Contractor Provider Education Resources Listserv by sending an email to learnresource-l@cms.hhs.gov. The email shall include the e-mail addresses of the individuals, as well as a permanent corporate / resource box, at the contractor who are registering for the listserv. Several contractor staff shall register for this listserv. There is no limitation as to the number of registrants for any contractor. At a minimum, contractor contact center managers and managers overseeing provider education activities shall register for the listserv.

20 – Provider Outreach and Education (POE)

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

Providers require information about Medicare program, billing, and claims issues in order to manage Medicare-related matters on a daily basis. Therefore, Medicare contractors shall develop *plans* that offer Medicare providers a broad spectrum of information about the Medicare program (including billing the Medicare program appropriately), as well as reducing the number of provider inquiries and claims errors, through a variety of communication channels. At a minimum, *plans* shall *identify* basic Medicare topics, as well as the specific topics and subject areas identified later, as priorities for provider education. The CMS encourages contractors to be innovative and persistent in their identification of priorities and provider educational needs. Well-informed providers are more likely to bill correctly, thereby reducing the error rate.

Contractors shall utilize a variety of strategies and methods for the dissemination of information to providers -- including such *approaches as* print, Internet, telephone, *CD-ROM, educational messages on the general inquiries line (see §30.2.4.2 and Chapter 3, 20.1.3)*, face-to-face instruction, and presentations in classrooms and other settings -- to meet the needs of Medicare providers for timely, accurate, and understandable Medicare information. *POE education may be delivered by clinical and non-clinical staff to groups, to individuals, and through various in-person and media channels at the complete discretion of the contractor, with the goal of effectively and efficiently using the POE funding to reduce the error rate.*

Contractors shall, at a minimum, provide all the necessary information and cover the subjects needed in their POE activities to enable providers to understand the Medicare program and its policies and how to bill Medicare appropriately. Contractors shall provide basic Medicare programmatic and billing information and education to Medicare providers throughout the year to keep them abreast of fundamental national and local Medicare policies, programs, and procedures, including information about new Medicare programs, policies, initiatives, and significant changes to the Medicare program. This information shall include material providers and their staffs need in order to administer and bill the Medicare program appropriately.

Contractors shall ensure that all materials are written in a manner that is clear, concise, and accurate. POE materials produced shall bear the month and year they were produced or re-issued. These materials shall be made available, whenever practicable, in both electronic and print formats, and be disseminated in a format and means that are timely, efficient, and cost-effective.

All materials developed by Medicare contractors using CMS funding as the principal source for its development are considered the property of CMS, and shall be made available to CMS upon request. If a contractor reproduces or uses material, in whole or in part, originally developed by another Medicare contractor, that contractor shall be acknowledged either within the material, or on its cover, case or container.

POE activities shall be described in the annual Provider Service Plan (PSP) as well as reported on the *Education Activity Reports (EARs) described in § 20.5.*

20.1 - *POE Goals*

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

The primary goal of the POE program is to reduce the provider compliance error rate and the claims payment error rate by giving Medicare providers the information they need to understand the Medicare program, be informed timely about changes, and bill correctly. POE is driven by educating providers and their staffs about the fundamentals of the Medicare program, policies, and procedures, new Medicare initiatives, significant changes to the Medicare program, and issues identified through analyses of such things as provider inquiries, claim submission errors, medical review data, and Comprehensive Error Rate Testing (CERT) data.

20.1.1 - Internal Development of Provider Issues

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

Contractors shall coordinate internally with staff in appropriate areas (including personnel responsible for medical review, *provider inquiries,* enrollment, EDI/systems, appeals, and program integrity) to ensure that issues identified by these other areas in the organization are communicated and shared with the POE staff. At a minimum, periodic meetings shall be held with these various components to discuss any provider issues and potential mechanisms to resolve them. Documentation of these meetings and activities shall be retained by the contractor.

Additionally, POE should send a representative to the contractor's Contractor Advisory Committee (CAC) as part of its identification and development of provider issues (See IOM 100-08, Chapter 13).

20.1.2 - Partnering with External Entities

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

Contractors shall work toward establishing partnerships with external entities to help disseminate Medicare provider information. Whenever feasible, events and activities shall be coordinated with other Medicare contractors and entities, including quality improvement organizations (QIOs), State Health Insurance Assistance Programs (SHIPs), and End Stage Renal Disease (ESRD) networks as well as interested groups, organizations, and CMS partners. In addition, contractors shall routinely and directly notify other interested entities of their upcoming provider education events and activities.

Partnering entities may be medical, professional or trade groups and associations, government organizations, educational institutions, trade and professional publications, specialty societies, and other interested or affected groups. By establishing collaborative information dissemination efforts, providers will be able to obtain Medicare program information through a variety of sources. Partnering or collaborative provider information and education efforts can include:

1. Printing information in member newsletters or publications;
2. Reprinting and distributing (free-of-charge) provider education materials;
3. Giving out provider education materials at organization meetings and functions;
4. Scheduling presentations or classes to or for members;
5. Posting provider information on organization's websites; and,
6. Helping organizations develop their own Medicare provider education and training material.

Partnership activities shall not take the place of contractor-led POE events but shall supplement them.

20.2 – Data Analysis

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

The contractor shall implement a provider education plan that focuses on reducing the CERT Provider Compliance Error Rate (PCER.) The contractor shall perform analysis on all data available, such as the results of CERT, telephone and written inquiries, claims submission errors, appeals, CSR feedback, as well as feedback from across the contractor, as it develops an education methodology. The contractor should also use referrals from medical review, as discussed below.

20.2.1 – CERT Data

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

Medicare contractors shall use error rate information to design appropriate provider education. Contractors shall focus on the PCER as this rate is based on how the claims were presented to the claims processing contractor for payment. This data focuses on how the claims looked when they were received from the providers before the claims processing contractor engaged in edits or reviews. At this point, the claim represents the provider's understanding of the Medicare program and the provider's implementation of Medicare billing rules. Therefore, errors at this stage alert CMS to the need for further provider education. This error rate also serves as an indicator of how well the contractor is educating the provider communities.

For contractor types for which provider compliance error rate data is unavailable, the paid claims error rate shall be used until the PCER data becomes available to all contractors.

CERT data are primary sources of information to target education activities. Contractors shall utilize the reports accessible from these programs, using national data where available. Local data shall be compiled in a way to identify which providers in the contractor's area may be driving any unusual patterns. Contractors shall consider other sources of data when evaluating the CERT findings in order to develop an educational plan.

20.2.2 - Inquiry Analysis

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

For provider inquiry analysis, contractors shall maintain a systematic and reproducible provider inquiry analysis program that will produce a monthly list of the most frequently asked questions (FAQs) beyond claims status and eligibility *for telephone inquiries and written inquiries.* Contractors shall utilize information or instructions furnished by CMS to classify or categorize provider inquiries. (See § 30.*6, 90 and Chapter 3, § 20.5*) Educational efforts shall be developed and implemented to address the needs of providers as identified by this program.

20.2.3 – Claims Submission Errors

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

Data analysis is an essential first step in determining whether patterns of claims submission and payment indicate educational needs. Contractors shall maintain a provider data analysis program that will produce a monthly list of the most frequent collective claims submission errors from all providers in their jurisdiction. Claims submission errors are those that result in rejected, denied, or incorrectly paid claims. This information shall be utilized to develop and modify the provider education contained in contractor POE plans. Such data analysis may include identification of aberrancies in billing patterns within a homogeneous group, or much more sophisticated detection of patterns within claims or groups of claims. Data analysis itself may be undertaken as part of general surveillance and review of submitted claims, or may be conducted in response to information about specific problems stemming from complaints, provider input, alerts, or reports from CMS and/or other contractors.

20.2.4 – *Coordination with Medical Review*

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

In accordance with PIM Chapter 1, §1.2.3 and PIM Chapter 3, §3.11.1.6, the medical review area of the contractors will be analyzing medical review data and making education referrals to POE. There are two main types of coordination: 1) advisories of provider notification and feedback letters that have been sent to Medicare providers and 2) priority referrals for education.

1. Provider Notification and Feedback Letters - When medical review does a probe, it sends a letter to the provider about the probe. These notification letters may include an offer for provider education to address the issues found in the probe. POE staff is responsible for providing the education when requested by a provider in response to these letters. The contractor shall ensure that POE staff has ready access to copies of the probe notification letters so that POE staff shall have this information available should a provider contact POE requesting education. POE staff also monitor the probe letters sent by medical review and determine whether broader education to the provider community may be warranted. See § 20.3.4.2 for further information

2. Priority Referrals -The second type of coordination with medical review, a priority referral, results when medical review believes that education is important for a provider or small group of providers in order to prevent further errors and reduce fraud. POE staff should collaborate with medical review when evaluating these referrals to determine what type of education, if any, is appropriate and whether this education fits with the overall contractor strategy to reduce the error rate. POE staff should also look for trends in the priority referrals sent by medical review and determine whether broader education to the provider community may be warranted. See §20.3.4.2 for further information.

Regardless of the type of coordination, POE staff shall ensure that it provides timely feedback to medical review about the disposition of the referral, including whether a provider requested education in response to a probe letter. POE staff shall work with medical review staff to develop an effective system of communication that, at a minimum, maintains information about referrals from medical review, requests for education from providers, follow up communication with medical review, and disposition of problems referred from medical review, including type of education given.

POE staff shall also evaluate the medical review referrals and work with medical review to determine whether there are topics that are appropriate for Frequently Asked Questions to post on the contractor's website (see §50.2.4.2).

20.3 – *Provider Education*

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

Whenever possible and practicable, contractors shall use CMS-provided national education materials in its provider outreach and education activities, such as MLN Matters Articles. All official CMS educational products are branded and available at http://www.cms.hhs.gov/MLNGenInfo/01_Overview.asp#TopOfPage.

20.3.1 - Provider Bulletins/Newsletters

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

Unless otherwise established with CMS, contractors shall print and distribute regular provider bulletins/newsletters, at least quarterly, which contain *Medicare* program and billing information. When feasible and cost-effective, contractors shall stop sending regular bulletins to providers with no billing activity in the previous 12 months. Contractors shall post on the provider *education* website newly created bulletins/newsletters/educational materials *(See § 50.2)*.

Contractors shall provide within the introductory table of contents, summary, compilation or listing of articles/information, an indicator (e.g. word(s), icon, or symbol) that denotes whether the article/information is of interest to a specific provider audience(s) or is of general interest. Contractors shall disregard this requirement if the introductory table of

contents, summary, or article/information compilation is structured by specialty or provider interest groupings.

Contractors shall encourage providers to obtain electronic copies of bulletins/newsletters and other notices through the Provider website. If providers are interested in obtaining additional paper copies on a regular basis, contractors are permitted to charge a fee for this. The subscription fee should be "fair and reasonable" and based on the cost of producing and mailing the publication. Contractors may also assess a charge to any provider who requests additional single paper copies.

Contractors may use alternative distribution methods to printing and mailing paper bulletins.

Contractors that were approved by CMS for alternative distribution before December 31, 2005, shall continue distribution in the manner that was approved. After December 31, 2005, *all contractors, including Medicare Administrative Contractors, interested in alternative distribution methods or contractors that want to modify their approved approach* shall develop a proposal and submit it to **ProviderServices@cms.hhs.gov** for approval. *The elements of the proposal include:*

1. Alternative distribution method, i.e. contractor website, CD-ROM;
2. Documentation that electronic bulletins will contain the same information as paper bulletins;
3. Projected savings over paper distribution (person hours and/or dollars);
4. Plans for use of projected savings;
5. Estimated savings during six months; *and*
6. Total number of paper bulletins distributed during the previous six months.

Contractors shall submit an evaluation of their alternative distribution method six months from its implementation date. Follow-up evaluations are required whenever the approach is modified. Contractors shall submit all evaluations electronically to CMS Central Office (CO) at **ProviderServices@cms.hhs.gov**. *At a minimum, the evaluation shall include:*

1. *Analysis of why paper bulletins were requested by providers/suppliers, and suggestions of ways to assist them in getting electronic bulletins;*
2. *Total number of providers/suppliers who are receiving paper bulletins after six months; and*
3. *Total number of provider praises and complaints along with a description of praises and complaints.*

20.3.2 – Training for New Medicare Providers

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

Contractors *shall offer training* that is tailored to the needs of new Medicare providers and billing staff. This *training* shall deal with fundamental Medicare policies, programs, and procedures and shall concentrate and feature information on *billing Medicare.*

20.3.3 - Training Tailored for Small Providers

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

Medicare contractors shall tailor education to *the needs of their* small providers. Small providers are defined by law as providers with fewer than 25 full time equivalents or suppliers with fewer than 10 full time equivalents. *This training may* involve interactive communication such as occurs in face-to-face trainings and in certain web-based tutorials or instruction. Contractors shall not be required to identify or validate providers meeting the definition of small provider.

Education and training of small providers may include the provision of technical assistance, such as review of billing systems and internal controls to determine program compliance and to suggest more efficient and effective means of achieving such compliance. Small provider technical assistance can also include educational seminars for groups of providers identified as having similar problems with their billing systems or internal controls. It also can include assistance from EDI support staff, since much of the billing system technical expertise at the contractor resides with that staff.

20.3.4 – Educational Topics

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

20.3.4.1 – Local Coverage Determinations

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

Contractors shall educate the provider community on new or significantly revised final Local Coverage Determinations. Contractors shall include pertinent information about the LCDs on their provider websites and as part of regular bulletin distributions, including articles drafted by the medical review personnel.

Clinical questions about the LCDs, such as the rationale behind coverage of certain items or services versus other similar ones, shall be directed to medical review. Medical review will respond in accordance with PIM Ch. 13 Sec. 13.9.

20.3.4.2 - Education Resulting from Medical Review Referrals

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

The contractor is under no obligation to provide specific education in response to all medical review referrals. The education provided as a result of medical review shall be determined in the context of the contractor's goal of reducing the provider compliance

error rate within the resources available. The type of education and the involvement of clinical staff are at the discretion of the contractors.

The contractor must provide some education when requested by a provider in response to a provider notification letter from Medical Review. The education can be of any type the contractor deems appropriate, including one-on-one training, referral of the provider to available web training, and upcoming workshops containing information on the topic. Contractors shall not charge for this education (See § 20.6).

20.3.4.3 - Medicare Preventive Service Benefits

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

Contractors shall promote *to its provider community* the use of preventive services and other benefits provided by the Medicare program to beneficiaries. These preventive services may include, but are not limited to, initial physical examinations, cardiovascular and diabetes screening tests, screening mammography, and screenings for colorectal, cervical, and prostate cancer.

20.3.4.4 - Electronic Claims Submissions

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

Contractors shall conduct training for providers or their staff in electronic claims submission. The contractor shall conduct training activities for providers to educate them on, and expand their use of, Medicare billing software and the electronic data interchange transactions supported by Medicare.

20.3.4.5 - Remittance Advice

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

Contractors shall promote the use and understanding of the *Remittance Advice (RA)* as an educational tool for communicating claims payment information. *A Medicare Learning Network (MLN) guide which provides information about the types of RAs, the purpose of the RA and the types of codes that appear on the RA is available at http://www.cms.hhs.gov/MLNProducts/MPUB/itemdetail.asp?filterType=keyword&filterValue=remit&filterByDID=0&sortByDID=1&sortOrder=ascending&itemID=CMS061410*.

Providers receive an RA, which is a notice of payment and adjustment, once a claim has been received and processed. An adjustment refers to any change that relates to how a claim is paid differently from the original billing. Adjustments can include denied claim, zero payment, partial payment, reduced payment, penalty applied, additional payment and supplemental payment. *Two important non-medical code sets are used to communicate an adjustment, or why a claim (or service line) was paid differently than it was billed. These code sets are Claim Adjustment Reason Codes and Remittance Advice*

Remark Codes. Descriptions for both of these code sets appear at: http://www.wpc-edi.com/products/codelists/alertservice.

Where a specific instruction has not been given by CMS to use specific Claim Adjustment Reason Codes and Remittance Advice Remark Codes to communicate claim payment and adjustment information and a code would help reduce provider inquiries, contractors shall use appropriate codes. Contractor provider inquiry, provider outreach and education and system staff shall work together to identify Claim Adjustment Reason Codes and Remittance Advice Remark Codes to help communicate an adjustment and reduce provider inquiries.

Contractors shall also promote the use of the free Medicare Remit Easy Print (MREP) software to obtain Electronic Remittance Advice (ERA). The benefits of using MREP software include saving time and money by printing remittance information directly on the day the HIPAA 835 is available without waiting for the mail, the ability to create and print special reports and the ability to create document(s) that can be included with claim submissions to secondary/tertiary payers. The ERA is the preferred method for claims payment communication. Carriers and DMERCs have stopped sending standard paper remittance (SPR) advices to providers if they have been receiving ERAs for 45 days or more. *When new versions of MREP software become available, contractors shall post this notification on their website(s) and communicate this information to their MREP contact list and/or provider listserv(s).*

If a provider elects to receive the SPR, contractors shall use the SPR provider messaging properties, when available, of this notice to convey Medicare programmatic information including, but not limited to, the promotion of their Provider websites, changes in policies and programs, and the promotion of their upcoming POE activities.

20.3.4.6 - "Ask-the-Contractor" Teleconferences (ACT)

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

"Ask-the-Contractor" Teleconferences provide a means for providers to ask their contractors specific questions concerning billing and Medicare policies or procedures. They are not to be confused with the functions of the POE Advisory Group which provides input and feedback to the contractor on provider education strategies and efforts (See § 20.4).

Contractors shall organize toll-free "Ask-the-Contractor" Teleconferences (ACT) to complement, but not replace, the work of the Advisory Group(s). Due to the explicit nature of the subjects covered, ACTs serve to identify provider issues and problems in a clear and timely manner. They also provide a method of sharing information, and function as a tool for listening to the contractor's provider community. Contractors shall offer ACTs at least quarterly. In designing ACTs, contractors shall consider other technological approaches, such as web-chat capabilities. Contractors shall also invite CMS *Central and* Regional Office staff to *listen to* ACTs.

Contractors shall use their Advisory Group(s) to assist in establishing the timing, frequency, size, topics, and provider type(s) to be included in ACTs. Contractors should also use other methods for ACT topic identification such as inquiry analysis, claims submission error analysis, Medical Review (MR) data analysis, and information gathered through partnerships.

20.4 - POE Advisory Groups

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

The primary function of the Advisory Group is to assist the contractor in the creation, implementation, and review of provider education strategies and efforts. The Advisory Group provides input and feedback on training topics, provider education materials, and dates and locations of provider education workshops and events. The group also identifies salient provider education issues, and recommends effective means of information dissemination to all appropriate providers and their staff. The Advisory Group shall be used as a provider education consultant resource, and not as an approval or sanctioning authority.

The contractor shall maintain the Advisory Group. It is not permissible for the contractor to allow outside organizations to operate the Advisory Group. After soliciting suggestions from the provider community, the contractor shall select the appropriate individuals and organizations to be included in the group. The main point of contact for all POE Advisory Group communication shall be within the contractor's provider outreach and education area or similar department. At a minimum, the contractor is responsible for recruiting potential members, arranging all meetings, handling meeting logistics, producing and distributing an agenda, completing and distributing minutes, and keeping adequate records of the advisory group's proceedings.

POE Advisory Groups operate independently from other existing contractor advisory committees. However, while Advisory Group members can be members of other advisory committees, the majority of group members shall not be current members of any other contractor advisory group. Contractors shall strive to maintain professional and geographic diversity within the Advisory Group(s) and have representatives of the major provider specialties or provider institutions they serve. Providers from different geographic areas, as well as from urban and rural locales, shall be represented in the Advisory Group.

Contractors shall consider having more than one POE Advisory Group when the breadth of its geographic service area, or range of the providers serviced, diminishes the practicality and effectiveness of having a single Advisory Group.

Medicare contractors shall have separate advisory groups for each kind of Medicare contract (e.g., intermediary, Part B carrier, regional home health intermediary, Medicare Administrative Contractors). It is also impermissible for contractors having geographic proximity or overlap with one another to share an Advisory Group. Each contractor shall have its own separate group.

The Advisory Group shall generally convene quarterly, but at a minimum, shall meet three times per year. Contractors may hold Advisory Groups in-person or via teleconferencing. The CMS recommends that, if possible, contractors hold at least one in-person meeting per calendar year. Teleconferencing or other technological methods shall be available for Advisory Group members who cannot be physically present for any meeting.

Contractors shall not reimburse or charge a fee to group members for membership or for costs associated with serving on an Advisory Group. Contractors shall have a specific area on their website that allows providers to access information about the Advisory Group. This information shall include, *at a minimum*, minutes from meetings, upcoming meetings dates and locations, list of organizations or entities comprising the Advisory Group, *and* an e-mail address for a contact point for further information on the Advisory Group.

Contractors shall consider the suggestions and recommendations of the Advisory Group, and implement those deemed feasible, practicable, and in the best interest of an effective PCSP. In the interest of maintaining a working relationship, the contractor shall explain to the group reasons for not implementing or adopting any group suggestions or recommendations.

Meeting agendas, which include discussion topics garnered from solicitation of group members, shall be distributed to all members of the group and the CMS regional office POE coordinator prior to any meeting. After each meeting, minutes shall be disseminated within a reasonable time to all group members and others who request them.

20.5 - POE Reporting

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

20.5.1 - Provider Service Plan (PSP)

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

Contractors shall prepare and submit a PSP annually. The PSP outlines the strategies, projected activities, efforts, and approaches the contractor will use during the forthcoming year to support provider education and communications. *The PSP should also include an evaluation of the success of the previous contract year's POE work, as well as how that evaluation was incorporated into the forthcoming year's educational plan*. The PSP shall address and support all the implementation strategies and activities stated in *§* 20 as well as all required activities stated in the yearly Budget and Performance Requirements (BPRs) *and Statements of Work (SOW).*

Contractors shall send the final PSP electronically *in MS Word* by *the last day of the first month of their contract year*, to their RO coordinator and to CMS Central Office (CO) at **ProviderServices@cms.hhs.gov**. *Contractors shall adhere to the PSP template/format*

and instructions located on the CMS website at http://www.cms.hhs.gov/FFSContReptMon/06_Provider_SupplierServicePlan(PSP)Template.asp#TopOfPage for its PSP submission. Contractors shall ensure that they are utilizing the most recent version of the PSP template/format. *Contractors shall be notified of updated templates via CMS Contractor Provider Education Resources listserv described in §10.*

20.5.2 – Education Activity Report (EAR)

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

Contractors shall prepare a semi-annual EAR. The EAR summarizes and recounts the contractor's provider education and training activities during the previous time period. These activities include efforts to reduce the error rate, training events, internet or website efforts, provider education conferences and teleconferences, inquiry analyses and follow-up actions, materials development and dissemination, and advisory group meetings.

The first report will be due to CMS and the RO on the 30th day after the first six months of the contract year with information about POE activities in months 1-6 of the contract year. If the 30th day falls on a weekend or holiday, the report will be due at close of business on the next business day. The second report, covering the months 7-12 of the contract year, is due 30 days after the last day of the contract year. All EARs shall be should be sent electronically in MS Word to ProviderServices@cms.hhs.gov.

Contractors shall adhere to the EAR template/format and instructions located on the CMS website at http://www.cms.hhs.gov/FFSContReptMon/ for its EAR submission. Contractors shall ensure that they are utilizing the most recent version of the EAR template/format. Contractors shall be notified of updated templates via the CMS Contractor Provider Education Resources listserv described in §10.

20.5.3 – Error Rate Reduction Plan (ERRP)

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

Every November and May, CMS will post to www.cms.hhs.gov/CERT, the Medicare Fee-for-Service Improper Payments Report that includes various types of error rates including contractor-specific error rates. Within 30 days of the posting of the long version of the report, contractors shall develop an Error Rate Reduction Plan (ERRP), according to the requirements in IOM 100-08, § 12.3.9. Each ERRP must include a description as to how the contractor will utilize the CERT findings to develop and implement educational efforts.

20.6 - Charging Fees to Providers for Medicare Education and Training Activities

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

CMS expects that contractors shall not charge for the development and presentation of provider education and training and provider education materials. However, there are

some circumstances under which contractors may charge fair and reasonable fees to participants to offset or recover costs associated with educational activities.

20.6.1 – No Charge

(Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06)

Contractors shall not charge providers who are attending or participating in an educational event based upon a medical review identified need for education (See §20.2.4 and §20.3.4.2).

20.6.2 – Fair and Reasonable Fees

(Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06)

Contractors may charge fair and reasonable fees in the following instances and/or for the following items to offset or recover the costs associated with the training or Education Activity or material; note that fair and reasonable means that the fee charged is in line with the actual cost of the activity or item and is within the means of likely participants.

At a contractor-sponsored training activity, contractors may charge to offset the costs for:

1. Facilities (i.e., costs for rental and set up),
2. Audio/visual equipment (i.e., costs for rental and set up),
3. Light food/refreshments, and
4. *Development and reproduction of materials expressly developed for, and disseminated at, the educational event.*

Contractors may charge for copies of information available on the contractor's website, including paper or other form (i.e., CD-ROM) sent directly to the provider (i.e., duplication costs, shipping and handling.)

*When a provider or external group or organization has requested training, c*ontractors may charge *them* for costs *related to* development, presentation, and duplication of materials, staff time and preparation, travel and accommodations, and registration fees (as appropriate). *Contractors* may accept nominal speakers' fees or recognition gifts, such as pens engraved with the host logo, coffee mugs, plaques, flowers, etc. However, *contractors are* not permitted to accept and/or use substantive gifts or donations associated with participation in education and training activities absent specific authority from CMS.

20.6.3 - Considerations and Record Keeping for Fee Collection

(Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06)

Fees collected in keeping with the above guidance *are intended* only to cover the costs of these POE activities and may not be used to supplement Medicare contractor activities *in other functional areas*.

Contractors shall keep records per event per *contract* year of the actual costs incurred, i.e., facility rental, audio/visual equipment, light refreshments, development and/or duplication of materials, and all fees charged to, and collected from, registrants.

Contractors shall keep records for at least one year from the date of the educational event and shall document actual costs used to support the fees charged.

20.6.4 - Excess Revenues from Participant Fees

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

Excess revenues from participant fees may occur when the total of the fees collected exceeds the total of the allowable costs. Contractors may use one of the following methodologies for the purpose of determining the treatment and disposition of any excess revenues collected from fee-associated provider education events:

Per event: The total of fees or charges for any event should not exceed by more than 10 per cent the actual costs incurred for the event. *If it is less than 10%, the contractor may incorporate the excess revenue into its POE program. If it exceeds 10%, the contractor shall refund the entire excess amount collected to all the registrants who paid a fee for that event*. For example, the contractor may charge participants a $50 registration fee for an event that cost the contractor $10,000 (e.g., light refreshments, meeting facility, and equipment rental), 250 individuals pay to attend and the contractor collects $12,500. Since the amount collected exceeded more than 10 per cent of the costs ($1,000), the entire excess amount collected ($2,500) is disbursed *equally* back to all paying registrants.

Per year: The contractor shall total, *as of the end of the ninth month of its contract year,* the fees or charges collected to attend *completed* fee-associated provider education and training events for that year. The contractor shall add to that amount total fees or charges the contractor estimates will be collected from attendance at all remaining scheduled events. The contractor shall subtract the total costs (meeting room rental, audio-visual/presentation equipment, light refreshment and food, and specially developed workshop material) from the total of fees collected and estimated for the remaining months of the *contract year*. If the remainder is a number that is *25* percent or less of total costs, the contractor shall note that amount in the *2nd EAR*, and incorporate the excess revenue into its POE program. If the remainder is above *25* percent of the total costs, the contractor shall send a message *by the end of the tenth month of its contract year* to CMS CO and the RO Coordinator explaining the amount of excess revenue, and *prepare* to refund the entire excess revenue equally to everyone who attended any of the contractor's fee-based training events.

20.6.5 - Refunds/Credits for Cancellation of Events

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

In order to secure sites needed for future provider training events, the contractor may have to make commitments under which it will incur contractual expenses for training accommodations and services. The contractor shall make full or partial refunds/credits to providers who register for an event, and cancel before the event, or do not attend the event, within the context of these contractual arrangements. If training is scheduled and the contractor cancels the event, the contractor shall make a full refund to registrants. If there are questions concerning the implementation of this policy in a given case, the contractor shall contact the RO coordinator.

20.6.6 - Recording of Training Events

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)
Entities not employed by CMS, or under contractual arrangement are not permitted to videotape or otherwise record training events for profit-making purposes. If a contractor records a training event, then the contractor may charge a fee for the duplication and mailing of the videotapes *or other records* upon request.

30 - Provider Contact Center (PCC)

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

It is important that all communication be coordinated to ensure consistent responses, due to the various communication channels available to providers today. Medicare contractors shall develop a Provider Contact Center (PCC) offering a range of Medicare expertise to respond to telephone, written (letters, e-mail, fax) and walk-in inquiries. The PCC assures a positive business relationship with Medicare providers through its responsiveness to provider's verbal and written inquiries. The PCC includes the provider contact center, the general written inquiries unit, and walk-in inquiries staff.

With the exception of technologies discussed in *§ 30.5.2 and 50*, CMS is not requiring the use of any specific technologies, as long as the contractor is able to meet all performance standards and requirements in a cost-effective and efficient manner while providing a high level of quality customer service to providers that includes accurate and timely information. To ensure that inquiries receive accurate and timely handling, contractors shall ensure, at a minimum, that contact center staff have readily-accessible information and tools (i.e., access to claims-related information, the contractor's and CMS' websites, a computer, and an outbound telephone line).

By the end of the first month of the contract year, each contact center shall appoint a primary provider inquiry contact person (i.e., the contact center manager or other designee.) The contact's name, business address, telephone number, and e-mail shall be submitted to **servicereports@cms.hhs.gov** and to the ROs. If the contact person is replaced, the contractor shall submit the new contact information to the service reports mailbox and to the RO within 2 weeks of the change. Contact centers shall also submit a high-level organizational chart for their provider inquiry function to **servicereports@cms.hhs.gov** and to the RO.

30.1 - Inquiry Triage Process

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

Provider inquiries may require varying degrees of expertise to answer. Using a triage mechanism, the contact center shall be able to route general inquiries within the PCC to the system or person best equipped to respond, with a minimal degree of transfer. The triage procedures shall be used for telephone inquiries, but a contractor may choose to employ a similar mechanism to triage general written inquiries as well. Contractors should develop mechanisms to quickly identify complex written inquiries needing

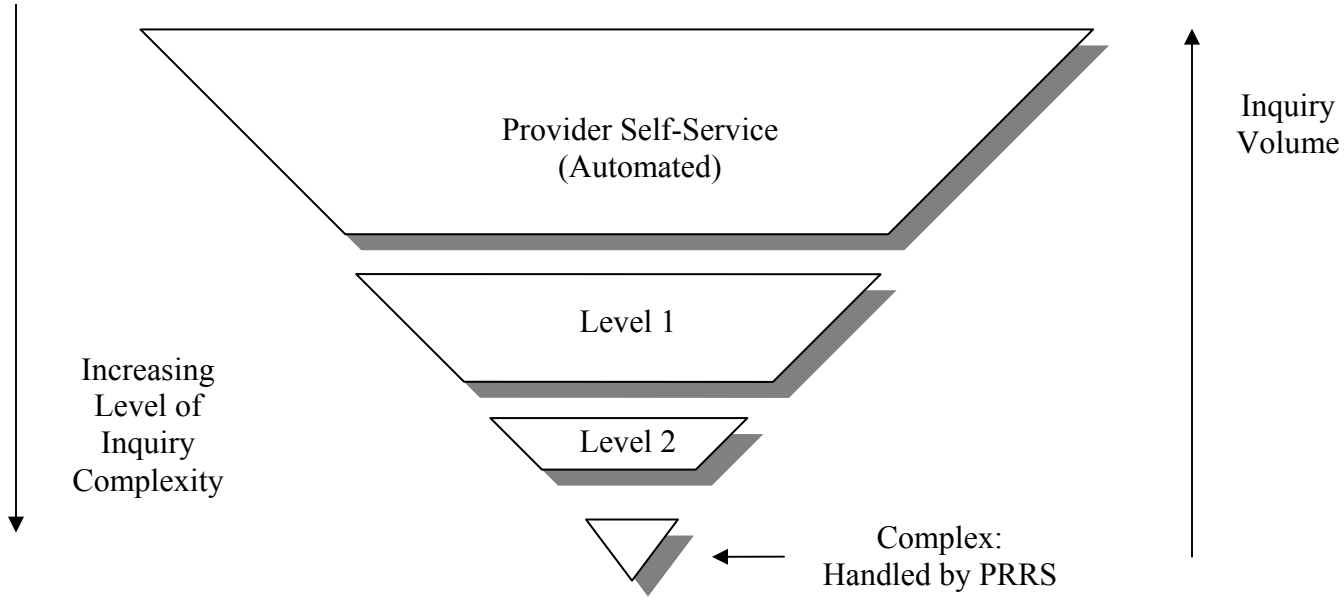
referral to the PRRS. Figure 1 illustrates the levels of complexity and the corresponding provider inquiry volume.

Each contractor shall organize its dedicated provider telephone *Customer Service Representatives (CSRs)* into at least two levels to handle questions of varying complexity. Contractors may also choose to specialize CSRs within levels or across contact centers to take full advantage of skill-based routing. Contractors may use technology to route callers to the appropriate level of CSR.

First level CSRs shall answer a wide range of basic questions that cannot be answered by the IVR or other interactive self-service technology. At a minimum, these CSRs shall handle questions that do not require substantial research and can easily be answered during the initial call. They shall have the authority to refer more complex questions to second level CSRs.

Second level CSRs shall have more experience and expertise enabling them to answer more complex questions, including telephone inquiries requiring a higher level of research. Contractors may organize these CSRs in any configuration that best suits the nature of the inquiries received. They may serve as consultant subject matter experts for first level CSRs and, therefore, do not always have to speak directly to a provider. These CSRs may be used to answer first level CSR questions, if the workload demands, and may also handle callbacks. The most complex questions shall be referred to the PRRS, discussed in Section § *30.5.*

Figure 1



Providers are responsible for determining the correct diagnostic and procedural coding for the services they furnish to Medicare beneficiaries. CSRs shall not make those

determinations about the proper use of codes for the provider. When providers inquire about interpretation of procedural and diagnostic coding they shall be referred to the entities that have responsibility for those coding sets. There are four places that CSRs shall refer callers that have questions about coding.

1. Current Procedural Terminology (CPT-4) codes are proprietary to the American Medical Association (AMA). As such, CPT coding questions from providers (with exception noted in 4 below) shall be referred to the AMA. The AMA offers CPT Information Services (CPT-IS). This new internet based service is a benefit to AMA members and is available as a subscription fee-based service for non-members and non-physicians. The AMA also offers CPT Assistant. Information about these resources is found at www.ama-assn.org.

2. ICD-9-CM related questions are handled by the American Hospital Association's Coding Clinic. Details about this resource are available at www.ahacentraloffice.org.

3. Level II Healthcare Common Procedure Coding System (HCPCS) codes related to Durable Medical Equipment or prosthetics, orthotics, and supplies are answered by the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) or, in the future, the Data and Analysis Coding function contractor (DAC). This contractor has a website with lots of information and a toll-free helpline.

4. The American Hospital Association's Coding Clinic for HCPCS responds to questions related to CPT-4 codes for hospital providers and Level II HCPCS codes, specifically A-codes for ambulance service and radiopharmaceuticals, C-codes, G-codes, J-codes, and Q-codes (except Q0136 through Q0181), for hospitals physicians and other health professionals who bill Medicare. Details about this resource are available at www.ahacentraloffice.org. Additional information can be found about these resources at: http://www.cms.hhs.gov/MedHCPCSGenInfo/20_HCPCS_Coding_Questions.asp#TopOfPage

30.2 – Telephone Services

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

The CMS will use the General Services Administration's FTS 2001 contract *or its successor* for its network. All inbound provider telephone service will be handled over the FTS network, with the designated Network Service Provider (NSP), currently *Verizon*. Therefore, contractors shall not maintain their own local inbound lines. Any new numbers and the associated network circuits used to carry these calls shall be acquired via the network.

The ongoing management of the entire provider toll free system requires a process for making changes, which may be initiated by either the contractor or CMS. All change requests associated with the FTS 2001 network (e.g., adding or removing channels or T1s, office moves, routing changes), shall be processed through the Provider Telecommunications Technical Support Contractor (TSC). *Contact information for the TSC is located at http://www.cms.hhs.gov/ProviderInquiryOp*. Any CMS-initiated changes (i.e., adding lines, removing lines, reconfiguring trunk groups) will be based

upon an analysis of Customer Service Assessment and Management System (CSAMS) data and traffic reports. *CMS reserves the right to initiate changes based on this information.*

If a contractor is requesting changes they shall provide an analysis of their current telephone environment (including a detailed traffic report) specific to the service being requested that shows the need for changes to their phone system (i.e., additional lines, trunk group reconfiguration). This information shall be gathered at the contractor site through the contractor's switch and through the *Verizon* Business Customer Center reports. This information should be sent to CO and the appropriate RO. Based on technical merit and availability of funds, CO will review the recommendation and make a determination. In cases where the request is approved, CO will forward approved requests to the designated agency representative (DAR) for order issuance.

30.2.1 - Inbound Calls

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

The CMS will pay for the rental of inbound T-1/PRI lines and all connect time charges for FTS-2001 services. The costs associated with the installation and monthly fees for these services will be paid by CMS and shall not be considered by contractors in their budget requests. However, contractors shall remain responsible for all other internal telecommunications costs and devices such as agent consoles, handsets, internal wiring and equipment (ACD, IVR, PBX, etc.) and any local or outbound telephone services and line charges. Since these costs are not specifically identified in any cost reports, contractors shall maintain records for all costs associated with providing telephone service to providers (e.g., costs for headsets) and shall provide this information upon request by CMS.

30.2.2 - Troubleshooting Problems

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

To monitor and report a problem, contractors shall follow these steps:

1. Isolate the problem and determine whether it is caused by internal customer premise equipment or the network service.

    - Internal Problem - The contractor's local telecommunications personnel shall resolve, but report per steps below.

    - External or Network Service Problem - Contractors reports the problem to *Verizon* by calling 1-888-387-7821.

2. Involve personnel from the provider TSC, if needed, to answer technical questions or to facilitate discussions with the *Verizon* Help Desk. *Contact information for the TSC is located at* http://www.cms.hhs.gov/ProviderInquiryOp/.

3. File an incident report with the provider TSC for major interruptions of service. Major interruption of service is defined as any incident with a trouble ticket opened for more than 24 hours or a total loss of service. The contractor shall send an e-mail to service reports that summarizes the problem and the steps taken to restore full service. The contractor shall send a follow-up e-mail to service reports when the problem has been resolved.

4. Use *Verizon*'s Business Customer Service Center to review documentation, track trouble tickets, or to close a trouble ticket online.

5. File a monthly report with CMS through **servicereports@cms.hhs.gov** about interruption of service, including both *Verizon* related and in-house and send a copy to the contractor's RO.

30.2.3 - Availability Requirements

(Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06)

Contractors shall make CSR telephone service available to callers continuously during normal business hours, including lunch and breaks.

Normal business hours for live telephone service are defined as 8:00 a.m. through 4:00 p.m. for all time zones of the geographical area serviced, Monday through Friday. Where provider call volume supports it, the normal business hours may be shifted to 8:30 – 4:30 for all time zones. Contractors adopting these hours shall notify CMS by sending an email to ServiceReports@cms.hhs.gov not later than the 1st day of the contract year, or one month in advance of an anticipated change within a contract year.

On Federal holidays, in lieu of answering telephone inquiries, contractors may choose to perform other appropriate contact center work, e.g., provide CSR training. Contractors shall notify CMS at **servicereports@cms.hhs.gov** by *the end of the first month of the contract year* about any planned contact center closures. This list shall also be sent to the appropriate RO. Changes made to this schedule shall be sent to CMS CO using the service reports mailbox and the RO for approval. Contact centers shall notify the provider community of the planned closure at least two weeks in advance of closure, *including Federal holiday closures.*

Contractors shall notify CMS via the service reports mailbox (servicereports@cms.hhs.gov) of any unplanned closures (those not submitted by the end of the contract year) at least three weeks before the planned date of closure. If CMS CO grants approval of the closure the contractor shall notify the provider community of the approved closure at least two weeks in advance of the closure.

Contact center staffing shall be based on the pattern of incoming calls per hour and day of the week, ensuring that adequate coverage of incoming calls throughout each workday is maintained.

In accordance with Section 508 of the Rehabilitation Act of 1973 and the Workforce Investment Act of 1998, all contact centers shall provide the ability for deaf, hard of hearing or speech-impaired providers to communicate via Teletypewriter (TTY)

equipment. A TTY is a special device permitting, hard of hearing, or speech-impaired individuals to use the telephone, by allowing them to type messages back and forth to one another instead of talking and listening. (A TTY is required at both ends of the conversation in order to communicate.) Contractors shall publicize the TTY line on their websites.

30.2.3.1 - Providing Busy Signals

(Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06)

Contact center customer premise equipment shall not be configured/programmed to return, "soft busies." Contractor contact centers shall only provide "hard" busy signals to the FTS network. At no time, shall any software, gate, vector, application, IVR, and/or ACD/PBX accept the call by providing answer back supervision to the FTS network and then providing a busy signal to the caller and/or dropping the call. The contractor shall optimize their inbound toll-free circuits to ensure the proper ratio of circuits to existing FTEs.

30.2.3.2 - Queue Message

(Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06)

Contractors shall provide a recorded message that informs callers of any temporary delay while the caller is waiting in queue to speak with an available CSR. They shall use the message to inform the provider to have certain information readily available before speaking with the CSR. The queue message shall also be used to indicate non-peak timeframes for callers to call back when the contact center is less busy.

Beginning October 1, 2006, the contractor's queue message shall announce to callers in queue the anticipated time until answer. The contractor shall also use the queue time to deliver educational information on issues identified by the contractor (See § 20).

30.2.3.3 – General Inquiries Line

(Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06)

The provider toll free numbers installed for FFS claims processing contractors general provider inquiry traffic shall not be used for other applications (e.g., MSP, reviews, EDI, provider enrollment, and other non-claim related provider inquiries) beyond answering general questions for each application. At a minimum, these general lines shall be used to handle questions related to billing, claims, eligibility, and payment. If contractors need new service for other Medicare applications currently being handled on the provider claims inquiry numbers, they shall follow the established process for adding additional toll free numbers. CMS will consider all requests for additional toll free numbers.

The general inquiries line shall answer provider inquiries. Contractors may choose to require other parties without provider numbers, such as consultants, lawyers and manufacturers to submit their inquiries in writing. Contact centers *may* limit the number of *inquiries* discussed during one phone call, but all contact centers shall respond to at least three *inquiries* before asking the provider to call back.

30.2.4 – CSR Requirements
(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

30.2.4.1 – *CSR* Equipment Requirements
(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

To ensure that inquiries receive accurate and timely handling, contractors shall provide the following equipment:

1. Online access to a computer terminal for each CSR responsible for claims-related inquiries. The computer terminal shall be physically located so that representatives can research data without leaving their desks/seats;
2. Access to the contractor's website and http://www.cms.hhs.gov/
3. An outgoing line for callbacks; and,
4. A supervisory console for monitoring CSRs.

30.2.4.2 – Sign-in Policy
(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)
Contractors shall establish and follow a standard CSR sign-in policy in order for CMS to ensure that data collected for telephone performance measurement are consistent from contractor to contractor. The sign-in policy shall include the following:

1. The CSRs available to answer telephone inquiries shall sign-in to the telephone system to begin data collection;
2. The CSRs shall sign-off the telephone system for breaks, lunch, training, and when performing any other non-telephone inquiry workload. (Note: If the telephone system supports an additional CSR category that accumulates this non-telephone inquiry performance data so that it can be separated and not have any impact on the measurements CMS wants to collect, this category may be utilized in lieu of CSRs signing-off the system); and,
3. The CSRs shall sign-off the telephone system at the end of their workday.

30.2.4.3 - CSR Identification to Callers
(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

The CSRs shall identify themselves with at least a first name when answering a call. In order to provide a unique identity for each CSR for accountability purposes, where a number of CSRs have the same first name, it is suggested that the CSRs also use the initial of their surname. If the caller specifically requests that a CSR identify himself/herself, the CSR shall provide both first and last name. Where the personal safety of the CSR is an issue, *or for other security reasons*, contact center management shall permit the CSR to use an alias, *such as an Operator ID or a telephone extension*. This alias shall be known for remote monitoring purposes. The CSRs shall also follow

the contractor's standard operating procedures for escalating calls to supervisors or managers in situations where warranted.

30.2.5 - Remote Monitoring Access

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

Contractors shall provide remote access to their incoming provider inquiries toll free lines to CMS. CMS monitoring personnel shall have the capability to monitor live provider calls in their entirety by specific workstation (CSR), next call from the network or next call from the CSR queue, and/or specific business line. *Whenever possible, CMS prefers to remotely monitor calls based upon next call in queue. This approach facilitates the monitoring process and increases the ability to monitor various CSRs*. CMS will take reasonable measures to ensure the security of this access (e.g., passwords will be controlled by one person.)

Contractors shall submit the instructions to remotely monitor their provider inquiry toll free lines to the servicereports@cms.hhs.gov mailbox. If the contractor monitoring system requires changes in its access codes or other parts of the instructions from what was previously submitted, the contractor shall submit the revised instructions or access codes to the servicereports@cms.hhs.gov mailbox at least 3 business days before the beginning of the affected month. For those contractors whose security procedures prohibit the emailing of passwords, contractors shall send an email to the servicereports@cms.hhs.gov mail for further instructions on how to submit this information.

30.2.6 - Disaster Recovery

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

When a contact center is faced with a situation that results in a major disruption of service, the contact center shall take the necessary action to ensure that callers are made aware of the situation. This service is intended to supplement the contractor's existing disaster recovery or contingency plans. Whenever possible, the contact center is responsible for activating its own emergency messages or re-routing calls. *However, when this is not possible and providers are unable to reach the contact center switch, the contact center shall contact the TSC using the contact information located at http://www.cms.hhs.gov/ProviderInquiryOp/ .* For all other FTS 2001 support requests, provider contact centers shall follow their normal procedures.

By the end of the third month of the contract year, contact centers shall *submit to CMS their current* written contingency plan describing how the Medicare provider telecommunications operations will be maintained or continued in the event of manmade or natural disasters. The plan shall cover partial loss of telecommunications capabilities due to equipment or network failures through the total loss of a contact center. The plan may include arrangements with one or more other contractors to assist in telephone workload management during the time the contact center is unable to receive provider phone calls. Plans *shall* be submitted to the service reports mailbox at **servicereports@cms.hhs.gov** or via postal mail, with a copy to the RO.

Contractors may choose to submit the portion of their contingency plan that deals with telecommunications developed in relation to the Centers for Medicare & Medicaid Services (CMS) Business Partners Systems Security Manual.

30.2.7 - Contractor Guidelines for High Quality Response to Telephone Inquiries

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

Contractors shall have a monitoring program in place to ensure the quality of telephone inquiries responses. That monitoring program shall, at a minimum, follow the requirements and performance standards as set forth in the Quality Call Monitoring (QCM) program. The guidelines established apply to contractors' general provider inquiry telephone numbers. The standards shall not apply to those inquiries handled by other units within the contractor (e.g., appeals, fraud, MSP). As contractors are ultimately responsible for the quality of their responses to provider inquiries, contractors shall use the results of their QCM program to identify, and act upon, areas of needed improvement, both for the PCC as a whole and for individual PCC staff. Contractors shall document their monitoring efforts and corrective action plans as applicable, and provide such information to CMS upon request.

A detailed description of each evaluation criteria can be found in the official QCM Scoring Chart. Copies of the QCM scorecard, guide, and chart can be obtained through the QCM database website at https://www.qcmscores.com/ .

30.2.7.1 - Quality Call Monitoring (QCM)

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

At a minimum, the contractor's call monitoring program shall ensure that:

1. Calls monitored are from providers and are of the type that the CSR's level typically handles *(Level 1, Level 2, Congressional)*;
2. Calls monitored are sampled randomly so as to be representative of varying days, time of the day, time of the month, and monitors/auditors;
3. Monitoring is done using the official QCM scorecard and chart and recorded in the QCM database;
4. CSR trainees and new CSRs are adequately monitored. However, scores for CSR trainees will be excluded from QCM performance for one 30-day period following the end of their formal classroom training;
5. Monitoring is done in a way that is conducive to the success of the monitoring program;
6. Feedback is provided to CSRs; and,
7. PCC staff are properly educated about the program and its use.

Contractors that tape calls for QCM purposes shall be required to maintain such tapes for an ongoing 90-day period during the year. All tapes shall be clearly identified by date and filed in a manner that will allow for easy selection of tapes for review. Contractors may reuse tapes after the 90-day period. Contractors shall dispose of tapes that are no

longer used in a manner that would prohibit someone from obtaining any personally identifiable information on the tapes.

30.2.7.2 – QCM Calibration

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

Contractors shall participate in all QCM national and regional calibration sessions organized by CMS. Calibration is a process to help maintain fairness, objectivity and consistency in scoring calls by staff within one or more contact centers. *National sessions are held once per quarter. Appointments will be sent to all provider contact centers via the PCUG listserv (see §30.7.)* Contractors with more than one contact center shall conduct regular calibration sessions among multiple centers. Contact centers with more than one reviewer shall conduct monthly calibration sessions within the contact center. *Contact centers shall keep written records of their internal calibration meetings, including attendance lists. These records shall be provided to CMS upon request.*

30.3 – *Contractor Guidelines for Written Inquiries*

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

All general written inquiries, including letters, faxes, and e-mails, shall be handled consistently for accuracy and timeliness. A general written inquiry is defined as any inquiry that is not forwarded to a specialized unit with its own CMS mandated timeliness standards, such as MSP and Appeals. All general written inquiries are subject to the 45-business day requirement, and are also subject to all provider written inquiry performance standards, as defined in section 30.3.1.

Every inquiry shall receive either a telephone or written response. In cases where a duplicate inquiry is received, the contractor shall verify by telephone or letter, that the provider has received a response. For written inquiries received that could be handled by the IVR, such as claim status and eligibility (see §50.1), it is strongly suggested that contractors include language in the responses to those inquiries that the information being requested is available on the IVR.

30.3.1 – Controlling Written Inquiries

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

Contractors shall control all general written inquiries until they are closed by the written inquiries unit. If an inquiry is transferred to another unit that has its own reporting system and timeliness standards, such as MSP and Appeals, the inquiry shall be closed by the general written inquiries unit and responsibility for the inquiry shall be transferred to unit to which the inquiry was referred. Documentation shall be kept in the provider

inquiry tracking system to identify that the inquiry was referred and/or forwarded to another unit (see §30.6).

The contractor shall stamp the cover page of all written inquiries including letters, e-mails and faxes, and the top page of all attachments with the date of receipt in the corporate mailroom and control them until a final answer is sent. E-mails and faxes received after the close of the contractor's normal business day should be date-stamped the next business day. *E-mails and faxes that contain system generated date stamps are not required to receive an additional corporate date stamp.* Contractors shall not be required to keep the incoming envelope. However, if it is a contractor's normal operating procedure to keep envelopes with the incoming correspondence, the envelope, incoming letter and the top page of all attachments shall be date-stamped in the corporate mailroom.

30.3.2 – Written Inquiry Storage

(Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06)

The majority of contractors currently retain all written inquiries on site. Some contractors house files at a remote location during the year due to cost and space constraints. Those contractors housing written inquiries off-site shall notify CMS within 6 weeks of the final BPR date of the exact address/location of their off site written inquiries. This information shall be sent electronically to the RO *and to the provider services mailbox at providerservices@cms.hhs.gov*. This notification is necessary in the event an onsite evaluation review is conducted. Contractors are required to allow CMS access to all written inquiries stored off site within 24 hours of notification to the contractor. All written inquiries, whether maintained on site or off-site, shall be clearly identified and filed in a manner that will allow for easy selection for review.

30.3.3 – Telephone Responses

(Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06)

Every contractor shall have the flexibility to respond to provider written inquiries by phone within 45 business days. For tracking and evaluation purposes, the contractor shall develop a report of contact for each telephone response. All reports of contact shall contain the following information:

- Provider name;
- Telephone number;
- Provider number;
- Date of contact;
- Internal inquiry control number;
- Subject */ nature of inquiry*
- Summary of discussion;
- Status - *closed / pending research / open*
- *Follow - up* action required (if any); and
- Name of the correspondent who handled the inquiry

Upon request, the contractor shall *either* send the provider a copy of the report of contact *or a letter of the results from the phone response. If the contractor decides to send the report of contact by letter, it must meet CMS' requirements for written responses.* The report of contact shall be retained in the same manner and time frame as the current process for written responses. The contractor shall use its discretion when identifying which written inquiries (e.g., provider correspondence that represents simple questions) can be responded to by phone. If the contractor cannot reach the provider by phone, the contractor shall develop a written response within 45 business days from the incoming inquiry. It is not acceptable to leave a message/response on the provider's voicemail,
.

30.3.4 - E-mail *and Fax* Responses

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

In some cases, inquiries received can be responded to by e-mail *or fax*. Since both represent official correspondence with the public, it is paramount that contractors use sound e-mail *and fax* practices and proper etiquette when communicating electronically. Contractors shall ensure that e-mail *and fax* responses utilize the same guidelines that pertain to all written inquiries. Responses that contain financial information, HICN or protected health information shall not be sent by e-mail *or fax*. If the response shall contain this information, it shall be mailed in hardcopy to the provider or a telephone response shall be given, rather than by e-mail *or fax*. *It is not acceptable to leave the response on the provider's voicemail.*

Contractors shall treat inquiries received via fax in the same manner as e-mail inquiries. Contractors shall follow the same guidelines that pertain to all written inquiries and shall not fax any responses containing financial information, HICN or protected health information. In these situations, the contractor shall be mail the response to the provider or give a telephone response. It is not acceptable to leave a message on the provider's voicemail.

30.3.5 – Check Off Letters

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

Check-off letters are appropriate for routine inquiries like claim status or eligibility. Check-off letters shall not be used to address more complex inquiries. Each check-off letter shall be personalized and *will be held to the same QWCM standards as all other general written inquiry responses*.

30.3.6 – Contractor Guidelines for High Quality Response to Written Inquiries

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

Contractors shall have a monitoring program in place to ensure the quality of written inquiries responses. The monitoring program shall, at a minimum, follow the requirements and performance standards as set forth in the Quality Written

Correspondence Monitoring (QWCM) program. The guidelines established apply to contractors' general provider written inquiry responses and PRRS responses. The standards shall not apply to those written inquiries handled by other units within the contractor (e.g., appeals, fraud, MSP). As contractors are ultimately responsible for the quality of their responses to provider inquiries, contractors shall use the results of their QWCM program to identify, and act upon, areas of needed improvement, both for the PCC as a whole and for individual PCC staff. Contractors shall document their monitoring efforts and corrective action plans as applicable, and provide such information to CMS upon request. Copies of the QWCM scorecard, guide, and chart can be obtained through the QWCM database website at https://www.qwcmscores.com/.

30.3.6.1 - Quality Written Correspondence Monitoring (QWCM)

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

At a minimum, the contractor's written inquiries monitoring program shall ensure that:

1. Written responses monitored are from providers and of the type that the correspondent typically handles *(general, PRRS, congressional)*;
2. Written responses monitored are sampled randomly so as to be representative of varying days, time of the day, time of the month, and monitors/auditors;
3. Monitoring scores are recorded using the official QWCM scorecards and charts through the QWCM database -- separate scorecards and scoring criteria are used to evaluate written and telephone responses;
4. Correspondent trainees and new correspondents are adequately monitored;
5. Monitoring is done in a way that is conducive to the success of the monitoring program;
6. Feedback is provided to correspondents; and,
7. PCC *staff is properly educated about the program and its use and each reviewer and correspondent has an up*-to-date copy of the scorecard and chart for reference.

30.3.6.2 – *QWCM* Calibration

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

Contractors shall participate in all QWCM national calibration sessions organized by CMS. *Calibration is a process to help maintain fairness, objectivity and consistency in scoring cases by staff within one or more contact centers.* National sessions are held *once per quarter. Appointments will be sent to all provider written inquiry units via the PCUG listserv (see §30.7.)* Contractors with more than one reviewer shall conduct monthly calibration sessions within the written inquiries unit. Contractors with more than one *written inquiries unit shall conduct regular calibration sessions among the multiple units.*

Contractors shall keep written records of their internal calibration meetings, including attendance lists. These records shall be provided to CMS upon request.

30.4 - Walk-In Inquiries

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

In the rare circumstance that a provider comes on-site to the contractor to make an inquiry, the contractor shall address the provider's concern(s) and shall count and report the contact as a written inquiry. The contractor shall maintain a log or record of walk-in inquiries. The log, at a minimum shall include the following:

1. Name of inquirer;
2. Time of arrival;
3. Time service was provided;
4. Name of the person handling the inquiry; and,
5. A statement indicating whether the inquiry is closed or still pending.

30.4.1 - Guidelines for Walk-In Service

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

The following are guidelines that the contractor shall use for providing high quality walk-in service:

1. After contact with a receptionist, the inquirer shall meet with a service representative;
2. Waiting room accommodations shall provide seating;
3. Inquiries shall be completed during the initial interview to the extent possible;
4. Current Medicare publications shall be available to the provider (upon request); and
5. Contractors shall maintain a log or record of walk-in inquiries during the year.

30.5 - Provider Relations Research Specialists (PRRS)

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

Contractors shall maintain PRRS as a joint effort between the PCC and POE units in order to provide consistent, accurate, and timely information to Medicare providers regarding complex inquiries that cannot be answered by the contractor's telephone or written inquiries staff and/or require significant research. Therefore, contractors shall design and staff the PRRS component so that questions beyond the expertise of the CSRs or general written inquiry staff which require more time to adequately research can be answered in a timely and efficient manner. In addition, the PRRS shall also handle complex beneficiary inquiries that cannot be resolved by the Beneficiary Contact Center (BCC) in the MAC environment.

For Contractor Reporting of Operational and Workload Data (CROWD) and Customer Service Assessment and Management System (CSAMS) reporting purposes, if a call is transferred between the two CSR levels, the inquiry shall remain open until it is fully resolved and shall only be counted once. Upon referral of a telephone inquiry to the PRRS, the telephone inquiry shall be closed and a written inquiry *shall be* opened.

30.5.1 - Complex Provider Inquiries

(Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06)

Once an inquiry is referred, the PRRS shall take ownership for the inquiry and research and resolve it. The PRRS staff shall respond to the more complex provider questions including those related to coverage policy, coding, and payment policy. Staff shall use the full spectrum of the contractor's resources (*e.g.,* contractor websites, bulletins, medical review staff, *contractor medical directors*, claims processing staff), and CMS resources (e.g. Internet-Only Manual, contractor instructions, training packages, Medicare law and regulations, the CMS website, MLN Matters articles, provider specific web pages, and RO staff) when researching answers to complex inquiries.

The PRRS shall include at least one certified coder to ensure adequate coding expertise although that staff does not have to be assigned exclusively to the PRRS. Durable Medical Equipment Regional Contractors (DME) and DME MACs are exempt from the requirement to have a coding expert staff since the Statistical Analysis DMERC (SADMERC) or the data analysis coding function resolves DME coding questions. The coding questions appropriately answered by the PRRS are those concerning the underlying Medicare payment or coverage policy. Pure coding questions (not related to a Medicare payment or coverage policy) shall be answered with referrals to the correct organizations such as the American Medical Association and the American Hospital Association's Coding Clinic. For more information, please go to: http://www.cms.hhs.gov/MedHCPCSGenInfo/20_HCPCS_Coding_Questions.asp#TopOfPage

30.5.2 - Complex Beneficiary Inquiries

(Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06)

In the MAC environment, complex beneficiary inquiries will be *identified and* referred to the PRRS by the Beneficiary Contact Center (BCC) via the Next Generation Desktop (NGD) and may include telephone, written, and email inquiries. Once an inquiry is referred, the PRRS shall take ownership *of* the inquiry and *be accountable for its resolution. While the PRRS is held accountable for the response, the contractor may use other resources to develop the response, as appropriate*. The contractor shall respond directly to the beneficiary and document the response in NGD (See IOM Pub 100-9, Chapter 2, 20.1.10 for NGD technical specifications). Complex inquiries from beneficiaries shall receive the same priority and attention as complex inquiries from providers.

The contractor shall have adequate language capabilities (English, Spanish, and TTY/TDD) to handle telephone communications with beneficiaries. The contractor shall obtain foreign language support service by contract for other languages. Additionally, the contractor shall fog written responses for reading level (8th grade or less), in accordance with IOM Pub 100-9, Chapter 2, 20.2.1(3.)

The contractor shall provide feedback via the NGD to the BCC identifying inappropriate referrals (routine inquiries that shall have been handled by the BCC) to the PRRS.

30.6 – Inquiry Tracking

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

Contractors shall maintain a tracking and reporting system *for all provider inquiries* that identifies at a minimum:

1. The type of inquiry (telephone, letter, e-mail, fax, walk-in);
2. The person responsible for answering the provider inquiry (by name or other unique identifier);
3. Category of the inquiry (using CMS-provided categories listed in § 90);
4. The disposition of the inquiry, including referral to other PCSP areas or areas elsewhere at the contractor (e.g., appeals, medical review, MSP); and
5. The timeliness of the response.

Tracking information on referrals to the PRRS shall include details of the inquiry and information about how to reach the provider in case there is a need to clarify the question. Contractors have discretion to determine the additional minimum referral information needed by the PRRS. Data from the tracking system shall be used to analyze the number and types of inquiries in order to generate FAQs to be posted on the website, identify areas for telephone CSR training, and identify areas for broader provider education. The tracking system will also be used to generate quarterly reports for CMS use.

CMS requires all contractors to track and report the nature of their inquiry types (reason of the calls) for telephone and written inquiries using categories and subcategories listed according to definitions provided in the CMS Standardized Provider Inquiry Chart, listed in § 90.

These categories are to be used to capture the reason for the inquiry, not the action taken. Contractors may use an additional level of detail, if necessary, to assist in identification of provider education or CSR training needs. However, inquiries reported to CMS shall use categories and subcategories in the chart.

For all provider general telephone and written inquiries, contractors shall track multiple issues raised by a provider during a single call or in a piece of written correspondence.

*Beginning October 1, 2006, contractors shall submit a contractor inquiry tracking report to **ProviderServices@cms.hhs.gov** on a quarterly basis. This report is due at the end of the month following each quarter of the contract year. For example, if the contractor year begins October 1, the inquiry tracking reports shall be submitted no later than January 31, April 30, July 31, and October 31. The format for the reports shall be found at http://www.cms.hhs.gov/FFSContReptMon/.*

30.6.1 - Updates to Chart

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

Contractors shall recommend changes to CMS Standardized Provider Inquiry Chart, listed in § 90, including modifications to existing categories and subcategories and new inquiry categories and subcategories. Contractors shall submit changes or comments related to the CMS Standardized Provider Inquiry Chart via the Provider Services mailbox, **ProviderServices@cms.hhs.gov**. Suggested changes shall include the following information:

- a definition of the inquiry type to be added,
- examples of questions where the inquiry type could be used, and
- information about the number of inquiries associated with it.

The chart will be updated on a quarterly basis, as needed. CMS will define categories to be tracked under the "Temporary Issues Category" and the reporting period for those subcategories through separate instructions. *Between updates, contractor may create and add contractor-specific temporary codes, if their call volume requires them to do so.*

30.7 - Provider Contact Center User Group (PCUG)

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

The Provider Contact Center User Group (PCUG) is a conference call created to discuss new and ongoing projects related to the provider customer service program. Contractors shall ensure that they are represented in the monthly PCUG calls. Contact centers may submit topics for consideration in agenda planning to the PCUG mailbox at *pcug_listserv@cms.hhs.gov*. Further information about the PCUG, including schedules, can be found at: http://www.cms.hhs.gov/ProviderInquiryOp/04_ProviderContactCenterUserGroup(PCUG).asp#TopOfPage

30.9.1 - Customer Service Operations Surveys

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

Contractors shall complete periodic surveys of customer service operations *within the time frames and in areas indicated on the specific notice as directed by CMS.* Examples include annual contact center technology surveys, staffing profiles, training needs, etc.

30.9.2 - Provider Satisfaction Surveys

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

The contracting reform provisions of the Medicare Modernization Act direct CMS to measure provider satisfaction with the performance of Medicare contractors. Contractors shall assist CMS in its efforts to implement this requirement. While the current survey is the Medicare Contractor Provider Satisfaction Survey, contractors

shall assist CMS in implementing any provider satisfaction surveys that may be developed in the future.

30.9.2.1 - Contractor Activities Related to the Medicare Contractor Provider Satisfaction Survey (MCPSS)

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

A. Contractor Activities Related to the Medicare Contractor Provider Satisfaction Survey (MCPSS)

Contractors shall:

1. Provide data for the MCPSS--Contractors shall provide CMS with current data that may be used to:

a) determine if a provider is actively participating in the Medicare program,

b) contact active providers for the MCPSS (e.g., names, Identification Numbers (IDs), business and mailing addresses, business telephone numbers, provider types, key contact information for the appropriate respondent in each provider organization), and

c) address non-response bias in the survey (e.g., claims volume/workload, practice size, number of beneficiaries served).

2. Perform marketing and outreach for the MCPSS--Contractors shall support CMS in disseminating information about the MCPSS to providers. Contractors shall place information about the survey on listservs, newsletters, bulletins, and other provider communications channels. Contractors shall also post information about MCPSS on their Web sites and create a link to the MCPSS Study Website at www.mcpsstudy.org and CMS' MCPSS Web page at www.cms.hhs.gov/MCPSS. Contractors shall include information about the survey on their Interactive Voice Response (IVR) systems, or automatic call distributor (ACD) systems, and any other communications channel with providers (survey information can be included as part of general Medicare information referenced in § 50.1). A media kit with sample documents to use about the survey, a project timeline and key tasks will be available at www.mcpsstudy.org.

3. Create a letter, using contractor letterhead, signed by a senior official, to be included in all survey packages. CMS will provide a template so that the same information can be shared with the provider community. The template and instructions will also be available at www.mcpsstudy.org. The Contractors shall customize the letter to reference the particular services (see #4) that the Contractor provides. The survey contractor will work closely with the Contractor and will make copies of the letter to include in the notification packet to providers. The survey contractor will be responsible for the mailing and administration of MCPSS.

4. Review and confirm the services that they offer to providers with the survey contractor at MCPSS@westat.com. The survey is customized to include ONLY those services that pertain to the Contractor's providers. A matrix of services that CMS considers apply to the Contractor will be available at www.mcpsstudy.org.

5. Appoint a MCPSS contact person. Contractors shall submit the contact name, business address, business telephone number and e-mail to CMS or designated survey contractor. CMS will provide the contact person a username and secured-password to access information relevant to the Contractor's individual survey results and/or response rates. Contractor shall send this information to MCPSS@westat.com by October 15 each year.

6. Participate in conference calls, focus groups, or in-depth interviews that will provide feedback about Contractor-Provider interaction, MCPSS, and any other related provider satisfaction survey that will enhance the MCPSS project and CMS' ability to measure provider satisfaction with Medicare Contractors. Arrangements for conference calls will be made in advance by the MCPSS administrator.

B. Contractor Use of MCPSS Results

Contractors shall use the MCPSS survey results and provider feedback to identify and implement process improvement initiatives.

C. Information for Contractors

A main objective of MCPSS is to support and assist Contractors in using provider feedback to implement process improvement initiatives. To this effect, CMS will provide detailed results of the survey on a secure Web page on the MCPSS Study Web site at www.mcpsstudy.org. This page will include:

1. *Data Collection Reports: The reports will include counts and percentages overall and by provider type for completed responses and each category of the survey sample disposition (e.g., postal non-deliverables, non-locatables, refusals and ineligibles)*
2. *Survey Results: The results of the survey will be available via an interactive online reporting system. A model of the online reporting system is currently available to provide an example of the functions and analysis capabilities of the system. Please note that the site does not include real data; the information is for illustrative purpose s only.*
3. *Study updates, fact sheets, FAQs and media messages. As the project progresses, we will continue to update the MCPSS Study Web site with new materials (e.g., fact sheets, frequently asked questions (FAQs), media messages). Contractors may access their secure Web page at any time to download relevant project information.*
4. *CSR Script: The script is part of the media kit material that Contractors can access through the MCPSS study Website page at www.mcpsstudy.org.*

The dates when this information will be available to Contractors will also be listed in the MCPSS Project Timeline. This timeline can be found under Reference Documents tab at the MCPSS Study Web page or www.mcpsstudy.org.

40 - PCSP Staff Development and Education

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

Contractors shall be fully responsible for the education, development, evaluation, and management of PCSP staff. This shall be accomplished by contractors providing initial and ongoing education and training of all PCSP staff. In addition, contractors shall have an education and development plan in place and documented for each staff member that addresses the education of new staff and the continued education and development of existing staff. Education and reference materials and tools, as well as policy manuals, shall be made readily available and accessible for all staff.

Contractors shall ensure that educational opportunities are afforded the PCC staff, and that staff are afforded promotion pathways through the design and implementation of the PCC. Contractors may elect to have a small number of provider inquiry staff cross-trained to answer either provider or beneficiary inquiries to assist with disaster recovery or during periods of unusually high inquiry activity. Contractors shall not use such staff on a regular basis, such as to cover the lunch period. It is only permissible to use such staff to assist with beneficiary workload if the provider inquiries performance requirements are being met. Please be aware that MACs will not handle beneficiary inquiries, *except for the complex inquiries referred by the BCC to the PRRS (outlined in § 30.5.2).*

Contractors shall send training representatives to 2-4 national train-the-trainer conferences provided by CMS. Contractors shall be prepared to send at least one customer service/provider education representative to these training sessions. Contractors shall expect training sessions to run from 2-4 days. This representative shall be responsible for training additional contractor customer service staff. These staff members shall also be prepared to develop training programs for Medicare providers and suppliers on the various initiatives.

40.1 – *POE Staff Training*

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

Contractors shall implement a developmental plan for training new provider *outreach and* education personnel, and periodically assess the training needs of existing education staff. The plan, which shall be written and available to the education staff, shall include schedules, course or instruction vehicle descriptions, and satisfaction criteria. Training materials such as workbooks, manuals, and policy guidelines shall always be readily available to the education staff.

40.2 – PCC Staff Development and Training

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

The contractor shall train the PCC staff on provider issues and shall equip them with the knowledge and tools to meet CMS' performance requirements for provider inquiries. The PRRS shall be involved in the development of training materials for the general inquiries

staff. CMS will also continue to increase and improve the consistent national training information available to CSRs. Training shall be tailored to the *level*/degree of specialization of the CSR.

Contractors shall ensure that PCC staff receives both initial and ongoing education and training in order to successfully meet the information needs of providers. Information from the national calibration sessions, as well as regular feedback to CSRs and PRRS regarding their performance, shall be a part of the staff development of the PCC, in addition to the requirements set forth in this manual.

Contractors shall ensure that *CSRs and written correspondents* are equipped with the tools they need to handle providers' inquiries while meeting the CMS' performance requirements for telephone *and written provider inquiries*. These tools, at a minimum, shall include the use of the CMS' websites, the contractor's Provider website, CMS-produced CSR education and reference materials, and CMS-produced provider education materials. Standardized training materials and other educational information will be posted at *http://www.cms.hhs.gov/ContractorLearningResources/02_Training.asp#TopOfPage*

40.2.1 - General Requirements

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

Contractors shall provide training for all new CSR hires and refresher training updates for existing personnel. This training shall enable the CSRs to answer the full range of customer service inquiries. Contractors shall have a training evaluation process in place to certify that the trainee is ready to independently handle inquiries.

Upon receipt of CMS developed standardized CSR training materials, contractors shall implement these materials for all CSRs on duty and those hired in the future. Since the development of these materials will be done by CMS, it is not expected that there will be any costs to the contractors to use these training materials. *Standardized training materials and other training information will be posted to the following website: http://www.cms.hhs.gov/ContractorLearningResources/02_Training.asp#TopOfPage* Contractors may supplement the standard materials with their own materials as long as there is no contradiction of policy or procedures.

All contractors shall train their CSRs about how to find, navigate and fully use their Provider website and http://www.cms.hhs.gov/. CSRs shall be connected to and able to use the contractor's website and the CMS website *to assist* providers.

The contractor provider contact center staff shall be trained in the use of the contractor and CMS FAQs in order to maintain consistency of the information given to Medicare providers.

Contractors' staff working with telephone and written inquiries shall be trained to log their inquiry types according to CMS Standardized Provider Inquiry Chart in the tracking system used by the contractor.

40.2.2 - Provider Contact Centers Training Program

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

The CMS recognizes the need for provider *CSR* training. The goal is to help CSRs improve the consistency and accuracy of their answers to provider questions, to increase their understanding of issues, and to facilitate CSRs' retention of the facts of their training by increasing its frequency. To accomplish this goal, all Medicare Provider Contact Centers may close for up to 8 hours per month for CSR training and/or staff development with the following limitations:

1. The 8 hours approved by CMS for contact center closure shall be used for training time only.
2. The training time shall not be used for corporate meetings.
3. Contractors shall request permission to close according to § *40.2.5 and 40.2.6* of this chapter.
4. Training time not used within a specific month shall not be carried over to the next month.

Time used for training on Federal holidays is in addition to the 8 hours per month allowed by CMS for CSR training closure. This 8 hour allowance is separate from any training time occurring during Federal holidays.

40.2.3 - Closure Determination

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

Contractors shall perform an analysis to evaluate the appropriate time for closure to anticipate the impact on their ability to meet all CMS performance requirements as instructed in *§60.2 and 60.3* of this chapter. Contractors shall consult their POE Advisory Group (§ *20.4*) about the best hours for training closures and training topics. CMS will not view performance waivers favorably if the training time closures are the justification for poor performance.

40.2.4 - Provider Complaints

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

Contractors shall monitor provider complaints about training time closures and take action to resolve them and decrease the volume of complaints. Reports about provider complaints and their resolution shall be kept on site and available to CMS upon request.

40.2.5 - Training Schedule

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

Contractors shall submit to CMS a training schedule, including dates, times, topics, sub-topics and contact information by the 15th of the month prior to when the training will be performed via **ProviderServices@cms.hhs.gov** using the subject line "Training Schedule". *CMS will post training schedules and contact information submitted by all provider Medicare contractors at http://www.cms.hhs.gov/ContractorLearningResources/02_Training.asp#TopOfPage* Upon receipt of the training schedule, CMS will send an acknowledgement e-mail. Contractors shall assume approval of closures of 4 hours or less unless they receive notification to the contrary.

40.2.6 - Training Closures of More than Four Hours

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

For training of more than four hours on the same day, contractors shall request CMS approval at least a month in advance of the training dates via **ProviderServices@cms.hhs.gov** using the subject line "One Time Approval Request". CMS will provide one time authorization for training closure requests of more than four hours. CMS will evaluate this type of authorization on a case by case basis and authorize it under special circumstances within one week of receipt. If the contractor does not receive a confirmation from CMS within one week of submitting its request for training closure, the contractor can close for training under the assumption that its request was approved.

In instances where changes to previously approved training schedules are necessary, contractors shall submit all requests for changes via **ProviderServices@cms.hhs.gov**, using the subject line "Change of One Time Approval". A new CMS approval is required to proceed with changes to previously approved training schedules. Changes shall be submitted to CMS within a reasonable time, enough to allow provider notification.

40.2.7 - Provider Notifications

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

Contractors shall notify providers about their closure time for training. At a minimum, contractors shall post a closure notification for providers on their IVRs and websites. Contractors with separate lines for IVR and CSRs shall post a closure notification for providers on both lines. See additional instructions regarding IVR posting in § 50.1 of this chapter. In addition to the IVR and website, contractors shall use their listserv to notify providers of CMS authorized one time only-training closure or a training closure out of the contractor's regular training schedule. Contractors shall use their listserv to

notify their provider community of their closure times the first time that they implement the Training Program in their site.

Contractors shall notify providers of all training closures or changes in their training closure schedule at least two weeks in advance of the training date. For training of more than four hours approved by CMS, contractors shall notify providers at least three weeks in advance of training closures.

40.2.8 - CSR Feedback

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

To assure that CSRs are receiving the maximum benefit of the training program, contractors shall use CSRs' feedback from training, CSRs' pre-and post-training and retention results to determine improvement opportunities to their training program and for development of refresher training. Contractors shall implement a process to evaluate the CSRs' progress pre- and post- training on a monthly basis. Also, contractors shall implement a process to evaluate the CSRs' retention of training information on a periodic basis.

40.2.9 – Reports

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

Contractors shall report in CSAMS the following: (1) the number of hours per month that the contractor closed for training during normal business hours and (2) the number of hours used for training on Federal holidays. For additional information on Customer Service Assessment and Management System (CSAMS) reporting requirements, please refer to § 70 of this chapter. Copies of CMS written approval, training schedule, training plan, training materials, as well as CSR attendance sheets, shall be made available upon request.

40.2.10 - CMS Monitoring

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

For monitoring purposes, contractors' telephone systems shall allow calls from CMS or CMS representatives to CSRs. These CMS callers will not have a provider number. *CSRs shall respond to these calls as if they were calls from the provider community.*

40.3 - PRRS Staff Training

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

Education and training opportunities shall provide PRRS staff with the knowledge and tools to enable them to answer the full range of complex provider inquiries while meeting CMS performance requirements and standards for PRRS. The PRRS will need specialized training in the use of the CMS Internet-Only Manual, the CMS websites, the contractor's websites, regulation, law, and other information tools to accurately and

completely respond to complex provider inquiries, Contractors shall provide these educational opportunities and tools in addition to utilizing CMS-produced PRRS training materials.

50 - Provider Self-Service Technology

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

Contractors shall use self-service and electronic communication technologies as efficient, cost-effective means of disseminating Medicare provider information, education, and assistance. As such, contractors shall take every opportunity to market, educate providers about, and encourage the use of their self-service technologies. At a minimum, such educational opportunities shall include incorporating messages to providers in marketing materials, educational seminars, listserv messages, and instructions on the contractor's website and IVR.

One important way to successfully manage the provider inquiry workload is to increase and enhance the self-service technology tools available to Medicare providers and to require providers to use these tools when appropriate. Use of self-*service* technology enables the provider contact centers to more efficiently handle the increasing volume of provider calls by allowing providers access to certain information without direct personal assistance from contractor staff. Contractors shall offer a variety of self-service options they make available to providers including, but not limited to:

1. Interactive voice response units (IVRs) for telephone inquiries;
2. A provider website;
3. Internet-based provider educational offerings; and
4. Use of electronic mailing lists (Listservs).

Contractors shall expand the use of their *self-service* options and offerings as appropriate, and shall periodically analyze the options they offer, as well as the utilization of such offerings, in order to decide whether and how to expand those offerings.

50.1 - Interactive Voice Response System (IVR)

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

Although the provider shall have the ability to speak to a CSR during normal contact center operating hours, automated "self-help" tools, such as IVRs, shall also be used by all contractors to assist with handling inquiries. IVR service is intended to assist providers in obtaining answers to various Medicare questions, including those listed below:

1. Contractor hours of operation for CSR service.

2. General Medicare program information. *(Contractors shall target individual message duration to be under 30 seconds. Contractor shall have the technical capability to either require callers to listen or to allow them to bypass the message as determined by CMS. In cases where CMS makes no determination the contractor shall use its own discretion.)*

3. Specific information about claims in process and claims completed. *For claims status inquiries handled in the IVR, all contact centers shall adhere to the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule by authenticating callers as required in § 80 of this Chapter.*

4. Official definitions for the 100 most frequently used Remittance Codes as determined by each contractor. Contractors are not limited to 100 definitions and may add more if their system has the capability to handle the information. This requirement may be satisfied by providing official Remittance Code definitions for specific provider IVR claim status inquiries.

Providers shall be required to use IVRs to access claim status and beneficiary eligibility information. *IVRs shall be updated to address provider needs as determined by contractors' inquiry analysis staff at least once every six months.*

The IVR shall be available to providers 24 hours a day, 7 days a week with allowances for normal claims processing and system mainframe availability, as well as normal IVR and system maintenance. *When information is not available, contractors shall post a message alerting providers on the IVR. IVRs shall be programmed to provide callers with an after-hours message indicating normal business hours. (It is not necessary to duplicate this message if the caller is informed of the normal business hours via the telephone system prior to being delivered to the IVR.)*

Contractors shall print and distribute a clear IVR operating guide to providers upon request. The guide shall also be posted on the contractor's website.

50.2 - Provider Web Site

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

50.2.1 – General Requirements and Content

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

Contractors shall offer a provider website as a provider self-service technology to serve as a self-help tool for Medicare providers in gaining information and assistance regarding the Medicare program. This website shall be dedicated to furnishing providers with timely, accessible, and understandable Medicare program information. The information contained on this website shall be structured in such a way that information is easily found and searchable, so as to reduce the number of pages a user has to go through in order to gain access to the information they are seeking.

To reduce costs, the contractor shall use existing resources and technologies whenever possible. Contractors are ultimately responsible for the structure of their provider website, but are encouraged to design it so that it is clear to providers that they are accessing a provider website for their particular interest (specifically, A/B MAC, Part A, Part B, DMERC, DME MAC, etc.). To maintain the quality of the site, contractors shall *periodically* ensure that information posted is current and does not duplicate information posted at http://www.cms.hhs.gov/ and http://www.medicare.gov/.

Contractors shall consider the use of their website for every educational offering they provide to Medicare providers, including approaches such as Web-based conferencing and trainings and computer-based training. However, contractors shall have solutions in place for providers who lack Internet access, such as hosting sites for Web- and computer-based training.

50.2.2 – Webmaster and Attestation Requirements

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

Contractors shall assign a Webmaster responsible for maintaining and updating relevant portions of the contractor's website in a timely manner. The Webmaster shall ensure that the website complies with CMS' Contractor website guidelines and standards located at *http://www.cms.hhs.gov/AboutWebsite/13_contractorwebguidlines.asp#TopOfPage*.

Contractors shall periodically review the CMS Contractor Guidelines to determine their continued compliance. *By the end of the sixth month of their contract year, c*ontractors shall send two signed and dated statements from their Webmaster *to the ProviderServices@cms.hhs.gov mailbox and* their RO coordinator, attesting that their website complies with:

1. CMS Contractor Guidelines; and
2. Requirements stated in Publication 100-04, Chapter 23, Subsection 20.7 of the Claims Processing Manual regarding the use of Current Procedural Terminology (CPT)[1] codes and descriptions.

Contractors may submit these attestations separately or together.

50.2.3 – Feedback Mechanism

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

Contractors shall develop and implement a feedback mechanism for users of their websites. Users shall be able to easily reach the feedback instrument from the Provider website. This mechanism shall ask site users for their appraisals of the helpfulness and ease of use of the site and the information contained on it, as well as their thoughts and suggestions for improvement or additions to the site. Any contractor response provided that is directly related to feedback received related to the format of the website shall not be counted and reported as part of the contractor's provider inquiry workload.

Within their feedback *mechanism contractors shall provide information about how providers can offer comments* to CMS about contractors' performance in dealings with providers. Contractors shall provide the post office mailing address of their CMS Regional Office PSP Coordinator as the referral point for these reactions.

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[1] *Current Procedural Terminology © 2005 American Medical Association.*

50.2.4 – Contents

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

Provider websites shall consist of information that is easy to use and easily searchable and shall contain, at a minimum, the following:

1. Provider bulletins or newsletters for the past 2 years;
2. Information *on how to* join contractor provider listservs;
3. Frequently Asked Questions updated at least quarterly *(See § 50.2.4.2);*
4. A schedule of upcoming provider education events (e.g., seminars, workshops, fairs);
5. Ability to register for contractor *sponsored* education events;
6. Search engine functionality;
7. A "What's New" or similarly titled section that contains important information that is of an immediate or time sensitive nature;
8. A site map that shows in simple text headings the major components *of the provider website* and allows users direct access to these components through selecting and clicking on the titles. This feature shall be accessible from the home page of the website using the words "Site Map";
9. A tutorial explanation of how to use the website that is accessible from the home page. The tutorial shall describe how to navigate through the site, how to find information, and explain features. The tutorial information can be on a "help" page as long as the" help" feature is accessible from the home page;
10. Information for providers on electronic claims submission;
11. Information about the contractor, at a minimum including the telephone number(s) for provider inquiries, a fax number(s) for provider inquiries, and a mailing address for provider written inquiries;
12. An IVR operating guide;
13. CMS products, articles and messages posted, as directed; and,
14. A feedback mechanism *as described in 50.2.3.*

In addition, the contractor websites shall contain the following links to other web addresses:

1. *The CMS we site at http://www.cms.hhs.gov/*
2. *The MLN at http://www.cms.hhs.gov/MLNGenInfo/*
3. *The site for downloading CMS manuals and transmittals at http://www.cms.hhs.gov/Manuals/ and http://www.cms.hhs.gov/Transmittals/*
4. *CMS' Quarterly Provider Update (QPU) website page at http://www.cms.hhs.gov/QuarterlyProviderUpdates/*
5. *The site that contains descriptions for Remittance Advice reason codes and remark codes at http://www.wpc-edi.com/servicesreview.asp*
6. *CMS' HIPAA website at http://www.cms.hhs.gov/HIPAAGenInfo/*
7. *CMS' central provider page at http://www.cms.hhs.gov/center/provider.asp*

8. *CMS' Competitive Acquisition Program page at http://www.cms.hhs.gov/CompetitiveAcquisforBios/*
9. *Other CMS Medicare contractors, partners, QIOs, and other sites that may be useful to providers.*
10. *CMS' MREP Software information at http://www.cms.hhs.gov/AccesstoDataApplication/*
11. *Medicare Contractor Provider Satisfaction Survey (MCPSS) page at http://www.cms.hhs.gov/MCPSS/*

50.2.4.1 - Information from CMS

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

Contractors shall receive instructions from CMS to print a provider education article or other information in their provider bulletin or newsletter and also place it on their website. Unless specifically directed otherwise, the article or information *or the pertinent link* shall be put on the website *and sent on their listserv within 1 calendar week* after receipt, and shall remain on the website for 2 months, or until the bulletin or newsletter in which it is appearing is put on the website, whichever is later.

50.2.4.2 – FAQs

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

All contractors shall maintain regularly updated *local* FAQs on their *provider* websites and link to the CMS FAQs *for national information. The FAQs are an important tool for the providers to use to get answers to their questions without contacting the provider contact center. The contractor FAQs must be updated for accuracy and relevance at least quarterly and the date the FAQ was last reviewed must be noted on the website. The contractor shall develop local FAQs based upon its data analyses described in §20.2. At a minimum, the contractor shall post FAQs based upon the Top 10 telephone and Top 10 written provider inquiries as well as medical review topics.*

50.2.4.3 – Quarterly Provider Update (QPU)

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

The Quarterly Provider Update (QPU) is a listing of the regulations and program instructions issued by CMS that impact Medicare providers. The QPU is maintained by CMS and available to providers through the CMS website. Providers may elect to join a CMS electronic mailing list, to be notified periodically, of additions to the QPU.

Contractors shall promote the existence and usage of the QPU and its electronic mailing list/listserv to their provider community.

50.2.4.4 - Internet-based Provider Educational Offerings

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

Contractors shall offer internet-based training and educational resources*, such as, but not limited to, computer based training and webcasting*, as self-help tools to acquire information about the Medicare program. Contractors shall encourage providers to use the CMS and contractor websites for these offerings as well as to sign-up for listservs on both sites so they can learn of them.

50.3 - Electronic Mailing List/Listserv

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

Contractors shall offer electronic mailing lists/listservs to *assist* Medicare providers in gaining information about the Medicare program. These listservs shall notify registrants via e-mail of important, time-sensitive Medicare program information, upcoming provider communications events, and other announcements necessitating immediate attention. Providers/suppliers shall be able to join electronic mailing lists via Provider websites. Subscribers to the electronic mailing lists shall also be able to unsubscribe via the website. Notices shall be published on the websites and in bulletins/newsletters that encourage subscription to the electronic mailing lists. Contractors' electronic mailing lists shall be capable of accommodating all of the providers/suppliers it serves. It is recommended that electronic mailing list(s) be constructed for only one-way communication, i.e., from contractors to subscribers.

Contractors shall protect electronic mailing list(s) addresses from unauthorized access or inappropriate usage. Electronic mailing lists, or any portions or information contained therein, shall not be shared, sold or in any way transferred to any other organization or entity. In special or unique circumstances where such a transference or sharing of listserv information to another organization or entity is deemed to be in the best interests of CMS or the Medicare program, the contractor shall first obtain express written permission from its CMS RO Coordinator.

Contractors shall maintain records of their electronic mailing list usage. These records shall include when the electronic mailing list(s) were used, text of the messages sent, the number of subscribers transmitted to per usage, and the author of the message. Records shall be kept for one year from the date of usage.

50.3.1 - Targeted Electronic Mailing Lists/Listservs

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

Targeted electronic mailing lists shall be used to send messages and information regarding the Medicare program, policies, or procedures that are of relevance or interest to specific provider audiences. *Contractors shall use the list of provider types located at http://www.cms.hhs.gov/center/provider.asp* to determine applicable and appropriate audiences. This list does not preclude *contractors developing or using* additional, categorically different or more finite groupings.

50.3.2 – *Listserv* Promotion

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

The contractors shall actively market and promote the benefits of being a member of the listserv(s) through the use of all regular provider communications tools and channels (*e.g.*, bulletins, workshops, education events, advisory group meetings, ACT calls, and written materials.)

60 – *PCSP* Performance Management

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

60.1 – *POE - Listserv Membership*

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

For fiscal intermediaries, the total number of unique, individual members of its listserv(s) shall be at 60% or higher of its active provider count. For carriers, the total number of unique, individual members of its listserv(s) shall be at 25% or higher of its active provider count. Medicare Administrative Contractors shall have their listserv population at 25% or higher of their active provider count one year after becoming a Medicare contracting entity. For the purpose of calculating this percentage, no one individual member of a contractor's listserv(s) can be counted more than once, and active providers are all individual providers who have had billing activity during the previous 12 months. It is a goal of CMS that listserv(s) populations continually increase. CMS will periodically adjust the percentage requirement in order to accomplish this goal.

60.2 – *Telephone Inquiries*

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

60.2.1 - Initial Call Resolution

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

Contractors shall handle no less than 90 percent of the calls to completion during the initial contact with a CSR. A call is considered resolved during the initial contact if it does not require a return call by a CSR *or it is referred to the PRRS*. This standard will be measured quarterly and will be cumulative for the quarter.

60.2.2 - Call Completion

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

- *Beginning October 1, 2006, each CSR and IVR combined line shall have a completion rate of no less than 70%. From February through September 2006, e*ach CSR and IVR combined line shall have a completion rate of no less than 80%. This standard will be measured quarterly and will be cumulative for the quarter.
- *Beginning October 1, 2006, each CSR-only line shall have a completion rate of no less than 70%. From February through September 2006, e*ach CSR-only line shall have a completion rate of no less than 80%. This standard will be measured quarterly and will be cumulative for the quarter.
- *Beginning October 1, 2006, each IVR-only line shall have a completion rate of no less than 90%. From February through September 2006, e*ach IVR-only line shall have a completion rate of no less than 95%. This standard will be measured quarterly and will be cumulative for the quarter.

60.2.3 – Call Acknowledgment
(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

Calls *shall be* acknowledged within 20 seconds by a CSR, IVR, or ACD prompt.

60.2.4 – Average Speed of Answer (ASA)
(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

Beginning October 1, 2006, the contractor shall maintain an average speed of answer of 120 seconds. This standard shall be measured quarterly and will be cumulative for the quarter.

Of all calls answered by the contractor by a customer service representative (CSR) during *February through September 2006,* the contractor shall maintain an average speed of answer of *60* seconds or less. During the quarter, no month shall have an average speed of answer greater than *80* seconds. This standard shall be measured quarterly and will be cumulative for the quarter.

The ASA standard will be applied to the speed at which the initial call is answered by a CSR. Should the caller need to be transferred to another level CSR, the time associated with that transfer shall not be included in the ASA calculation.

60.2.5 – Callbacks
(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

Between January 2005 and January 31, 2006, the callback requirement was 5 days. Contractors shall make 3 attempts to reach a provider for a callback. The contractor may leave a message requesting a return call, including the patient's name if appropriate, but no PHI should be left on the message. If the provider does not respond after 3 callbacks, the contractor has the discretion to prepare a written response,

completed within 10 business days of the original inquiry. The contractor shall not close out the inquiry without any type of response to the caller. Contractors shall not leave the responses on provider voicemails. All callbacks shall be completed and closed out within 10 business days of the original inquiry and documented in the inquiry tracking system, discussed in § 30.6 and 90.

60.2.6 – QCM Performance Standards

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

Contractors shall monitor a minimum of *three* calls per CSR per month. *In centers where CSRs answer both beneficiary and provider calls, contractors shall monitor a minimum of three calls, including at least one of each type, during the month. Any deviation from this requirement shall be requested and justified to the RO in order to determine if a waiver is warranted.*

- *Beginning October 1, 2006, of all calls monitored for the quarter, the percent scoring as "Pass" shall be no less than 90 percent for Adherence to Privacy Act. From February through September 2006, o*f all calls monitored for the quarter, the percent scoring as "Pass" for Adherence to Privacy Act shall be no less than 93 percent. During the quarter, no month shall fall below 85 percent. This standard will be measured quarterly and will be cumulative for the quarter.
- *Beginning October 1, 2006, of all calls monitored for the quarter, the percent scoring as "Achieves Expectations" or higher shall be no less than 90 percent for Customer Skills Assessment. From February through September 2006, o*f all calls monitored for the quarter, the percent scoring as "Achieves Expectation" or higher shall be no less than 93 percent for Customer Skills Assessment. During the quarter, no month shall fall below 85 percent. This standard will be measured quarterly and will be cumulative for the quarter.
- *Beginning October 1, 2006, of all calls monitored for the quarter, the percent scoring as "Yes" shall be no less than 90 percent for Knowledge Skills Assessment. From February through September 2006, o*f all calls monitored for the quarter, the percent scoring as "Yes" shall be no less than 93 percent for Knowledge Skills Assessment. During the quarter, no month shall fall below 85 percent. This standard will be measured quarterly and will be cumulative for the quarter.

60.3 – Written Inquiries

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

60.3.1 – QWCM Performance Standards

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

Contractors shall evaluate and enter into the QWCM application a minimum of 3 provider responses per correspondent per month or the entire universe available for

monitoring, whichever is less, regardless of how many locations for which the correspondent is responding. Contractors shall meet the following standards:

- *Beginning October 1, 2006, of all provider written responses monitored for the quarter, the percent scoring as "Pass" shall be no less than 90 percent for Adherence to Privacy Act. From February through September 2006, o*f all written responses monitored for the *quarter, the* percent scoring as "Pass" for Adherence to Privacy Act shall be no less than 93 percent. During the quarter, no month shall fall below 85%. This standard will be measured quarterly and will be cumulative for the quarter.
- *Beginning October 1, 2006, of all provider written responses monitored for the quarter, the percent scoring as "Achieves Expectations" or higher shall be no less than 90 percent for Knowledge Skills. From February through September 2006, o*f all written responses monitored for the quarter, the percent scoring as "Achieves Expectations" or higher for Knowledge Skills shall be no less than 93 percent. During the quarter, no month shall fall below 85 percent. This standard will be measured quarterly and will be cumulative for the quarter.
- *Beginning October 1, 2006, of all provider written responses monitored for the quarter, the percent scoring as "Achieves Expectations" or higher shall be no less than 90 percent for Customer Skills. From February through September 2006, o*f all written responses monitored for the quarter, the percent scoring as "Achieves Expectations" or higher for Customer Skills Assessment shall be no less than 93 percent. During the quarter, no month shall fall below 85 percent. This standard will be measured quarterly and will be cumulative for the quarter.

60.3.2 – General Inquiries Timeliness

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

All written inquiries shall be responded to in writing or by telephone within 45 business days. This timeframe begins the day the inquiry is originally received and date-stamped by the contractor and ends the day the contractor sends the response from the mailroom. There may be instances when an inquiry is mistakenly sent to another address used by the contractor. If the contractor has done a proper job of publicizing the correct address to the provider community then the 45 business day timeframe will begin once the inquiry is received in the contractor mailroom where written inquiries are routinely sent. This does not apply to contractors who choose to have all of their mail sent to a separate location and then forwarded to the proper written inquiry unit. For these contractors, the 45 business day timeframe starts the day that the mail is received at the initial location.

Substantive action shall be taken and a final response shall be sent to all provider correspondence with 45 business days from receipt of the inquiry. In instances where a final response cannot be sent within 45 business days (e.g., inquiry shall be referred to a specialized unit for response), the contractor shall send an interim response acknowledging receipt of the inquiry and the reason for any delay. When possible, inform the provider about how long it will be until a final response will be sent.

If the contractor is responsible for handling both Part A and Part B claims, inquiries requiring response from both of these areas share the same time frame for response (i.e., the 45 business day period starts on the same day for both responses). Therefore, the contractor shall ensure that the inquiry is provided to both responding units as quickly as possible. The response to these inquiries may be combined, or separate, depending on which procedure is most efficient for the contractor's conditions. If a contractor responds separately, each response shall refer to the fact that the other area of inquiry will be responded to separately. See the chart below for assistance with converting calendar days to business days.

Business Days	Calendar Days
5	7
10	14
15	21
20	28
25	35
30	42
35	49
40	56
45	63

60.4 – PRRS *Timeliness*

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

For those provider and beneficiary complex inquiries, both telephone and written, that cannot be answered in final within 45 business days, contractors shall issue an interim response within 45 business days explaining the reason for the delay. Acceptable reasons for an interim response include referral to CMS, a shared systems maintainer, or other non-contractor entity. The final response shall be sent within 5 business days after receipt of the needed information.

The PRRS staff shall provide clear, accurate, and complete *responses* within *25 business days for at least 75 percent of cases referred by the telephone CSRs, and 45 business days for 100%* of all cases referred by telephone CSRs or from the general written inquiries area. The business day count begins the day the inquiry was originally received / date stamped by the contractor, either by telephone or in writing, and ends the day the contractor sends the response. Interim responses shall not comprise more than 5% of all general written inquiries and PRRS responses. Final responses shall be issued within 5 business days of receipt of the outstanding information necessary to complete the response.

70.1 - Definition of Contact Center for CSAMS

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

All contractors shall ensure that monthly CSAMS data are being reported by individual contact centers and that the data are not being consolidated. Telephone performance data shall be reported at the lowest possible physical location in order to address performance concerns. A contact center is defined as a location where a group of CSRs *is* answering *Medicare provider calls*.

70.2- Data to Be Reported Monthly

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

Contractors shall capture and report the following data each month:

Data Reported	Definition
Number of Attempts	This is the total number of calls offered to the provider contact center via the FTS Toll-Free during the month. This shall be taken from reports produced by FTS toll-free service provider. The current provider is *Verizon* and the reports are available at their Web site http://www.verizonbusiness.com/us/.
Number of Failed Attempts	This represents the number of calls unable to access the contact center via the toll-free line. This data shall also be taken from reports produced by FTS toll-free service provider. The current provider is *Verizon* and the reports are available at their Web site http://www.verizonbusiness.com/us/.
Number of Attempts (TTY/TDD)	This is the total number of calls offered to the TTY/TDD line at the provider contact center via the FTS Toll-Free during the month. This shall be taken from reports produced by FTS toll-free service provider. The current provider is *Verizon* and the reports are available at their Web site http://www.verizonbusiness.com/us/.
Number of Failed Attempts (TTY/TDD)	This represents the number of calls unable to access the contact center via the TTY/TDD toll-free line. This data shall be taken from reports produced by FTS toll-free service provider. The current provider is *Verizon* and the reports are available at their Web site http://www.verizonbusiness.com/us/.
Number of Attempts	(for those contact centers with IVR-only lines) - This is the total number of calls offered to the IVR-only line at the provider contact center via the FTS Toll-Free during the month. This shall be taken from reports produced by FTS toll-free service provider. The current

	provider is *Verizon* and the reports are available at their Web site http://www.verizonbusiness.com/us/.
Number of Failed Attempts for those contact centers with IVR-only lines)	This represents the number of calls unable to access the contact center via the IVR-only toll-free line. This data shall be taken from reports produced by FTS toll-free service provider. The current provider is *Verizon* and the reports are available at their Web site http://www.verizonbusiness.com/us/.
Call Abandonment Rate	This is the percentage of provider calls that abandon from the ACD queue. This shall be reported as calls abandoned up to and including 60 seconds.
Average Speed of Answer	This is the amount of time that all calls waited in queue before being connected to a CSR. It includes ringing, delay recorder(s), and music. This time begins when the caller enters the CSR queue and includes both calls delayed and those answered immediately.
Total Sign-in Time (TSIT)	This is the amount of time the CSRs were available to answer telephone inquiries. This time includes the time that CSRs were plugged-in, logged-in, handling calls, making outgoing calls, in the after call work state or in an available state.
Number of Business days	This is the number of calendar days for the month that the contact center is open and answering telephone inquiries. For reporting purposes, a contact center is considered open for the entire day even if the contact center was closed for a portion of the day and/or not able to answer telephone inquiries for a portion of the day.
Total Talk Time	This is the total amount of time that all CSRs were connected to callers and includes any time the caller is placed on hold by the CSR during the conversation.
Available Time	Available time is the amount of time that CSRs were signed-in on the telephone system waiting for a call to be delivered (i.e., the CSR is not handling calls, making outgoing calls, or in the after call work (ACW) state).
After Call Work Time	This includes the time that CSRs need to complete any administrative work associated with a call after the customer disconnects.
Status of Calls Not Resolved at First Contact	Report as follows: 1. Number of callbacks required. This number is based on calls received for the calendar month and represents the number requiring a callback as of the last workday of the month.

	2. Number of callbacks closed within 10 workdays. This number is based on calls received for the calendar month and represents the number closed within 10 workdays even if a callback is closed within the first 10 workdays of the following month.
IVR Handle Rate	For contact centers with combined CSR and IVR lines , this includes: 1. The number of calls offered to the IVR (defined as the total number of calls receiving a prompt offering the use of the IVR during or after business hours); and 2. The number of calls handled by the IVR. For contact centers with separate CSR and IVR lines this includes: 1. The number of calls offered to the IVR (defined as the total number of IVR-only calls receiving a prompt offering the use of the IVR during or after business hours plus the total number of calls offered to CSRs); and 2. The number of calls handled by the IVR (defined as the number of calls where the caller selected and played at least one informational message).
Calls in CSR queue	This is the total number of calls delivered to the CSR queue.
Calls Answered by CSRs	This represents the total number of calls answered by all CSRs for the month from the CSR queue.
Calls Answered <= 60 Seconds	This represents the total number of calls answered by all CSRs within 60 seconds from the CSR queue.
Quality Call Monitoring (QCM)-Number of CSRs Available for Monitoring	This is the number of CSRs (not FTEs) that take calls on a regular basis, both full-time and part-time CSRs. This number is obtained from the QCM Database.
QCM-Number of Completed Scorecards	This is the number of scorecards that were completed and entered into the QCM database for the month. This number is obtained from the QCM Database.
QCM-Customer Skills Assessment	This is the percent of calls monitored that scored greater than or equal to Achieves Expectations. This number is obtained from the QCM Database.
QCM-Knowledge	This is the percent of calls monitored that scored greater than or equal to Achieves Expectations. This number is obtained from the QCM

Skills Assessment	Database.
QCM-Privacy Act	This is the percentage of calls that scored as pass. This number is obtained from the QCM Database.
Training Hours – Normal Business Days	Report the number of hours (rounded to the nearest half-hour) that the provider contact center closed for CSR training per month. This indicator is used to measure the time the provider contact center is closed during normal business hours for staff development. The number of hours used each month can not exceed 8 hours per month.
Training Hours – Federal Holidays	Report the number of hours (rounded to the nearest half-hour) that the provider contact center closed for CSR training on a Federal holiday(s) per month. This indicator is to measure the time the contact center closed on a Federal Holiday for staff development

90 - Provider Inquiry *Standardized Categories*

(*Rev.18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06*)

CMS requires all contractors to track and report the nature of their inquiry types (reason *for the inquiry*) for telephone and written inquiries using categories and subcategories listed according to definitions provided in the CMS Standardized Provider Inquiry Chart *(See Inquiry Tracking, § 30.6).*

These categories are to be used to capture the reason for the inquiry, not the action taken. Contractors may use an additional level of detail, if necessary, to assist in identification of provider education or CSR training needs. However, inquiries reported to CMS must use categories and subcategories in the chart.

For all provider general telephone and written inquiries, contractors shall track multiple issues raised by a provider during a single call or in a piece of written correspondence.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
Adjustments	Changing the information on a submitted claim to correct an error or the correction of a claim denied in error.	*Cancellation of Claim/Return Claim/Billed in Error*	Contact is asking to cancel a claim that was submitted in error. Includes "services not rendered."
		Claim Processing Error	Contact is asking for an adjustment of an incorrect payment due to a processing error by the local or shared systems, imaging errors, interest not paid or penalties applied in error.
		Claim Information Change	Contact is asking for change or correction of information on a submitted/processed claim; for example, contact asks to add or remove modifiers or procedure codes to correct the amount of units provided, etc.
		Medical Review	Contact is asking about corrections/changes in diagnosis/treatment on processed claim.
		MSP	Contact is asking about the adjustment process for changes in the beneficiary MSP or HMO record.
Administrative Billing Issues	The mechanism and processes of how to bill for Medicare Services, which includes the explanation of CMS instructions, procedures and decision-making criteria for claim review and payment decisions. This does not include an explanation of why a particular claim was denied.	*1500/UB-92 Form*	Contact is asking how to complete the claim form and/or where to find it, including an electronic equivalent of both 1500 and UB92 Forms.
		Advance Beneficiary Notice (ABN)	Contact is asking for general information on ABN, for example, When is it appropriate to use an ABN?, What do I have to do with an ABN?
		Claims Related Reports	Contact is asking for information about accessing and/or receiving reports produced by Medicare regarding to billing trends, history of Medicare payments, comparative billing reports, medical review reports, etc.
		Claim Documentation	Contact is asking what information is necessary to submit with a claim to allow processing and/or adjudication of the claim, for example, medical record, progress notes, physicians orders, x-rays, etc.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		Coinsurance	Contact is asking for the amount of coinsurance and/or deductible that a beneficiary must pay before Medicare begins to pay for covered services and supplies. This subcategory applies to inquiries at a general level. Use "Deductible" subcategory under "Eligibility" for inquiries on annual deductible for a specific beneficiary.
		Fraud and Abuse	Contact is reporting a fraud and abuse allegedly done by a Medicare provider. This subcategory also includes providers calling for guidelines to assure compliance of Medicare rules and regulations against fraudulent and abusive practices.
		Filing/Billing Instructions	Contact is asking for instructions on filing a claim, type of bill necessary for a type of claim, how to correct a claim (adjust a claim), mandatory submission of claims, and time filing limits. Includes inquiries on "How to meet the 72 hr rule for dx services".
		HPSA/PSA	Contact is asking for information about Health Professional Shortage Area (HPSA) and/or Physician Scarcity Area (PSA) classification. This subcategory includes questions such as how to bill based on location class as urban vs. rural area, the use of appropriate modifiers and the amount of bonus payment applicable to them.
Allowed Amount	The amount that Medicare will pay for a certain procedure code according to the Medicare payment systems, fee schedules and locality rates applicable.	*Ambulance Fee Schedule*	Contact is asking for the Ambulance Fee Schedule payment amount for a particular item or service provided to a Medicare beneficiary.
		Ambulatory Surgical Center	Contact is asking for the Ambulatory Surgical Centers payment amount for a particular item or service provided to a Medicare beneficiary.
		Anesthesia Fee Schedule	Contact is asking for the Anesthesia Fee Schedule payment amount for a particular item or service provided to a Medicare beneficiary.
		Critical Access Hospitals	Contact is asking for the Critical Access Hospitals payment amount for a particular item or service provided to a Medicare beneficiary.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		Clinical Lab Fee Schedule	Contact is asking for the Clinical Laboratory Fee Schedule payment amount for a particular item or service provided to a Medicare beneficiary.
		Drug Average Sales Price (ASP) Resource	Contact is asking about the Medicare Part B Drug Average Sales Price Resource payment amounts. This extensive listing of drugs is a guide. It may not include all drugs that could be considered for payment by Medicare.
		ESRD Composite Rate	Contact is asking for the ESRD Composite Rate payment amount for a particular item or service provided to a Medicare beneficiary.
		Home Health PPS	Contact is asking for the Home Health PPS payment amount for a particular item or service provided to a Medicare beneficiary.
		Hospital Inpatient PPS	Contact is asking for the Hospital Inpatient PPS payment amount for a particular item or service provided to a Medicare beneficiary.
		Hospital Outpatient PPS	Contact is asking for the Hospital Outpatient PPS payment amount for a particular item or service provided to a Medicare beneficiary.
		Hospice Payment System	Contact is asking for the Hospice Payment System payment amount for a particular item or service provided to a Medicare beneficiary.
		Long Term Care Hospital PPS	Contact is asking for the Long Term Care Hospital PPS payment amount for a particular item or service provided to a Medicare beneficiary.
		Physician Fee Schedule	Contact is asking for the Physician Fee Schedule payment amount for a particular item or service provided to a Medicare beneficiary.
		DMEPOS Fee Schedule	Contact is asking for the DMEPOS Fee Schedule payment amount for a particular item or service provided to a Medicare beneficiary.
		Psychiatric Hospital PPS	Contact is asking for the Psychiatric Hospital PPS payment amount for a particular item or service provided to a Medicare beneficiary.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		Rehabilitation Hospital PPS	Contact is asking for the Rehabilitation Hospital PPS payment amount for a particular item or service provided to a Medicare beneficiary.
		Skilled Nursing Facility PPS	Contact is asking for the Skilled Nursing Facility PPS payment amount for a particular item or service provided to a Medicare beneficiary.
Appeals	Action initiated by the provider due to disagreement on a Medicare's claim determination.	*Process/Rights*	Contact is asking for general appeal information, appeal process instructions and/or appeal rights.
		Status/Explanation/Resolution	Contact is asking the status of the appeal. This involves whether an appeal has been received and/or whether the time to file an appeal has expired, an explanation of Medicare's determination with respect to the submitted appeal and requests for duplicates of Medicare Redetermination Notices (MRN).
		Qualified Independent Contractor (QIC) Contractor	Contact is asking about an appeal status or information related to appeals reviewed by the QIC.
Claim Denials	Claim that has been fully adjudicated and a non-payment determination has been made based on Medicare rules and regulations.	*ABN*	Contact is asking for clarification on a particular claim denial where the use of ABN applies and the patient is not required to pay the provider for a service.
		Certification Requirements	*Contact is asking about claim(s) denied due to certification requirements not being met. This includes Hospice certifications and/or Certificates of Medical Necessity (CMNs).*
		Claim Overlap	Contact is asking about claim(s) denied due to an overlap in service dates with a previously processed claim. This may include the denial of a Part B claim for physical therapy services that conflicted with a previously processed inpatient claim with overlapping dates of service.
		Coding Errors/Modifiers	Contact is asking about a claim(s) denied due to an invalid or incorrect code. Includes the absence or incorrect use of a modifier and global surgery denials.
		Contractor Processing Errors	Contact is asking about a claim(s) denied due to a contractor error (incorrect edit, shared systems issue, etc.), when processing the claim.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		Contractual Obligation Not Met	Contact is asking about a claim(s) denied because the provider did not comply with their Medicare contractual obligation (for example, the claim was submitted with missing information, the claim was not filed timely, etc).
		CWF Rejects	Contact is asking about a claim(s) denied because information on the claim does not match the CWF beneficiary information (for example, *Managed Care/HMOs status,* discharge status, name mismatch, female patient with a male procedure claimed). Log under this sub-category CWF issues that need to be corrected through SSA because the provider submitted correct information on the claim and CWF file needs to be updated. Please note that "frequency limit" issues identified by CWF should be categorized under "frequency limitation" (See below).
		Denial Letter Request	Contact is asking for a copy of the Medicare denial letter, establishing the reason for non payment of services in order to bill another insurer.
		DME POS Issues	Contact is asking about a claim(s) denied due to equipment, item or service not received by a beneficiary or returned to a supplier and other maintenance/services issues*. Also, includes break-in service denials.*
		Duplicate	Contact is asking about a claim(s) denied due to same date of service, claim previously processed or paid for the same date and same provider.
		EMC Filing Requirements	*Contact is asking about a claim(s) where payment was denied as not being covered unless they are submitted electronically.*
		Eligibility	Contact is asking about a claim(s) denied due to incorrect patient information submitted by the provider that does not agree with CWF (for example, incorrect suffix, transposed numbers) and affects the patient's eligibility for Medicare Benefits. Log under this sub-category, issues were there is no need to update information on CWF files.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		Evaluation & Management Services	Contact is asking about a claim(s) where payment was denied or reduced due to a changed E&M code. E&M codes explain how the physician gathered and analyzed patient information determined a condition and advised the best treatment. Includes services such as: office visits, hospital visits, consultation visits, and care plan oversight.
		Frequency / Dollar Amount Limitation	*Contact is asking about a claim(s) that was denied because the allowable number of incidences or dollar amount limit for that service in a given time period has been exhausted or exceeded due to a service that was previously billed. Also, includes inquiries related the outpatient therapy cap and to billing frequency limits for durable medical equipment and supplies (same or similar equipment denials) such as Capped Rental.*
		LCD	Contact is asking about a claim(s) that was denied or reduced based on a local coverage determination (LCD) by the contractor. Coverage determinations reflect the local contractor decision as to whether a product, service, or device is reasonable and necessary.
		Life Time Days Met	Contact is asking about claim(s) denied because a particular benefit is disallowed for a Medicare beneficiary due to the lifetime days limit exhausted.
		Medical Necessity	Contact is asking about a claim(s) denied because the information presented did not indicate services or supplies are reasonable and necessary for the diagnosis and treatment of the illness or injury.
		MSP	Contact is asking about a claim(s) denied due to other insurance existing on the beneficiary file that is primary to Medicare.
		NCD	Contact is asking about a claim(s) that was denied or reduced based on a national coverage determination (NCD) by CMS. Coverage determinations reflect national Medicare coverage policies governing specific medical service, procedure or device.
		Statutory Exclusion	Contact is asking about a claim(s) that items or services were denied by law.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
Claim Status	Information about where the claim is in the process and whether it has been paid. Routine claim status questions are to be referred to the IVR.	*Additional Development Request (ADR) Letters*	Contact is asking about a Medicare letter received from the contractor that requests more information or documentation to process pending claim(s). Contact may also be providing a response to a written request.
		Applied to Deductible	Contact is asking about a processed claim where payment was not generated because the payment amount was applied to the beneficiary's annual deductible amount.
		ATP Amount/Check Information	Contact is asking for current Approved to Pay (ATP) amount, current pending claims totals and/or payment information on a claim (i.e., status of check, check number, check amount and issued date).
		Crossover	Contact is asking for information on a claim that is covered by a supplemental insurer, such as Medigap or other private insurance.
		Not on File	Contact is asking for a claim that Medicare does not have on file or that has not been received by the contractor.
		Paid in Error	Contact is asking about a claim that they believe was paid in error.
		Payment Explanation/Calculation	Contact is asking for explanation on how the claim was paid or how the payment amount was calculated. Includes "reimbursement" questions.
		Suspended	Contact is asking about the status of a claim that is pending while waiting for information needed to complete processing.
Coding	Any set of codes used to encode data elements, such as tables of terms, medical concepts, medical diagnostic codes or medical procedure codes. Includes the codes, their descriptions, and how to use them.	*CCI Edits*	Contact is asking about Correct Coding Initiative edits that identify types of inappropriate coding combinations, such as comprehensive and component code combinations and code combinations of services or procedures that could not be performed together.
		Condition Codes	Contact is asking about billing codes that indicate whether the claimant meets a condition of the service.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		Procedure Codes	Contact is asking about the numeric representation of a procedure code used to determine reimbursement for services rendered on a claim or for other medical documentation. Includes CPT-4 codes, which belong to the American Medical Association and indicate physician services, physical and occupational therapy services, radiology procedures, clinical laboratory tests, medical diagnostic services, and hearing and vision services. Also, includes HCPCS Codes Level II that determines reimbursement for equipment and medical supplies.
		Diagnosis codes	Contact is asking about the numeric representation of a disease, injury, impairment, or other health problem that providers must use to report the diagnosis for each service and /or item they provide.
		Evaluation & Management Codes (E&M)	Contact is asking about codes that explain how the physician gathered and analyzed patient information, determined a condition, and advised the best treatment. Examples are: care plan oversight, office visits, hospital visits and consultations. E&M codes are a part of the AMA's CPT-4 coding system.
		Modifiers	Contact is asking about two digit codes used in conjunction with a procedure code that provides additional information about the service. The modifier may affect the reimbursement rate of a service.
		MSP Payer/Value Codes	Contact is asking about codes used to designate that another insurer is responsible for full or partial payment where Medicare has no payment or secondary payment responsibility.
		Revenue Codes	Contact is asking about codes that identify specific accommodations or ancillary charges that are provided in a hospital, (e.g., blood, cardiology, radiology, laboratory services, etc.
		Patient Status Codes	Contact is asking about codes that indicate the patient's status as of the "Through" date of the billing period. These codes reflect the destination of the patient not the service received at the ending date. Includes also inquiries related to source of admission codes and discharge status codes.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		Place of Service Codes	Contact is asking about codes on professional claims to identify where the service was rendered.
		Specialty Codes	Contact is asking about codes used on a claim form to indicate a provider's type or medical specialty.
Complaints	An expression of dissatisfaction with service from providers in regards to different aspects of the Medicare operation.	*Contact Center Closure*	Contact is expressing dissatisfaction due to hours of operation or call center closures for CSR training.
		Medicare Contractor Operation	Contact is expressing dissatisfaction due to contractor operational errors, procedures, policies, processes, and staff issues not addressed by other subcategories included in this section.
		Medicare Program	Contact is expressing dissatisfaction due to issues with the Medicare program. Includes provider expressions of intentions of leaving the Medicare program.
		Provider Education and Outreach	Contact is expressing dissatisfaction with educational activities, education staff performance or availability of educational resources or activities for Medicare providers.
		Self Service Technology	Contact is expressing dissatisfaction due to content, functionality, instability, formatting and processes related to Provider Self Service tools such as CMS or contractor website, online tools for eligibility inquiries or claim submissions, IVR, etc.
		Staff	Contact is expressing dissatisfaction due to CSR or Staff attitude, incorrect information given or non response to an inquiry.
Direct Data Entry (DDE)	The Direct Data Entry system is an on-line application that allows direct on-line access to Medicare claims, such as: claim entry, error correction, eligibility inquiry, claims status, claim adjustment and roster billing.	*Connectivity/Installment/Processing Issues*	Contact is requesting assistance with the connection, installment, password resets, claim processing and adjustments through DDE.
		Orientation Package	Contact is requesting information or an orientation package related to DDE.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
Electronic Data Interchange (EDI)	The system for submitting claims electronically and retrieving Electronic Remittance Advices.	*Connectivity/Installment Issues*	Contact is requesting assistance with the connection, installment and password resets through EDI.
		Front End or Vendor Editing	Contact is requesting information or assistance with errors in the transmission or status of claims submitted electronically.
		Information package/HIPAA Compliant Billing Software	Contact is requesting information or an orientation package related to EDI.
Eligibility/Entitlement	The qualification of an individual to receive Medicare, including various qualifying aspects of Medicare coverage (as described in the associated subcategories). If multiple sub-categories are discussed in the same inquiry, log main category for tracking purposes.	*Beneficiary Demographic*	Contact is asking to verify or update (within the contractor's ability) beneficiary personal information, such as HIC number, address, date of birth, date of death, etc.
		Benefit Days Available	Contact is asking for the number of days in a hospital or SNF that remain available for the beneficiary.
		Deductible	Contact is asking if the beneficiary's annual deductible amount has been met so that Medicare payment for providers' services or supplies can begin.
		DME Same or Similar Equipment	*Contact is asking if beneficiary has a DME Certificate of Medical Necessity (CMN) or DMERC Information Form (DIF) active, or if a beneficiary has same or similar equipment previously covered by Medicare on file.*
		HMO Record	Contact is asking whether the beneficiary is enrolled in an HMO, when HMO enrollment began, or for HMO contacts information.
		Hospice	Contact is asking if beneficiary has a hospice record open.
		MSP Record	Contact is asking for information related to other insurance coverage that the beneficiary might have that is primary to Medicare.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		Next Eligible Date	Contact is asking when is the next eligible date for the beneficiary to receive one or more preventive services.
		Outpatient Therapy Cap	*Contact is asking if the beneficiary's outpatient therapy cap amount has been reached.*
		Part A Entitlement	Contact is asking when the beneficiary became eligible for Part A benefits.
		Part B Entitlement	Contact is asking when the beneficiary became eligible for Part B benefits or whether the beneficiary is eligible for Part B benefits.
Financial Information	The financial responsibility of providers and/or Medicare. These types of inquiries normally involve the information that comes from the contractor's financial department or requests that are processed by the contractor's financial department.	*Check Copies*	Contact is requesting a copy of a check.
		Cost Report	Contact is asking about the annual report that institutional providers are required to submit in order to make proper determination of amounts payable under the Medicare program; for example, How do I submit a cost report? What supporting documents are needed for an acceptable cost report? Have you received my cost report?

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		Credit Balance/Account Receivable	Contact is asking about a credit balance that is due to Medicare. A credit balance is an improper or excess payment made to a provider as the result of patient billing or claims processing errors. Examples of Medicare credit balances instances are: 1) Paid twice for the same service either by Medicare or another insurer; 2) Paid for services planned but not performed or for non-covered services; 3) Overpaid because of errors made in calculating beneficiary deductible and/or coinsurance amounts; or 4) A hospital that bills and is paid for outpatient services included in a beneficiary's inpatient claim. Also, includes inquiries to confirm if a payment was applied to an open receivable.
		Do Not Forward (DNF) Initiative	Contact is requesting information about CMS initiative that entails the use of "Return Service Requested" envelopes to preclude the forwarding of Medicare checks and remittance advices to locations other than those recorded on the Medicare provider files, and the provider is not receiving its checks.
		Electronic Fund Transfer	Contact is asking about electronic transfer of Medicare payments directly to a provider's financial institution.
		Offsets	Contact is asking the reason that payment was withheld or for an explanation of the Financial Control Number (FCN#) that appeared on the Remittance Advice.
		Overpayment	Contact is asking about the notice that they have received due to Medicare funds in excess of amounts that are due and payable to them under the Medicare statute and regulation. The amount of the overpayment is a debt owed to the U.S. Government.
		Refunds	Contact is asking about a refund, such as, its status, notifying Medicare that a refund is needed, or asking about the process to request it.
		Stop Payment / Check to Be Reissued	Contact is requesting a stop payment, reissuance a check, asking how to request it or verifying the status of a previous request. Also, includes check reissue inquiries due to stale dated checks and checks sent to wrong provider.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
General Information	Information that cannot be included in other categories.	*Address /Phone/Fax/Web Address*	Contact is asking for contractor's addresses including website, fax and phone numbers.
		Issue Not Identified/Incomplete Information Provided	Contact failed to explain the reason for the inquiry, or omitted a HIC number or provider number. This sub-category may apply to written correspondence only.
		Misrouted Telephone Call/Written Correspondence	Contact is asking a question that should be handled in another contractor area, by another contractor and or by another agency/program.
		Reference Resources Referral/Request	Contact is asking where to find or access information about specific topics or requesting information about resources available for provider education or self service options, such as, MEDPARD directory, online claim status availability, electronic remittance advice, IVR, etc.
		Other Issues	Contact is discussing subjects that are not classifiable into the defined categories or subcategories.
HIPAA Privacy/ Privacy Act	The statutory authorities that govern the protections for personally identifiable patient health information and the conditions of its release.	*Authorizations*	Contact is asking for a consent/authorization form or a copy of their patient's authorization, which is necessary to release the information requested.
		Release of Information Request	Contact is requesting a copy of patient history or record.
		Requirements	Contact is asking about the HIPAA Privacy or Privacy Act requirements. Also, includes inquiries related to HIPAA contingency plans and the compliance with HIPPA transaction rules.
MSP	The term used when Medicare is not responsible for paying primary on a claim that is otherwise the primary responsibility of another payer.	*COB/MSP Rules*	Contact is asking about Coordination of Benefits Rules and/or Medicare Secondary Payer Rules.
		Coordination of Benefits (COB) Contractor	Contact is asking about the COB contractor responsibilities and contact information. Includes situations that require a referral to the COB contractor.
		File Updates	Contact is asking for beneficiary MSP/COB files information or providing information for MSP/COB file update.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		Liens and Liabilities/Settlements	Contact is asking about requesting or accepting a Medicare conditional payment, for services that would otherwise be covered under Workers Compensation, No Fault Insurance, Liability and Group Health Plans (GHP). Also, includes questions about settlement information and the status of a conditional payment.
Policy/ Coverage Rules	Includes inquiries related to policy questions, coverage rules and benefits information.	*Benefits/Exclusions/ Coverage Criteria/Rules*	Contact is asking for clarification of rules and criteria used by Medicare to cover and pay for services furnished to Medicare beneficiaries by Medicare providers.
		Certifications Requirements	Contact is asking about requirements, electronic submissions and/or status, when applicable, of certifications for Medicare Benefits. This may include Hospice certifications and/or Certificate of Medical Necessity.
		Local Coverage Determination (LCD)	Contact is asking about a local coverage policy developed by the Medicare contractor to describe the circumstances for Medicare coverage for a specific medical service, procedure or device within their jurisdiction.
		National Coverage Determination (NCD)	Contact is asking about a national coverage policy developed by the Centers for Medicare & Medicaid Services to describe the circumstances for Medicare coverage for a specific medical service, procedure or device.
		Non-published Items	Contact is asking about the coverage of items with no criteria published by contractor or CMS.
		Pre-authorization	Contact is asking about or requesting a pre-authorization for providing Medicare benefits.
		Statutes and Regulations	Contact is asking about the Federal law and regulations that govern the Medicare Program and its operation.
Provider Enrollment	The forms and process by which an individual, institution or organization becomes a provider in the Medicare program, eligible to bill for their services.	*National Provider Identifier*	Contact is asking about the National Provider Identifier (NPI).
		Provider Demographic Information Changes	Contact is asking for verification of their provider demographic information or asking how to request a change/correction of its existing information.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		Provider Eligibility	Contact is asking about his or her status as a Medicare Program participant or not participant provider, and how to change it. Also, includes inquiries related to a provider alert/sanction status period.
		Provider Enrollment Requirements	Contact is asking about the requirements to become a participating provider of the Medicare Program. Also, includes inquiries from a provider not certified by Medicare, overview/orientation of the Provider Enrollment Forms (CMS 855 Form), where to find it and/or instructions on how to complete it.
Provider Outreach	The contractor's educational effort and activities with the provider community.	*Education Referrals*	Contact is requesting contact/visit from Professional Relations Staff to provide supplemental education, discuss an issue in-depth, or to request clarification of a confusing situation.
		Workshop Information	Contact is asking for information about provider outreach activities or educational opportunities for providers and their staff.
Remittance Advice (Remit)	The paper or electronic summary statement for providers, including payment information for one or more beneficiaries.	*Duplicate Remittance Notice*	Contact is asking for a duplicate remittance notice. Includes inquiries where provider did not received his/her remittance notice, needs to send it to the patient's second insurance, needs a single line or a no pay remittance notice.
		ERA Election	Contact is asking for information about how to access and/or receive remittance notices electronically.
		How to read RA	Contact is asking for assistance in reviewing and/or understanding their remittance notice. Includes explanation of the Claim Adjustment Reason Codes and Remittance Advice Remark Codes on the Remittance Notice.
RTP/Unprocessable Claim	A claim(s) with incomplete, invalid, or missing information will be returned to the provider as unprocessable. This action cannot be appealed and the corrected claim(s) needs to be submitted as a new claim. Includes "W Status of Claim" and status of claims to be returned to provider.	*1500 / UB-92 Form Item*	Contact is asking about a claim(s) that was returned because the CMS claim form was not completed with the required information, such as, missing or invalid HICN, name, date of birth or sex. Includes the explanation of narrative of reason codes in the contractor's claims correction file, claims processing system and reports.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		Clinical Laboratory Improvement Act (CLIA)	Contact is asking about a claim(s) that was returned because the claim had a missing or incorrect CLIA number.
		Contractor Error	Contact is asking about a claim(s) that was returned to provider as unprocessable due to a contractor error.
		Contractual Obligation Not Met	Contact is asking about a claim(s) rejected because the provider did not comply with his or her Medicare contractual obligation. For example, the claim was presented with missing information (other than codes or modifiers), the billing was not timely, etc.
		Shared Systems	Contact is asking about a claim(s) that was returned because the patient information on the claim does not match information on any CMS shared systems (FISS, MCS, VMS and CWF).
		Missing/Invalid Codes	Contact is asking about a claim(s) that was returned because of a missing or invalid or changed code. Includes "Invalid CPT" inquiries.
		Place of Service	Contact is asking about a claim(s) that was returned due to invalid place of service or the place of service was not related to the procedure.
		Provider Information	Contact is asking about a claim(s) that was returned due to an incorrect or missing UPIN/NPI.
		Submitted to Incorrect Program	Contact is asking about a claim(s) that was returned because it was submitted to the incorrect program (FI, Carrier or DMERC).
		Truncated Diagnosis	Contact is asking about a claim(s) that was returned due to incorrect, invalid or missing diagnosis information.
Systems Issues	Medicare electronic systems, including the Medicare Claims Processing Systems and/or customer self-service applications (I.e. CMS website, contractor website, IVR, etc).	*Medicare Claims Processing System Issues*	Contact is presenting situation related to issues with the Medicare Processing Systems; for example, issues due to an aged claim, recycling claim and release of claims, etc.
		Website Issues	Contact is reporting problems with the functionality, stability or use of the CMS and contractor website.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		IVR Issues	Contact is reporting problems with the functionality or use of the contractor's IVR.
Temporary Issues	Includes inquiries that CMS would like to track temporarily due to special circumstances. CMS will provide specific timeframes for the monitoring of temporary issues. For contractor specific temporary issues, please follow instructions on IOM 100-9, Chapter 3, Section 20.5 or Chapter 6, Sections 30.1.1 – 30.1.1.2.	*Part D Drug Coverage*	Contact is presenting situation related to issues with the implementation of the Part D Medicare Prescription Drug Coverage.
		CD-ROM Initiative	Contact is requesting a hard-copy of the Annual Disclosure Statement, the "Dear Provider" letter and provider enrollment material in CD-ROM form, or asking for clarification of the CD-ROM content. Includes logging of CD-ROM related problems that providers encountered.
		CERT	Contact is asking information related to the Comprehensive Error Rate Testing (CERT) Program.
		Competitive Acquisition Program (CAP)	*Contact is asking general questions about the CAP.*
		HIGLAS	Contact is presenting a situation due to the implementation of HIGLAS, the new financial accounting system. Includes inquiries about HIGLAS's training material, its impact on claim processing, recoup overpayments, demand letters, settlements and penalty withholdings, HIGLAS changes on remittance advices and checks (voided/reissued).
		Recovery Audit Contractor (RACs)	Contact is asking information about a CMS initiative using RACs to identify underpayments and overpayments and to recoup overpayments. Includes inquiries related to demand letters and records requested by RACs.