

Medicare Contractor Beneficiary and Provider Communications Manual

Chapter 2 - Beneficiary Customer Services

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(Rev. 12, 07-15-05)

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10 - Introduction

(Rev. 1, 10-01-03)

This chapter contains general instructions and requirements for Medicare carriers, including DMERCs and intermediaries for processing correspondence. 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, this will be specified.

20 - Beneficiary Services

(Rev. 11, Issued: 06-03-05, Effective: 07-05-05, Implementation: 07-05-05)

The Centers for Medicare & Medicaid Services (CMS) goal is to continuously improve Medicare customer satisfaction through the delivery of high quality and cost-effective customer service. The CMS’ vision is for customer service to be responsive to the needs of diverse groups, a trusted source of accurate and relevant information, convenient and accessible assistance and courteous and professional.

Every member of the customer service team should be committed to providing the highest level of service to our primary customer, the Medicare beneficiary. This commitment should be reflected in the manner in which contractors handle each beneficiary inquiry. The following guidelines are designed to help contractors to ensure CMS’ goal and vision are met.

Each contractor should prioritize its workload in such a manner to ensure that funding is allocated to accomplish the priority goals of the listed activities. CMS expects that each Medicare contractor meet standards for inquiry workloads in the following order of precedence:

1. Beneficiary Telephone Inquiries- (including Quality Call Monitoring and the Next Generation Desktop);
2. Screening of Complaints Alleging Fraud and Abuse;
3. Written Inquiries; and
4. Beneficiary Outreach to Improve Medicare Customer Service (i.e., customer service plans).

All resources shall be devoted to performing only these activities.

20.1 - Guidelines for Beneficiary Telephone Service (Activity Code 13005)

(Rev. 11, Issued: 06-03-05, Effective: 07-05-05, Implementation: 07-05-05)

Contractors shall make CSR telephone service available to callers continuously during normal business hours, including lunch and breaks. While there are no required standard hours of operations for beneficiary call centers, the preferred normal business hours for CSR telephone service continues to be 8:00 a.m. to 4:30 p.m. for all time zones of the geographical area serviced, Monday through Friday. Contractors are expected to respond to all beneficiary telephone calls routed to them up to the end of their business day. Contractors must not stop taking calls prior to the end of the business day in order to

Comment [C1]: CR4375 is modifying this section. The analyst is Creedella White, CBC, 67434. Please coordinate with him/her before to revising this section. Implementation date: 30 days from issuance
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eliminate calls waiting in queue. Contractors should notify the Beneficiary Network Services (BNS) of their normal hours of operation for CSR service and provide advance notice of any deviation from these hours. **The BNS will notify CMS Regional and Central Offices of any changes to a call center's hours of operations.** In any situation where CSRs are not available to service callers or the call center is experiencing reduced beneficiary customer service due to diminished answering capacity, CMS plans to re-route call traffic within the national network to ensure that callers receive the best possible service. These situations include, for example, emergency and weather-related closings, training closings, and other deviations from normal hours of operation.

The contractor shall follow standard operating procedures (SOP) to identify and address situations that will require action by the contractor to notify CMS to re-route beneficiary calls. The SOP will include the various procedures call centers must follow including whom to contact, when to contact, etc.

When a determination is made whether to close a beneficiary call center due to emergency or weather-related circumstances, the contractor shall consider whether it is also closing other co-located Medicare operations (e.g., medical review, claims processing, provider operations, appeals, MSP, etc). As a general rule, if other co-located Medicare operations are open, the beneficiary call center should be open.

Under no circumstances shall a beneficiary call center close to avoid a negative impact on call center performance statistics or to staff provider call center operations.

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 BNS at the start of the fiscal year for any planned call center closures. Changes to the schedule should be reported to BNS no later than 60 days in advance. The BNS can be reached by calling 1-866-804-0685, prompt #1.

Call center staffing should 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.

A. Automated Services-Interactive Voice Response (IVR)

All beneficiary premise-based IVR services provided by the contractor, including "auto attendant" and "vectoring" that allows callers the option to select to listen to an announcement (such as a message concerning a lost Medicare Card) to have their questions answered were discontinued upon migration to 1-800-MEDICARE. Now that the migration to 1-800-MEDICARE has been completed, contractors display only CMS' branded 800 number, 1-800-MEDICARE (1-800-633-4227) and branded TTY 800 number (1-877-486-2048) based on instructions from CMS.

B. Telephone Service for the Hearing Impaired

Beginning in FY 2005 all beneficiary TDD/TTY calls will be routed to 1-800-Medicare call centers. At that time, contractors should modify their MSNs to replace their TDD/TTY number with CMS' branded TTY/TDD toll-free number, 1-877-486-2048. Standard operating procedures (SOP) will be developed to address those occasions when Medicare contractors are needed to work with the 1-800-Medicare contractor to respond to beneficiary callers that require additional assistance.

The migration of all TDD/TTY traffic to 1-800-Medicare call centers will eliminate all reporting requirements associated with the contractor's premise-based TDD/TTY service. This will also eliminate the requirement that the monthly Incompletion Rate (also known as the All Trunks Busy (ATB) External Rate) shall not exceed 20% for any beneficiary call center's TDD/TTY service.

C. Bilingual Services

Contractors shall maintain the ability to respond directly to telephone inquiries in both English and Spanish through the use of CSRs or, when necessary, interpretation/translation services.

20.1.1 - Toll Free Network Services

(Rev. 11, Issued: 06-03-05, Effective: 07-05-05, Implementation: 07-05-05)

A. Inbound Services

The CMS will use the General Services Administration's FTS 2001 contract for its toll-free network. All inbound beneficiary telephone service, including TTY service, will be handled over the toll-free FTS network, with the designated long-distance contractor (currently MCI). Any new toll-free numbers and the associated network circuits used to carry these calls will be acquired via the FTS 2001 network.

B. Beneficiary Network Services (BNS)

The BNS will coordinate problem resolution for beneficiary call centers dealing with FTS 2001 toll free network issues. The BNS also acts as the single point of contact for both beneficiary and provider call centers in a disaster recovery situation. The BNS can be contacted at 1-866-804-0685, prompt # 1 or via e-mail at bnsadmin@bah.com.

C. Problem Reporting

Level 1 Problems:

The call center is still responsible for 1st level problem management including

- Fault isolation of call center equipment and facilities located on premise used for access to the FTS2001 network
- Managing user related trouble calls or issues
- Managing service levels
- Reporting, monitoring, and maintenance of their customer premise equipment, local FTS2001 network connections, and any other CMS reporting requirements including CSAMS

Additionally, the call center's technical support organization is responsible for resolving PBX, ACD, and other customer premise equipment problems including issues related to headsets, phones, computer hardware, and call center desktop applications.

Level 2 Problems: Contractors shall report all other problems with the FTS 2001 telephone network service to the BNS at 1-866-804-0685, prompt # 1.

Change Requests: All change requests regarding the FTS 2001 lines, (e.g., adding or removing channels or T-1 circuits, office moves, routing changes), shall be processed

through the BNS toll-free number. The BNS can also be contacted at bnsadmin@bah.com for situations that are not time-critical.

D. 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. These costs will be paid centrally by CMS and only for these telephone service costs. All other costs involved in providing telephone service (e.g., internal wiring, local telephone services and line charges) to Medicare beneficiaries will be born by the contractor. Since these costs are not specifically identified in any cost reports, contractors must maintain records of all costs associated with providing telephone service to beneficiaries (e.g., costs for headsets) and provide this information upon request by CMS regional or central offices.

20.1.2 - Publication of Toll Free Numbers

(Rev. 11, Issued: 06-03-05, Effective: 07-05-05, Implementation: 07-05-05)

A. Directory Listings

Contractors will not be responsible for the publication of their inbound 800 services in any telephone directory. The CMS will publish inbound 800 numbers in the appropriate directories. No other listings are to be published by the contractor.

B. Printing Toll Free Numbers on Beneficiary Notices

The 1-800-MEDICARE toll free number shall be printed on all beneficiary notices. Contractors must display the toll free number prominently.

20.1.3 - Call Handling Requirements

(Rev. 11, Issued: 06-03-05, Effective: 07-05-05, Implementation: 07-05-05)

A. Call Acknowledgement

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

B. Providing “Hard Busy” Signals

Contractor call centers shall only provide hard busy signals to the Federal Telephone System (FTS) network. ACD or PBX system shall not accept the call from the FTS network, thereby allowing the FTS network to provide the busy signal to the caller. At no time, shall any software, gate, vector, application, IVR, and/or accept the call by providing answer back supervision to the FTS network and then providing the busy signal to the caller. Providing a hard busy signal will keep the call in the FTS-2001 network and provide CMS with the opportunity to send the call to another site for answering if circumstances warrant. The contractor should optimize their inbound toll-free circuits to ensure the proper ratio of circuits to existing FTEs. The contractor contacts the BNS on 1-866-804-0685, prompt # 1 for assistance with the optimization.

C. Queue Message

Contractors provide a recorded message that informs callers waiting in queue to speak with a CSR of any temporary delay before a CSR is available. They use the message to inform the beneficiary to have certain information readily available (e.g., Medicare card or health insurance claim number) before speaking with the CRS. 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.

D. 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 should provide both first and last name. Where the personal safety of the CSR is an issue, call center management should permit the CSR to use an alias. This alias shall be known for remote monitoring purposes. CSRs should also follow local procedures for escalating calls to supervisors or managers in situations where warranted.

E. 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. Other support staff assigned beneficiary telephone workload should follow the same sign-in policy as CSRs to ensure data consistency. The sign-in policy will include the following:

- The CSRs available to answer telephone inquiries will sign-in to the telephone system to begin data collection;
- The CSRs should 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 should sign-off the telephone system at the end of their workday.

F. Service Level

Each month, contractors answer no less than 85 percent of all callers who choose to speak with a CSR within the first 60 seconds of their delivery to the queuing system.

G. Initial Call Resolution

Contractors 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.

H. All Trunks Busy (ATB)

The Trunks Busy (ATB) External Rate (also known as the monthly Incompletion Rate) shall not exceed 20 percent for any Beneficiary call center. This includes all of the call center's voice lines as well as any "hidden" toll-free lines terminating at the call center. Any situation that disturbs the usual operation of the call center, and results in extreme variances in the call center's performance level will be considered as an exceptional event by CMS and reviewed on a case-by-case basis.

I. Quality Call Monitoring

- **Frequency of Monitoring:** Contractors monitor a minimum of three calls per CSR (including part time CSRs) per month. Any deviation from this requirement shall be requested and justified to CMS, per established channels, to determine if a waiver is warranted.
- **Performance Standards for Quality:**
 1. Of all calls monitored each month, the percent of scoring as "Pass" for Adherence to Privacy Act should be no less than 90 percent.
 2. Of all calls monitored each month, the percent of scoring as "Achieves Expectation" or higher should be no less than 90 percent for Customer Skills Assessment.
 3. Of all calls monitored each month, the percent of scoring as "Achieves Expectation" or higher should be no less than 90 percent for Knowledge Skills Assessment

J. Equipment Requirements:

- To ensure that inquiries receive accurate and timely handling, contractors must provide the following equipment:
 1. Online access to a computer terminal for each CSR responsible for claims-related inquiries to retrieve information on specific claims. Locate the computer terminal so that representatives can research data without leaving their seats;
 2. An outgoing line for callbacks; and
 3. A supervisory console for monitoring CSRs.
- Any contractor call center purchases or initiatives for purchases or developmental costs for hardware, software or other telecommunications technology that equal or exceed \$10,000 shall first be approved by CMS. Contractors shall submit all such requests to the servicing CMS regional office (RO) for review. The RO shall forward all recommendations for approval to The Center for Beneficiary Choices, Division of Contractor Beneficiary Services (DCBS) for a final decision.

K. Duplication of Options, Services or Messages:

- Options, services or messages offered callers at one level in the network or by premise-based equipment should not be duplicated and offered to callers again. For example, if callers are offered the option of transferring to the Interactive

Voice Response Unit (IVR) or to a bilingual queue in the network, they should not be offered this service again at the call center level.

L. Recording of Voice Messages:

- Premise-based equipment shall not be programmed to allow for the recording of voice messages by callers at any time.

M. Implementation of Services and Technologies:

- Implementation by CMS of various services and technologies (e.g. single 800 number, network IVRs, network call routing) may result in modifications to some call handling requirements. For example, queue messages may be delivered in the network rather than by the premise-based equipment. As these transitions occur and changes are necessary to these requirements, CMS will provide instructions to those contractors impacted at the appropriate time.

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

(Rev. 11, Issued: 06-03-05, Effective: 07-05-05, Implementation: 07-05-05)

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. 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 CMS timely. The call center shall supply the missing data to CMS within two workdays after it becomes available to the contractor. To change data after the 10th of the month, users shall inform CMS central office via CSAMS at csams@cms.hhs.gov. 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>.

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 are answering similar type calls (A, B, DMERC, A&B, MCSC, or some breakout or consolidation of these calls). The physical location could be in the same room, building, or complex but not in a separate geographic location, city, state, etc.

B. Data to Be Reported Monthly

Contractors capture and report the following data each calendar month:

- **Number of Attempts** - This is the total number of calls offered to the beneficiary call center via the FTS Toll-Free during the month. This should be taken from reports produced by FTS Toll-Free service provider. The current provider is MCI and the reports are available at their Web site <https://customercenter.MCI.com/>.

- **Number of Failed Attempts** - This represents the number of calls unable to access the call center via the toll-free line. This data should also be taken from reports produced by FTS Toll-Free service provider.
- **Call Abandonment Rate** - This is the percentage of beneficiary calls that abandon from the ACD queue. This should 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 workstate 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).
- **ACW** - 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 5 workdays. This number is based on calls received for the calendar month and represents the number closed within five workdays even if a callback is closed within the first 5 workdays of the following month. For call centers that have transitioned to the Next Generation Desktop (NGD), the collection of this data point will be automated and will be based on seven calendar days rather than 5 workdays.

NOTE: Implementation by CMS of various services and technologies (e.g. single 800 number, network IVRs, network call routing) may result in changes to some of the data element definitions currently being reported as well as the potential elimination of others. As this transition occurs, every effort will be made by CMS to accommodate those call

centers that have converted to the latest technology and those who have not converted. While the sources of the data may change, CMS will attempt to maintain the current definitions to the fullest extent possible.

20.1.5 - CSR Qualifications

(Rev. 5, 04-23-04)

Fully trained CSRs to respond to beneficiary questions, whether of a substantive nature, a procedural nature, or both. To ensure that these services are provided, CSRs should have the following qualifications:

- Good telephone communications skills;
- Good keyboard computer skills;
- Sensitivity for special concerns of the Medicare beneficiaries;
- Ability to handle different situations that may arise; and
- Experience in Medicare claims processing and review procedures.

Prior customer service experience in positions where the above skills are utilized, e.g., claims representative or telephone operator, is desired.

20.1.6 - CSR Training

(Rev. 11, Issued: 06-03-05, Effective: 07-05-05, Implementation: 07-05-05)

Contractors will provide training for all new CSR hires and training updates as necessary for existing personnel. This training should enable the CSRs to answer the full range of customer service inquiries. The training, at a minimum, should include:

- Medicare policy and procedures;
- Use of the Internet-Only Manual (IOM);
- Customer service skills, including special needs of the Medicare population;
- Telephone techniques; and
- The use of a computer terminal, including the Medicare Customer Next Generation Desktop (MCSC-NGD) for those call centers using NGD.

Contractors shall have a training evaluation process in place to certify successful performance before the trainee independently handles inquiries.

Contractors are required to implement standardized CSR training materials, including job aids, for all CSRs on duty and those hired in the future upon receipt from CMS. The development of the materials will be done by CMS and 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/callcenters>, under the Call Center Learning Resources section. Contractors should 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.

To facilitate consistency in training and ability to share training materials across call centers, CMS has developed guidelines and standard training material formats for print and Web-based training materials. The guidelines and a sample format can be found at <http://www.cms.hhs.gov/callcenters> under Call Center Learning Resources.

The above-mentioned Web site also contains frequently asked questions and answers for call center management and inquiry staff. This information is to be used in responding to beneficiary inquiries. As CMS develops additional questions and answers, they will continue to be posted on this site and all call center managers will be notified directly through e-mail. Call center managers shall subscribe to the call center Listserv by going to <http://list.nih.gov/archives/cam-callcenters.html>. The Listserv subscribers will be notified directly through E-mail regarding new and updated training, scripting, and/or frequently asked questions and answers regarding the Medicare Modernization Act. If the call center manager would like to designate another individual to receive their e-mail notifications, they may unsubscribe and provide another name and e-mail address.

Single 1-800-Medicare Standardized Procedures/Training:

Standardized business procedures and training for the Single 1-800-Medicare initiative will be posted on the Medicare Beneficiary Telephone Customer Service web site, <http://www.cms.hhs.gov/callcenters/>. Contractors should access this site monthly for updates.

20.1.7 - Quality Call Monitoring (QCM)

(Rev. 11, Issued: 06-03-05, Effective: 07-05-05, Implementation: 07-05-05)

Contractors shall:

A. Process and Tools

Monitor, measure and report the quality of service continuously by utilizing the CMS-developed QCM process. Monitor all CSRs throughout the month, 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. Record all monitored calls on the standard scorecard, using the QCM chart as a guideline. Copies of the scorecard and chart may be obtained at <https://www.qcmscores.com>. Use only the official versions of the scorecard and chart that are posted on the Web site. The QCM reporting tools and format, also posted on the Web site, shall be used to collect monitoring results which will be reported monthly in CSAMS. Train every CSR and auditor on the scorecard and chart and ensure that each person has a current copy of the chart for reference. If there is more than one auditor, rotate the CSR monitoring assignments regularly among the auditors. Contractors shall analyze individual CSR and call center level QCM data frequently to identify areas needing improvement or best practices. Document and implement corrective action plans. Also analyze QCM data to determine where training is indicated, whether at the individual, team, or call center level and provide such training.

B. Frequency of Monitoring

- **Experienced CSRs** - Monitor a minimum of three calls per CSR (including part time CSRs) per month.

- **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 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. Type - Monitor the calls in one or more of the following ways:

live remote; live side by side (shadow); or taped.

D. Giving Feedback to CSRs

Complete the scorecard in its entirety and give written feedback to the CSR within two working days for calls monitored live or seven working days for taped calls. Coach and assist the CSR to improve in areas detected during monitoring or compliment on good performance, as appropriate.

E. Calibration

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. Instructions on how to conduct calibration are posted at the telephone customer service Web site at <http://www.cms.hhs.gov/callcenters/qcm.asp>. National sessions are held on the first Wednesday of February, May, August and November at 1:30 Eastern Standard Time. Conduct regular calibration sessions within the call center or between multiple centers. Monthly calibration sessions within the call centers are recommended.

F. Retention of Taped Calls

Contractors that tape calls for QCM purposes will be required to maintain such tapes for an ongoing 90-day period during the year. All tapes must be clearly identified by date and filed in a manner that will allow for easy selection of tapes for review.

G. Remote Access

The contractor shall provide remote access to CMS Central Office personnel to one of the following: agent split/group, DNIS, trunk, or application. This will allow CMS Central Office personnel to hear calls as they are occurring. The CMS will take reasonable measures to ensure the security of this access, (e.g., passwords will be controlled by one person, no passwords will be sent via e-mail, no one outside of CMS service will have access to the passwords, etc.).

H. Impact of MCSC-NGD on Quality Call Monitoring

The MCSC-NGD does not change the QCM Process or Tools. Quality call monitors shall attend NGD CSR training so they are aware of MCSC-NGD functionality and how CSRs will be using MCSC-NGD in responding to inquiries. Quality call monitors shall ensure that CSRs are correctly logging calls using MCSC-NGD functionality, including logging multiple issues on each call. All logging is to be recorded under the Call Action portion of the Knowledge Skills Assessment section of the QCM scorecard. Correct logging of calls falls under the performance criteria of “completes call activities”.

MCSC-NGD will provide on-line references including a partner directory, scripting and other reference material. These references are approved by CMS and updated on a regular basis. Quality call monitors shall encourage the use of these references to ensure accuracy and consistency of the information conveyed by the call centers.

20.1.8 - Disclosure of Information (Adherence to the Privacy Act and the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule)

(Rev. 11, Issued: 06-03-05, Effective: 07-05-05, Implementation: 07-05-05)

Contractors are to follow the guidelines for disclosure of information that are provided in subsection 30 – Disclosure Desk Reference Guide for Call Centers. Frequently asked questions on how to score Adherence to Privacy Act for QCM are located at <http://www.cms.hhs.gov/callcenters/QandA.asp>. The CMS developed standardized Web-based training to assist Medicare contractors and CMS employees comply with disclosure guidelines for beneficiary-specific information via telephone. This Privacy and Disclosure of Information Training is mandatory for employees of Medicare contractors, fiscal intermediaries, regional home health intermediaries, and durable medical equipment contractors who respond to, monitor, or train on beneficiary telephone inquiries. This includes all current and future CSRs, managers, supervisors, CSR trainers, and quality assurance staff.

Also see CMS Publication 100-01 Chapter 6 Disclosure of Information.

20.1.9 - Fraud and Abuse

(Rev. 5, 04-23-04)

If a caller indicates an item or service was not received or that the service provider is involved in some potential fraudulent activity, the complaint should be screened for billing errors or abuse before being sent to the Benefit Integrity Unit. After screening has been performed, if abuse is suspected, the Medicare Review Unit would handle the complaint. If fraud is suspected, the complaint should be forwarded to the Benefit Integrity Unit and the caller should be told the Benefit Integrity Unit will contact him/her about the complaint. Ask the caller to provide the Benefit Integrity Unit with any documentation he/she may have that substantiates the allegation. Give assurance that the matter will be investigated.

20.1.9.1 - Second Level Screening of Beneficiary and Provider Inquiries (Activity Code 13201)

(Rev. 11, Issued: 06-03-05, Effective: 07-05-05, Implementation: 07-05-05)

Refer to PIM Chapter 4, §4.6-4.6.2 for instructions on this Activity Code.

The Medicare fee-for-service contractor reports the costs specified below that are associated with second level screening of potential fraud and abuse inquiries for beneficiaries and the referral package for provider fraud and abuse inquiries in Activity Code 13201.

For beneficiary inquiries of potential fraud and abuse, report costs for the following:

- Second level screening of beneficiary inquiries that are closed;
- The number of medical records for beneficiary inquiries that are closed; and
- *The number of potential fraud and abuse beneficiary inquiries that are referred to the Program Safeguard contractor (PSC) or Medicare fee-for-service contractor Benefit Integrity unit (BIU).*

For provider inquiries, report the costs associated with compiling the referral package and sending it to the PSC or Medicare fee-for-service contractor BIU.

Report the number of second level screening of beneficiary inquiries that were closed in workload column 1; report the total number of medical records ordered for beneficiary inquiries that were closed in workload column 2; and report the total number of potential fraud and abuse beneficiary complaints identified and referred to the PSC or Medicare fee-for-service contractor BIU in workload column 3.

20.1.9.2 - Second Level Screening of Provider Inquiries (Miscellaneous Code 13201/01)

(Rev. 11, Issued: 06-03-05, Effective: 07-05-05, Implementation: 07-05-05)

The Medicare fee-for-service contractor must keep a record of the cost associated for all provider inquiries of potential fraud and abuse that are referred to the PSC or Medicare fee-for-service contractor Benefit Integrity Unit in Miscellaneous Code 13201/01.

20.1.10 – Medicare Customer Service Next Generation Desktop (MCSC-NGD)

(Rev. 11, Issued: 06-03-05, Effective: 07-05-05, Implementation: 07-05-05)

The CMS is developing a new MCSC- NGD application to be deployed at Medicare contractor sites. The new desktop will allow Customer Service Representatives (CSRs) to answer written and telephone inquiries from beneficiaries. The NGD application will enable CSRs to address, at a minimum, the same general Medicare and claims inquiries currently handled, but in a more user-friendly and efficient manner. The NGD is being developed on requirements gathered from call center personnel currently handling telephone and written inquiries. Although NGD may be found useful by other components interacting with the telephone and written inquiries areas, specific requirements are not being identified for those areas.

The initial rollout of NGD will provide contractors with access to information from the VIPS Medicare System (VMS), Fiscal Intermediary Standard System (FISS), and Multi Carrier System (MCS) claims processing systems used today. Initially contractors will only access information to perform the functions required within their existing workload. However, the technology being built into the NGD will ultimately allow contractors to access claim information outside their service areas and to access additional CMS databases once those business processes have been defined. This increased access will enable contractors to support each other in times of heavy call volumes, disaster situations, emergency closings, and other downtime as well as to handle more of the calls currently being blocked in the network. As NGD is rolled out, those contractors utilizing NGD will have call history information displayed for beneficiaries who have previously

contacted other sites using NGD. For example, call history in Ohio will be visible to both the Carrier and the Intermediary Call Centers for Ohio after both Call Centers begin utilizing NGD. The call history information does not contain claim information, only a record of and reason for the call.

Implementation Approach and Schedule

- **Technical Kick-off Meeting:** Contractors deploying NGD will be required to send technical representation to a 2-day technical kick-off meeting conducted by NGD infrastructure personnel in a central location. This meeting will take place prior to beginning the project plan to deploy NGD. Once all needed connectivity is obtained, an official deployment kickoff meeting will take place to begin the rollout of NGD to the contractor location(s).

Those contractors who will be deploying NGD in FY 2005 shall include NGD implementation costs in their FY 2005 budget requests. These costs shall be reported in Miscellaneous Code 13005/01 and need to be identified separately as NGD implementation costs.

Contractors utilizing the MCSC-Forte desktop application should budget for minimum support and maintenance of that application until call centers are transitioned over to MCSC-NGD.

Call centers will be notified at a minimum of 6 months in advance of beginning deployment discussions. Call centers will be implemented with consideration to business impact to the Medicare program as a whole. Input from contractors regarding the desired timing of implementation will be considered, as well as other implementation activity and specific circumstances of each call center.

Centers Using Non-Standard Claims Processing Systems.

Currently, plans provide for the NGD to support FISS, MCS, and VMS (Part B and DMERC) claims processing systems. Centers using other systems will not implement the NGD until they have converted to one of these standard systems.

Technical Considerations

Hardware: The hardware necessary to implement the NGD application includes Siebel Systems' eHealthcare product, centrally-located servers, and personal computers (PCs).

Siebel: The NGD is being built using Siebel Systems' eHealthcare product. This product employs a "zero footprint" Web-based client, which means that no specialized hardware or software is required on the agents' desks other than a typical Personal Computer (PC) and a Web browser. The PCs that will be used to generate correspondence will also require Microsoft Word '97, or a higher version of Word, which will be the responsibility of the Medicare contractor to procure. The CMS is purchasing the necessary Siebel software licenses and ongoing Siebel software maintenance contracts.

Servers: All servers needed to run the NGD application will be centrally-located (initially at the AdminaStar Federal data center in Shelbyville, KY). Each call center site will access the servers via the Medicare Data Communications Network (MDCN); CMS currently uses AT&T Global Network Services (AGNS) to provide service to the MDCN.

Prior to implementation, each call center's network configuration will be evaluated to ensure that sufficient network bandwidth will be available.

Firewalls: All Internet Protocol (IP) access to the MDCN/AGNS network will be firewall protected. Each call center will be responsible for the installation and configuration of a firewall solution between themselves and the MDCN/AGNS network. Call centers will access the NGD system via IP. The NGD will provide access to the mainframe processing systems at the data centers via IBM's System Network Architecture (SNA). The SNA connectivity will not require firewall protection. Future plans may include access to the mainframe processing systems via IP; however, CMS will work closely with the data centers if and when this option becomes available. The contractors are only responsible for having the firewall(s) implemented at their call centers and/or data centers.

Mercury Topaz: Mercury Topaz will be installed on one Personal Computer (PC) at each call center location prior to the rollout of NGD. Mercury Topaz is a service that measures call center transaction response times. This tool is useful to CMS to measure the true response time of a CSR at a call center. One PC per call center with the minimum requirements of an NGD Personal Computer will be required to be available at each call center to run simulated transactions. CMS will work closely with each call center on the initial set up of the PC beyond that of normal NGD PC. The NGD team will provide further guidance on the overall process once Topaz is installed.

Personal Computers

NGD Personal Computer (PC) Requirements: Following are updated PC software requirements for MCSC-NGD. These requirements supercede those listed in Change Request 2079, dated 5/16/02, and the former Medicare Carriers Manual. The only additional software requirements for FY 2004 are the Microsoft Word and Adobe Acrobat viewers which can be downloaded free of charge. Consideration will be required for coexisting software applications in addition to NGD. The system requirements may increase based on these additional applications. Please consult the software vendor for this information and make appropriate modifications to these requirements on the basis of that information.

Requirements for an NGD Personal Computer	
Processor:	500MHz Pentium III or comparable AMD 800MHz Celeron or comparable AMD
Disk Space:	100MB available
Memory:	224MB for Windows 2000 288 MB for Windows XP
Operating System:	Windows 2000 Service Pack 2

	<p>OR</p> <p>Windows XP Service Pack 1</p> <p>Note: XP Service Pack 2 will be supported once NGD is upgraded to Siebel 7.7.2</p>
Browser:	<p>Internet Explorer 5.5 Service Pack 2 with the latest cumulative patch for Internet Explorer from Microsoft that includes patch Q832894</p> <p>OR</p> <p>Internet Explorer 6 Service Pack 1 with the latest cumulative patch for Internet Explorer from Microsoft that includes patches Q832894 and Q831167. As of 1/10/2005, the latest appropriate cumulative patch is Q889293</p> <p>Note: XP Service Pack 2 will be supported once NGD is upgraded to Siebel 7.7.2</p>
Monitor:	21"
Pointing Device:	Mouse with scroll
Network Interface:	Network Interface Card compatible with the call center LAN, which will ultimately allow workstation access to MDCN
Word Processor:	Microsoft Word '97 (or higher version) – Required only for generation of correspondence.
Viewers:	Microsoft Word Viewer (provided free by Microsoft) and Adobe Acrobat Reader (v4.05 or v5.0 free from Adobe) are required to view correspondence and some reference materials available in NGD.

Integration Methods

- Standard Systems: Integration between the NGD and VMS, CWF, MCS, and FISS will be accomplished using Jacada's Integrator software product. Jacada uses TN3270 sessions to work these systems. This allows NGD to be implemented without any changes to the standard systems. Access to CWF will be through the claims systems. The NGD Integration Layer will log and timestamp all interactions, recording the NGD user, the back-end system user, and the transaction being performed along with the transaction's data. Integration with EDB and MBR will be done using IBM CICS Transaction Client Application Program Interface (API). Access to these systems will be via the CMS Traffic Cop application.

- **Computer Telephony:** The CTI is not currently in the scope of the NGD development for releases One and Two. The CTI may be integrated in a future release.

Impact on Contractor Resources: Although implementing the NGD will improve the overall efficiency of the call center operations, there will be some short-term impact on resources during the initial implementation. Resources potentially affected include CSRs, trainers, information services, and technology staff. A reduction in CSR efficiency is expected during the learning curve of first using the new system. As CSRs become proficient with the new environment, efficiency should improve.

Early in the deployment process CMS and the NGD team will review with each site the expected staffing levels that will be in place when NGD is implemented. Performance measures available from previously deployed locations will be shared to assist in determining potential impact and needed support.

A Deployment Assistance Center (DAC) has been established to support call centers during NGD implementation. The DAC is staffed with CSRs trained to handle Medicare inquiries from all lines of business. Certain functions may need to be transferred back to the site, however, it is expected the sites deploying NGD will utilize the services provided by the DAC prior to requesting any performance waivers. During the period of implementation, CMS will work with the contractor to determine the support needed from the DAC and relax performance standards where it is still deemed appropriate.

Call Center CSRs: It is expected that CSRs already trained to handle Medicare inquiries will need to attend 3-4 days of training on the new system. Contractors will continue to provide new CSRs with Medicare program training and any changes to local procedures resulting from NGD. Generally, CSRs will continue to answer the same types of inquiries they currently answer today, so the primary focus of the initial NGD training will be on how to access the same information within the new desktop. Additionally, NGD will offer some enhanced features and functionality which will deliver improved service to CMS customers. Training materials will be provided for any new functionality in NGD. Although contractors can choose to phase in the implementation of any new NGD features, it is expected that CSRs will fully utilize the functionality built within NGD.

Below is a sample of identified changes to pre-NGD procedures:

Scripted Responses: The NGD will include standard CMS-approved scripted language for some Medicare topics to be used by CSRs when responding to inquiries. The purpose of scripted language is to ensure accuracy and consistency of the information conveyed by the call centers.

Callbacks Closed: The counting for this CSAMS metric will change for those call centers using MCSC-NGD. Currently this number is based on calls received for the calendar month and represents the number closed within five workdays, even if a callback is closed within the first five workdays of the following month. For MCSC-NGD call centers, the desktop will provide a report based on seven calendar days which will be used to satisfy this requirement. The callback report will be provided to NGD sites after the eighth day of the month.

Logging Issues: The NGD provides the functionality to log multiple issues on one call. Once NGD Release Two is implemented, many of the high frequency topics or activities worked on a call are automatically logged. There is a need for some manual logging by CSRs. Those conducting quality call monitoring should ensure that CSRs are making use of this additional functionality to log multiple issues. This will provide the call centers and CMS with more accurate and thorough reporting. For quality call monitoring (QCM) purposes, all logging and coding including the logging of multiple issues is to be recorded under the Call Action portion of the Knowledge Skills Assessment section of the QCM scorecard. Correct logging of calls falls under the performance criteria of “completes call activities”.

Ordering a Replacement Medicare Card: The NGD has built in the functionality to allow for a CSR to order a replacement Medicare card. The NGD will perform the edit checks for the CSR which will minimize the training needed for this function.

Training: This project will use a “Train the Trainer” approach. This approach requires each contractor to provide trainers and training facilities to instruct CSRs, supervisors, quality assurance personnel, and other support staff on how to use the system. Training materials will be provided by CMS. The initial “Train the Trainer” classes (covering each contractor’s primary line of business) will be 5 days of instruction. An additional 2 days are required for any added line of business (Part A, Part B, DME). “Train the Trainer” classes will be held in a central location or at contractor locations if warranted by the number of trainees

Contractors deploying NGD need to plan for five additional days of NGD training/workshop to be held at a central location for the purpose of identifying any business process changes that need to be implemented.

The local call centers trainers will have the responsibility to train all CSRs on the NGD. For example, the training may take a phased approach in which some CSRs are trained while others continue to take calls in the current manner. At some point in time an individual call center may have some CSRs utilizing the current methods, some in training, and others using the NGD if a phased-in approach is followed. Regardless of the approach followed during the period of implementation, CMS will work with each contractor to define the extent of the impact during the transition, schedule support from the Deployment Assistance Center and relax performance standards where it is deemed appropriate.

The NGD Local System Administrators (LSA) are required to complete the LSA certification requirements including attending centralized LSA training. This requirement applies to both primary and back-up LSAs.

The NGD will have the ability to facilitate national web-based training. Contractors who wish to have their locally-developed web-based training accessible directly from the NGD are encouraged to comply with CMS standards. The CMS standards for both print and web-based training design can be found on the Medicare Beneficiary Telephone Customer Service home page at <http://cms.hhs.gov/callcenters/>. In addition to the PC requirements outlined previously, in order to fully utilize the national web-based training modules, contractors will also need to have an audio player capable of playing .wma files

(generally Windows Media Player); sound card and speakers (headphones are suggested); and Microsoft Word 97 or higher.

• **Local Site Administration:** Several administrative functions will be performed at the call center level by contractor personnel. Two-three days of mandatory training on these functions will be provided by NGD trainers at a central location. These functions include:

- Creating and Maintaining User Profiles;
- Adding User Accounts (includes identifying each user's zip code, state, and time zone);
- Disabling User Accounts;
- Adding and Maintaining Personal Information;
- Adding, Maintaining and Resetting User Passwords;
- Defining and Maintaining User Responsibilities;
- Defining and Maintaining User Positions;
- Defining the local Organizational Structure;
- Receive Step by Step instructions for Setting up Public Queries;
- Creating and Maintaining System User Alerts and Broadcast Messages; and
- Initiate Time Out Settings.

The CMS is standardizing some of the business processes for the users of NGD to facilitate consistent customer service performance, reporting and training. Standardized NGD business procedures will be posted on the Medicare Beneficiary Telephone Customer Service website, <http://www.cms.hhs.gov/callcenters/>. Contractors using NGD are required to train and use these procedures within 30 days of posting. Contractors should access the website monthly for updates. Training for the standard procedures is being developed by CMS and will be distributed to the contractors as developed. The training will be incorporated into the CMS NGD training package on a quarterly basis.

Help desk: Each contractor will be expected to operate a local help desk (Tier One) for NGD. The NGD trainers will provide a two-day training course for helpdesk personnel at a central location. The Tier One Help Desk Analysts are responsible for supporting the call center personnel in resolving issues they experience within the NGD application. This may be incorporated within the contractor's existing help desk or defined independently. The local help desk will be expected to triage NGD-related issues to determine if resolution can occur in-house, and those issues that need to be documented and submitted to the NGD Help Desk (Tier Two).

Local Tier One application support will likely be comparable to existing MCSC-Forte and Custom View sites. Support levels for those locations currently using mainframe applications only will probably increase. The call centers will need to provide Tier One help desk support. Tier One help desk support will be a focal area for each call center and will begin the resolution process. They will help identify if the issue resides at the

call center or if it is an issue that need to be resolved outside of the call center. If the issue can be resolved locally, then the normal call center process will be followed. If the issue cannot be handled locally, the local help desk will contact the NGD Tier Two Help Desk. The NGD help desk will work to resolve the issue within forthcoming Service Level Agreement standards. If the issue cannot be resolved by the NGD help desk, the NGD help desk will contact the appropriate NGD resources (Tier Three), including Siebel and AT&T for MDCN/AGNS issues. Once resolved, the NGD help desk will contact the local help desk so any log entries opened there can be closed.

At a minimum, the local help desk will handle:

- Determining if the reported issue is a training issue
- Determining if the reported issue is a business process issue
- Determining if the reported issue is a result of the contractor's mainframe or CWF being unavailable
- Establishing local workstations and verifying correct configuration
- PC and PC software configurations – Tier Two can assist Tier One or provide guidance in correcting the problem, but ultimately it is the responsibility of Tier One to resolve PC configuration/setup issues. The settings shall follow NGD and CMS guidelines.
- Providing technical “floor support” during First Live Calls
- Resolving Internet browser issues
- Resetting passwords
- Reporting Local Area Networks (LAN) & AGNS line outages and mainframe system outages affecting the NGD to the Tier II NGD Help Desk. Contracting AT&T for any AGNS issues related to the sites connectivity.

The help desk training provided by the NGD trainers will provide more details on what is expected of the local help desk.

Information Technology: For those sites that currently have PCs on the CSRs' desktops, little, if any, change in demand for infrastructure support is expected. Connectivity between the NGD servers in Shelbyville, KY and contractor mainframe claims processing systems (i.e., data center) is planned to be via MDCN/AGNS using SNA. Contractor PCs at Call Centers using the NGD will access the NGD servers in Shelbyville using MDCN/AGNS via IP.

Existing call monitoring applications, such as e-Talk Recorder and Witness eQuality Balance, that are integrated with a call center's Automatic Call Distribution (ACD) system should continue to function with no change.

Impact on Data Center Resources: Contractors shall work with their respective data centers to ensure Data Center staff performs the following tasks in support of the NGD implementation. These tasks include, but are not limited to:

- Provide a Data Center Point of Contact (POC) to coordinate NGD testing and deployment activities;
- Assist in planning for adequate MDCN/AGNS bandwidth and routing changes;
- Create and assign standard system mainframe User IDs per CMS/NGD requirements;
- Provide TN3270, TCP /IP, or SNA connectivity information and create any required SNA LUs to establish the necessary sessions; and
- Ensure that claims systems test regions and test data are available as required for system testing.

After initial testing the following are required:

- Test regions need to be available during normal business hours beginning when system testing starts, and continuing through the deployment of the desktop at all call centers. Availability of test regions will also be required for subsequent quarterly release;
- Ensure system production regions are available by contractor Go Live date(s); and
- Ensure system production regions are available during Call Center hours of operation.

NGD Access for Other Departments: It may be desirable for other departments (Correspondence, Benefits Integrity, Medical Review, and so on) to have limited access to the new system. If so, some minimal training for the users from these departments will be required. Using the NGD in other departments will be considered on a case-by-case basis. Other departments will be expected to acquire the necessary NGD Siebel desktop licenses and appropriate PCs within their own budgets.

Security and Connectivity Issues

- **Call and Data Center:** NGD retrieves data from systems, such as the CMS Enrollment Database (EDB) and the SSA Master Beneficiary Record (MBR). These systems are Privacy Act protected and require high levels of security. Data and Call Centers are required to follow strict security controls in their data center implementation to segregate CMS data from other business data and to safeguard the confidentiality, integrity, and availability of such data.

- **NGD Network Traffic and Overview:** For MCSC NGD implementation, connectivity shall be established between Siebel NGD and SNA (System Network Architecture) servers, the Medicare Data Communications Network (MDCN) and the Medicare Call Center's servicing data center. Currently, the Siebel NGD and SNA gateway servers reside at the AdminaStar Federal Data Center in Shelbyville, Kentucky.

A customer service representative (CSR), as a NGD user located at the Medicare Call Center, uses a browser-based, thin client with zero footprint to access the Siebel NGD servers. All communications between client and server travel via the MDCN, provided by AT&T Global Network Services (AGNS). This configuration establishes Private Virtual Connection's (PVC) from each Call Center to the NGD Data Center, and between the NGD Data Center and all Medicare Data Centers. Call Centers are directly connected

to Shelbyville NGD via AGNS. Shelbyville NGD is connected to all host Medicare Data Centers. The Shelbyville DC queries the host for the information. After Shelbyville DC gets the information from the host data center, paints the screen and sends the data back to the call center's CSR desktop.

When the Siebel NGD application requests Medicare shared claims processing systems information for an NGD user, the NGD systems' Integration Server acts on behalf of the NGD user and utilizes a CICS transaction-based approach to retrieve the requested information. This SNA connection communicates directly with the Medicare shared claims processing systems (MCS, VMS, FISS) via the MDCN, to process the NGD users' information request.

The NGD update requests to Medicare shared claims processing systems are limited to users within the local call center, as controlled by their specific Local System Administrator and their local NGD security profile. Therefore, updates are allowed only to native users. **Non-native call center NGD users (e.g., other Medicare Call Centers) will have read-only access to the specific data center's Medicare systems as described in the Mainframe ID's paragraph below.** Memorandums of Understanding between the data center and call center contractors will be needed prior to NGD's authorization (or capability) to update Medicare shared claims processing systems that are not native to the NGD user. If this non-native update capability becomes necessary, CMS will work with call center contractors to establish these Memorandums of Understanding.

Mainframe Ids: The Siebel application identifies the information's requester and determines the source required to fulfill the information request. This information is passed to the Integration Server, which establishes a session between NGD Data Center and the source Data Center. The Integration Server uses an established Logical Unit (LU) connection from available LU session pools. Each Data Center will be assigned a specific number of LU session IDs, which will be assigned and controlled by AGNS.

- **CMS-Pub. 60AB:** The session pool concept is referred to as Master ID since only a limited number of sessions are available for a larger number of users sessions. Master IDs are used by NGD Integration Servers, which acts in behalf of NGD users, to access the source Data Center's mainframe. Master IDs have been successfully implemented within other CMS applications with similar large user base and technical requirements. It is important to note that allowing NGD users read-only access to other Medicare contractors databases is not a new idea, and in theory the NGD read-only access is not too different than the shared access that all Medicare contractors have to the Common Working File (CWF).

The Data Center's System Administrators restricts and controls access to the shared claims processing systems housed at their data center, thus protecting the Government's Medicare claims information that they have been entrusted to maintain. **It is the Data and Call Centers System Administrators' responsibility to establish, add, and maintain the NGD-provided LU sessions and Master IDs on the mainframe's security software for NGD access as needed for development, validation, training, and production.** The benefit of establishing and maintaining a limited number of LU

IDs and Master IDs for each Call Center, versus establishing individual accounts for each NGD user, results in reduced administrative tasks and costs.

- **NGD Security Responsibilities:** The NGD Contractor (currently AdminaStar Federal) is responsible for the security controls within NGD. **It is National NGD Security Administrators' responsibility to establish, add, maintain, and track the AGNS-provided LU sessions and Master Ids for all Medicare contractors on the applicable NGD software, (e.g., Siebel server, Jacada server, etc.).** The NGD software is developed to enable each Call Center to grant security access to its files, and will only retrieve/display data defined within the security access granted. Security tests have been developed to ensure access control mechanisms are in place and operating as intended.

Stringent controls and monitoring processes will be in place to ensure that only assigned personnel gain access to the range of IDs assigned to their center. Those transactions will be performed in NGD's authentication servers within a secured environment.

The NGD system generates transaction logs with information to fulfill user traceability requirements. The Siebel server, Integration server, and CICS/SNA gateway logs will document the transactions being performed, who performed them, when they were performed, what User ID and what LU session, host, and system were used to perform the transaction. This logging supports the use of Master IDs within the NGD, providing individual accountability for NGD users. Auditing will be performed within the NGD network and will provide a trace mechanism for the Medicare shared claims processing systems to validate users.

- **Security Oversight:** Oversight and separation of duties for NGD security will be accomplished by:

1. Establishing System Administrators for Call and Data Centers, when applicable, with access only to the range of IDs designated for their center;
2. Establishing a National NGD Security Administrator responsible for establishing user IDs and granting security access to Call and Data Center's System Administrators; and
3. Designating a third-party to audit security functions and logs, including the National NGD Security Administrator.

- **Shared/Standard System Issues:** The Next Generation Desktop relies on extensive interfaces with many standard Medicare systems, operated by the CMS as well as contractors. In order to make each contractor's deployment to the NGD as problem-free as possible, it would be helpful if each contractor provided systems documentation for any changes or customization that they have made to the standard system. By providing this documentation during the discovery period, it will allow the NGD developers to make any necessary adaptations before deployment. Once a site has implemented NGD, the NGD team will need to be made aware of any local planned changes to these shared systems well in advance. This will allow time to make sure that the interfaces with the shared systems continue to perform correctly.

The NGD updates will occur quarterly and will follow the release schedule used for the shared system updates. Once the NGD is implemented, contractors are requested to inform the NGD team of any notifications of changes being planned to the standard systems currently accessed. This will serve as a backup to the current process CMS has in place for notification of systems changes. It is important that the NGD sites work closely with the NGD team to coordinate any additional testing needed specific to NGD in conjunction with testing for the shared system quarterly releases.

Implementation Planning and Support: Implementation of the NGD will represent significant change for many call centers. Managers and staff will need to be available for pre-implementation meetings (e.g., conference calls, in-house meetings, completion of surveys), to provide information about the site in general, the technology used, and to plan for the rollout of the NGD. To minimize the impact of this change, at a minimum, the call centers will be provided with the following assistance:

- Planning for functional, technical, and business process changes;
- Deployment Notebook detailing key aspects of the deployment process;
- Deployment Checklist/Project Plan and updates to the project plan;
- Regularly scheduled NGD specific conference calls;
- Training assistance as described above; and
- 24 X 7 post-implementation support (on site, if required).

Future Changes to the Next Generation Desktop: The CMS will implement an NGD Change Control Board that will include representation from the contractor community. Change requests can be submitted in a variety of ways: Feedback forms within the NGD system, change requests submitted to the NGD helpdesk, participation in user acceptance testing, and functional workgroup meetings. The change control procedures will be provided in the call center deployment notebook for further reference. New releases of the NGD are expected to follow the current standard mainframe system quarterly release schedule.

Additionally, contractors using NGD will be required to participate in monthly NGD User Group calls for NGD updates and/or to provide input on suggested changes.

Retirement of Redundant Systems: After implementation of the NGD, several existing systems will become redundant. These include the current MCSC Forte application and the 1-800 GT-X application. There may be other contractor or call center specific applications that will also become redundant. Retirement of these redundant applications may involve archival of data and disposition of any surplus hardware. The CMS and the affected contractors will determine the specific tasks required.

20.1.11 - Publication Requests

(Rev. 11, Issued: 06-03-05, Effective: 07-05-05, Implementation: 07-05-05)

Contractors using the NGD should order publications using desktop functionality. NGD operational procedures for publication ordering can be found at the Medicare Beneficiary

Telephone Customer Service website, <http://www.cms.hhs.gov/callcenters/>. (Note: Procedures are in development and will be posted at this site when completed).

If a CSR does not have MCSC-NGD, but has Internet access, these items should be ordered on-line at www.medicare.gov. If a CSR does not have MCSC-NGD or Internet access, then callers with such requests should be referred to www.medicare.gov for on-line ordering or to the 1-800-MEDICARE Help line at 1-800-633-4227. Contractors should retain a minimum number of CMS publications for outreach/education efforts or for unique or extenuating circumstances, e.g., an outreach event or an event when there is a guest speaker. Contractors will maintain their in-house developed materials and products.

20.1.12 - Medicare Participating Physicians and Suppliers Directory (MEDPARD)

(Rev. 11, Issued: 06-03-05, Effective: 07-05-05, Implementation: 07-05-05)

Medicare carriers shall provide callers with participating physicians and suppliers directory (MEDPARD) information upon request. Medicare carriers using the NGD should order the MEDPARD information using desktop functionality. NGD operational procedures for ordering the MEDPARD directory can be found at the Medicare Beneficiary Telephone Customer Service website, <http://www.cms.hhs.gov/callcenters/>. (Note: Procedures are in development and will be posted at this site when completed). MEDPARD information shall be provided to callers verbally. Written or printout forms shall be provided only if the beneficiary insists on receiving a hard copy or if giving the list of participating physicians via telephone would significantly lengthen the call. Medicare carriers should use judgment to determine how to narrow the number of physicians names provided and when it is more efficient and cost-effective to provide the MEDPARD directory. For example, the Medicare carrier could narrow the list geographically (e.g., to ZIP code or county) or by special type. If for example, it would be more cost-effective to provide by telephone the names/ telephone numbers for four psychiatrists in a ZIP code than to mail a large directory with thousands of physicians' names. Conversely, if the beneficiary wants all physicians' names for a large city and the search results in a large number of physicians, the Medicare carrier should mail the directory. The Medicare carrier may, at its discretion, use the www.medicare.gov Participating Physicians Directory, if its current system does not easily facilitate searches by various criteria for narrowing the number of physicians.

20.1.13 - Call Center User Group (CCUG)

(Rev. 5, 04-23-04)

Call centers are required to participate in the monthly CCUG calls. The CCUG sessions provide a forum for CMS to discuss new and ongoing projects related to telephone customer service, for contractors to surface issues for CMS resolution, and call centers to share best practices in telephone customer service delivery. The CCUG is held the third Wednesday of each month at 2:00 p.m. Eastern Time. The call center manager or a designated representative shall participate at a minimum.

20.1.14 - Performance Improvements

(Rev. 5, 04-23-04)

As needed, the contractor develops a corrective action plan to resolve deficient performance by staff in the call center, and maintain results on file for CMS review.

20.1.15 – Transfer of Part A Telephone/Written Inquiries Workload

(Rev. 11, Issued: 06-03-05, Effective: 07-05-05, Implementation: 07-05-05)

In response to the draft BPRs, numerous large Part A intermediaries volunteered to take on additional telephone/written workload. However, since there were no small intermediary volunteers to have their inquiry workloads transferred to another intermediary, CMS is determining those small intermediaries whose inquiry workload will be moved in FY 2005 based on performance, call volume (50,000 calls or less), and unit cost (cost per call over \$10).

Based on the progress of transferring the inquiry workloads, some intermediaries will have their inquiry budgets further modified in FY 2005. CMS will work directly with the ROs and the Medicare intermediaries who are losing and gaining workload in FY 2005. Intermediaries receiving the additional inquiry workload will be chosen based on cost, quality, performance, and Next Generation Desktop (NGD) availability.

20.1.16 – Local Medical Review Policy (LMRP)/Local Coverage Determination (LCD) Requests

(Rev. 5, 04-23-04)

Customer Service Activities

Customer Service Representatives (CSRs) shall answer questions about LMRPs/LCDs using existing scripts or guidelines. If new scripts or guidelines are required, call center staff should develop them with input from the Medical Review (MR) Unit or other units as needed. (All work performed by call center, MR and other staff in developing these scripts or guidelines should be charged to a call center Contractor Administrative Cost and Financial Management System (CAFMS) code.)

Before you begin issuing the new MSN message for edits ensure that your Customer Service staff are able to respond to the beneficiary by informing him or her of the particular LMRP/LCD that was used in reviewing the claim. We intend to develop a LMRP/LCD database in the future that could be one toll assisting the CSR to respond to the beneficiary.

If the caller requests a copy of the LMRP/LCD, the CSR shall assist the caller in obtaining it. For example, if the caller has Internet access, the CSR could give the caller the URL where the LMRP/LCD is located on the Web site. Eventually, the beneficiary will also have the ability to look up the appropriate LMRP/LCD based on procedure codes for Part B and some Part A claims on their own. Instructions to this effect will appear in future educational material. If the caller does not have Internet access, the CSR shall mail a copy of the LMRP/LCD to the caller's address. In such cases, the CSR shall mail out the LMRP/LCD within 7 business days of receipt of the request. The CSR shall

also inform the beneficiary that should the LMRP/LCD not arrive within 2 weeks, the beneficiary should call back.

CSRs shall use established processes to escalate the beneficiaries' issues or questions for further research. An appropriate party shall call the beneficiary back.

20.1.17 - Utilizing CMS-approved Scripts and Communicating Preventive Services Information

(Rev. 8, Issued: 02-18-05; Effective and Implementation: 03-14-05)

Provisions §611, 612 and 613 of the MMA expanded coverage for certain preventive services. In an effort to inform Medicare beneficiaries of the preventive services they may be eligible to receive, CMS is requiring Medicare customer service representatives to offer beneficiaries with Medicare Part B information on Medicare covered preventive services. To ensure the accuracy of the information provided about the Medicare-covered preventive benefits CMS will require the use of CMS approved scripts.

The Interactive Voice Response system (IVR) will inform callers that preventive services information is available on the Medicare.gov website.

Effective March 14, 2005, Medicare contractors deployed on the NGD will ask callers upon completion of call activity if they would like to hear information about Medicare covered preventive services available to the Medicare beneficiary. Information provided in the NGD on the covered preventive services and when the beneficiary may have the service will be offered to the beneficiary.

Medicare contractors not yet deployed to the NGD will use the preventive services scripts when specifically asked by the beneficiary for information on the Medicare-covered preventive services.

In the event that CMS needs to expand the use of scripts for other Medicare initiatives or limit the proactive offering of preventive services information at a future date, contractors will be notified through the Single800 mailbox distribution.

20.2 - Guidelines for Handling Beneficiary Written Inquiries (Activity Code 13002)

(Rev. 11, Issued: 06-03-05, Effective: 07-05-05, Implementation: 07-05-05)

The Medicare contractor will date stamp the cover page of the incoming letter and the top page of each attachment for Written Inquiries with the date of receipt in the corporate mailroom or use the Correspondence Control number (CCN) or document control number (DCN) and will control them until it sends final answers. The contractor may continue to Date Stamp the envelope if it currently does so. However, date stamping the envelope is not required. (For MSP Situations, see the Medicare Secondary Payer (MSP) Manual, chapter 4, §§10, 80, 110; and chapter 5, §10). In addition, the contractor:

- Answers inquiries timely;
- Does not send handwritten responses;
- Includes a contact's name and telephone number in the response;

- The majority of Medicare 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 should be sent electronically to the servicing RO Beneficiary Branch Chief. This notification is necessary in the event an onsite CPE review is conducted. Contractors are required to allow CMS access to all written inquiries stored off site within one day of notification to the contractor so that cases can be retrieved timely. All written inquiries, whether maintained on site or off site, must be clearly identified and filed in a manner that will allow for easy selection for the CPE review. Identification data shall be kept that will allow electronic production of a sequential listing of the universe of written inquiries;

- Considers written appeal requests as valid if all requirements for filing are met. These need not be submitted on the prescribed forms in order to be considered valid. If appeal requests are valid, they are not considered written inquiries for workload reporting. (See the Medicare Claims Processing Manual, Chapter 29 for instructions on Appeals Processing.);

- Keeps responses in a format from which reproduction is possible; and
- Includes the CMS alpha representation on all responses, except for email responses.

20.2.1 - Contractor Guidelines for High Quality Written Responses to Inquiries

(Rev. 11, Issued: 06-03-05, Effective: 07-05-05, Implementation: 07-05-05)

Contractors maintain a correspondence Quality Control Program (containing written policies and procedures) that is designed to improve the quality of written responses. In addition, contractors perform a continuous quality review of outgoing letters, computer notices, and responses to requests for appeal of an initial determination. This review consists of the following elements:

1. **Accuracy** - Content is correct with regard to Medicare policy and contractor data. Overall, the information broadened the inquirer's understanding of the issues that prompted the inquiry.
2. **Responsiveness** - The response addresses the inquirer's concerns and states an appropriate action to be taken.
3. **Clarity** - Letters have good grammatical construction, sentences are of varying length, and paragraphs generally contain no more than five sentences. Use CMS-provided model language and guidelines, where appropriate. All written inquiries are to be processed using a font size of 12 points, and a font style of Universal or Times Roman, or another similar style for ease of reading by the beneficiary.

Contractors shall make sure that responses to beneficiary correspondence are clear; language shall be below the eighth grade reading level, unless it is clear that the incoming request contains language written at a higher level. In an effort to provide consistency to the Fogging process, all Medicare contractors shall use the

Fogging method as preferred by CMS. This is the same clarity tool that CMS uses in Contractor Performance Reviews. Please see the attachment for a copy of the Fogging Calculation Worksheet. When fogging a piece of written correspondence, if the 8th grade reading level is exceeded, documentation shall be in the file that explains why. Those contractors using standardized paragraphs provided through NGD are not required to fog those paragraphs. Whenever possible, written replies should contain grammar comparable to the level noted in the incoming inquiry.

Fog Calculation Worksheet

1. Total Number of words _____
2. Total Number of sentences _____
3. Average sentence length _____
(number 1 divided by 2)
4. Number of polysyllable words _____ X 100 = _____
(3 syllables or more)*
5. Percent of hard words _____
(number 4 divided by number 1)
6. Number 3 plus number 5 _____
7. Reading level _____
(number 6 X .4)

- Do not count words that are normally capitalized, combinations of short, easy words, or verb forms, which result in 3 syllables by adding “ed”, “ing”, “ly”, or “es”. Count hyphenated words as separate words. Do not count numbers or words, which are part of the structure of the letter. Count numbers, abbreviations, and acronyms as one-syllable words.
Except for exclusions noted above, no other exclusions are permitted.

NOTE: If a date is included in the body of the letter, the entire date will be counted as 1 word.

4. Timeliness - Substantive action is taken and an interim or final response is sent within 45 calendar days from receipt of the inquiry. In instances where a final response

cannot be sent within 45 calendar 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.

Contractors using Interactive Correspondence Online Reporting (ICOR) to document inquiries received from beneficiaries and others should record the correspondence in the electronic environment in a timely manner.

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-day period starts on the same day for both responses). The contractor ensures 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 must refer to the fact that the other area of inquiry will be responded to separately. Every contractor will have the flexibility to respond to beneficiary written inquiries by phone within 45 calendar days. A report of contact shall be developed for tracking purposes. The report of contact shall include the following information:

- Beneficiary's name and address;
- Telephone number;
- Beneficiary's HICN;
- Date of contact;
- Internal inquiry control number;
- Subject;
- Summary of discussion;
- Status;
- Action required (if any); and
- The name of the customer service representative who handled the inquiry.

Upon request, the contractor shall send the beneficiary a copy of the report of contact that results from the phone response. The report of contact shall be retained in the same manner and time frame as the current process for written responses. The contractor should use its discretion when identifying which written inquiries (i.e., beneficiary correspondence that represents simple questions) can be responded to by phone. When responding to written correspondence by telephone, the Customer Service Representative (CSR) should follow the instructions in Chapter 30 (Disclosure Desk Reference Guide for Call Centers)(AB-03-077). Use the correspondence that includes the requester's telephone number or use a requester's telephone number from internal records if more appropriate for telephone responses. If the contractor cannot reach the requester by phone, it should not leave a message for the beneficiary to return the call. It shall develop a written response within 45 calendar days from the incoming inquiry.

5. Tone - Tone is the touch that brings communication to a personal level and removes the appearance that a machine-produced response was used. Appraise all

responses, including computer-generated letters and form letters, for tone to make them user-friendly and comprehensible by the reader.

- **E-mail Inquiries** - Any e-mail inquiry received can be responded to by e-mail, with the exception shown below. 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. However, ensure that e-mail responses utilize the same guidelines that pertain to written inquiries (i.e., timeliness, accuracy, clarity, tone, comprehension, etc.). Exception: Responses that are personal in nature (contain financial information, HICN, etc.) cannot be answered by e-mail.

20.2.2 - Replying to Correspondence from Members of Congress

(Rev. 5, 04-23-04)

A3-3736

Contractors follow these instructions when preparing replies to correspondence from Members of Congress.

A. Congress Recessed

Generally, the contractor sends the original and the courtesy copy of the reply to the Washington office of the Member of Congress. However, if it is clear that the inquiry was sent from a home office, the contractor directs the original and the courtesy copy there.

B. Replying to a Letter Signed by More Than One Member of Congress

When replying to a letter signed by more than one Member of Congress, the contractor prepares a reply for each Member and encloses a courtesy copy with each. The contractor states in the opening paragraph that the same reply is being sent to each person who signed the letter and makes an official file copy for each Member of Congress.

C. Replying to More Than One Member of Congress on Same Case

The contractor releases the replies to each Member of Congress at the same time. The contractor indicates that similar information is being sent to the other Member. The contractor may use the following in its final reply:

Similar information is being sent to (Senator or Representative) (name of Member of Congress) who also inquired on behalf of (name of beneficiary).

D. Replying to a Letter Signed by an Employee in a Congressional Office

The contractor addresses replies to the Members of Congress even when the inquiries are signed by staff members.

E. Replying Directly to a Constituent at the Request of a Member of Congress

When addressing a reply to a constituent, the contractor sends a letterhead copy to the Member of Congress, along with a copy of the constituent's letter. The Division of Beneficiary Inquiry Customer Service (DBICS) sends the Member of Congress only a copy of the response that went to the constituent.

F. Replies to Inquiries from Former Members of Congress

Unless the former Member of Congress requests otherwise, the contractor addresses the reply to the constituent.

G. Replying to Congressional and Noncongressional Inquiries

The contractor releases the congressional and indicates in the reply to the Member of Congress that similar information is being sent to the constituent (or third party, if applicable) in response to an inquiry sent directly to us by that person. Congressional replies and non congressional replies are released at the same time the data is captured in the Correspondence Inquiry System (CIS).

H. Teletyping and Telephoning Award Information

As a general rule, the contractor should not call or write a congressional office about a check that was released more than one week previously. Instead, the contractor sends a letter. DBICS staff members may call congressional offices to discuss a congressional inquiry.

I. Forms of Address

When replying to the Washington office, address the letter:

Honorable _____	or	Honorable _____
United States Senate		House of Representatives
Washington, D.C. 20510		Washington, D.C. 20515

Dear Senator _____:	Dear Mr. or Ms. _____:
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Address replies to the home office:

Honorable _____	or	Honorable _____
United States Senator		Member, United States House of Representatives
(local address)		(local address)
City, State, ZIP Code		City, State, ZIP Code

Dear Senator _____:	Dear Mr. or Ms. _____:
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J. Courtesy Copies

The contractor prepares a courtesy copy for each congressional response (including those requiring special handling), if the congressional office has indicated by phone or letter that they want one. Document file if they indicate that they do not need a copy.

K. Constituent's Letter

Members of Congress frequently forward the constituent's letter for assistance in replying. The contractor should return the constituent's letter, if it is an original, with their first written response.

When the constituent's letter is the only enclosure, on the courtesy copy and all other copies of the reply (but NOT ON ORIGINAL), the contractor types:

Enclosure:

Constituent's inquiry

When an enclosure in addition to the constituent's letter is forwarded to the Member of Congress:

- On the original only, at the left margin two lines below the signer's title, the contractor types:

Enclosure

- On the copies, beginning at the same place (at the left margin), the contractor types:

Enclosures 2:

Including constituent's inquiry

The contractor does not mention the constituent's inquiry in the body of the response.

20.2.3 - Content of Request for Refund Letter

(Rev. 5, 04-23-04)

Any correspondence with a beneficiary concerning an overpayment must contain a clear and complete explanation of the overpayment. An overpayment that is not clearly explained is less likely to be refunded. Furthermore, lack of clarity may deprive the individual of sufficient information to decide whether there is a basis for questioning the contractor determination. Clarity is important because CMS and SSA may eventually use the letter for further recovery attempts. The contractor's letter and the referral form (Form CMS-2382) are usually the only sources available to CMS and the SSA for information regarding the overpayment.

The following is the minimum information to include in refund letters sent to a beneficiary:

- The name and address of the provider;
- Dates and type of services for which the overpayment was made;
- A clear explanation of why the payment was not correct;

- The amount of the overpayment and how it was calculated;
- A statement that the provider was without fault and that the individual is responsible for refunding overpayments where the provider was without fault;
- The refund should be by check or money order and how it should be made out (enclose preaddressed envelope);
- The refund can be made by installments (See Medicare Financial Management Manual.);
- That unless a refund is made, the overpayment will be referred to SSA for further recovery action;
- Possible recovery from other insurance (if applicable);
- An explanation of the beneficiary's right to a reconsideration or hearing as appropriate; and
- An explanation of the CMS/SSA waiver of recovery provisions. (See Medicare Financial Management Manual.)

20.2.3.1 - Sample Request for Refund Letter

(Rev. 5, 04-23-04)

The contractor may use or adapt the following model letter for requesting refunds of overpayments:

Dear Mr. _____:

A. Opening Paragraph

In (month and year) we paid (provider's name and location) \$ _____ as reimbursement for (inpatient) (outpatient) services provided to you from _____ through _____ on _____. We have reviewed the payment and determined that it was incorrect. The correct payment should have been \$ _____. (Include a clear and complete explanation of how the overpayment arose (see §30.2.3.2 for some suggested explanations), the amount of the overpayment, and how it was calculated.)

Add if applicable:

We have recovered \$ _____ from (specify source). Thus, the total remaining overpayment is \$ _____.

B. Liability of Beneficiary

Under the Medicare law, you are responsible for overpayments made on your behalf if the provider of services was not at fault in causing the overpayment. In this case, (provider's name) was not at fault. Therefore, you are liable for the \$_____ incorrectly paid for the services you received.

C. Request for Refund

Send us a check or money order for \$_____, within 30 days. Make the check or money order payable to (contractor name), and mail it in the enclosed self-addressed envelope. If you do not repay this amount, this overpayment will be referred to the Social Security Administration (or Railroad Retirement Board) for further recovery action, which among other actions, may result in the overpayment being deducted from any monthly social security (or railroad retirement) benefits to which you may be entitled.

D. Installment Payments

If you are unable to refund this amount in one payment, you may make regular installments. To refund in installments, you are required to pay a minimum of \$_____ each month for _____ months. However, we urge you to pay more each month so that this matter can be settled as soon as possible. If you prefer to repay this overpayment through installments, please notify us promptly how much you are able to pay and how often.

E. Possible Recovery from Other Insurance

(Do not use where it has been determined that the private insurer will not pay.)

If you carry private health insurance to supplement your Medicare benefits, you may be able to recover the amount of this overpayment by claiming benefits from the other plan, or (name of provider) may be able to submit such a claim on your behalf. If you plan to file a claim with a supplemental plan and use the proceeds to refund this overpayment, please let us know. If you need help in filing such a claim, please contact any Social Security office.

F. Notification of Appeal Rights

The notification of appeal rights must be in accordance with the Appeals Chapter of the Medicare Claims Processing Manual.

NOTE: If the overpayment was for medically unnecessary services or for custodial care, begin the first sentence of the appeals paragraph:

If you believe that this determination is not correct, or if you did not know that Medicare does not pay for these services.

G. Notification of Waiver of Recovery Provision

The law requires that you must repay an overpayment of Medicare benefits unless you meet **both** of the following conditions:

- You were without fault in causing the overpayment in that the information you furnished in connection with the claim was correct and complete to the best

of your knowledge, and you had a reasonable basis for believing that the payment was correct, **and**

- Paying back the overpayment would keep you from meeting your ordinary and necessary living expenses **or** would be unfair.

If you claim that repayment will cause you serious financial hardship, it will be necessary to submit a statement to the Social Security Administration regarding your income, assets, and expenses.

If you believe that both conditions for waiver of this overpayment apply in your case, please let us know, giving a brief statement of your reasons. You may contact your Social Security office. You will be notified if recovery of this overpayment is waived. If waiver cannot be granted, you will have the opportunity to present your case at a personal conference. The conference will be conducted by an employee of the Social Security Administration who did not participate in the initial waiver determination.

20.2.3.2 - Optional Paragraphs for Inclusion in Refund Letters

(Rev. 5, 04-23-04)

We suggest contractors use or adapt the following paragraphs in explaining how the overpayment occurred.

A. Inpatient Hospital Deductible or Coinsurance Not Properly Assessed

1. General

Medicare pays all costs of covered services furnished during the first 60 days of hospitalization except for the first \$_____ (the inpatient deductible). For the 61st through the 90th days Medicare pays all costs except for a coinsurance of \$_____ per day. After 90 days of benefits have been used, an additional 60 lifetime reserve days are available. There is \$_____ per day coinsurance for each lifetime reserve day used.

2. Deductible Overpayment

Our records show that the claim for the inpatient services you received at (provider's name) was improperly processed. Benefits were mistakenly paid for full _____ days. However, since these were the first inpatient hospital services furnished in this benefit period, the \$_____ inpatient hospital deductible should have been subtracted from the reimbursement paid (provider's name) on your behalf. Thus, (provider's name) was overpaid by \$_____.

3. Coinsurance Overpayment

Our records show that the claim for the inpatient services you received at (provider's name and address) was improperly processed. Benefits were mistakenly paid for _____ full days (less the \$_____ deductible). However, since you had previously been hospitalized for _____ days at (name of provider where previously hospitalized) during that benefit period, your claim should have been processed as _____ full days and coinsurance days (and/or lifetime reserve days). Therefore, (provider's name) has been overpaid on your behalf for _____ coinsurance days at \$_____ per day and/or lifetime reserve days at \$_____ per day less \$_____ for the inpatient hospital deductible which was improperly applied to your claim). The total overpayment is \$_____.

B. Payment Made Under WC

We paid \$_____ in benefits for services furnished you by (provider's name and location) from _____ to _____. However, these payments were in error since these services were covered under the (State) workers' compensation law and Medicare may not pay for services which are covered under workers' compensation. Since (provider's name) was not at fault in causing this overpayment, you are required to refund the \$_____ Medicare paid on your behalf. You may wish to submit the bill for these services to your employer or his workers' compensation carrier for payment under the State workers' compensation provisions.

C. Beneficiary Not Entitled to Medicare Benefits

The Social Security Administration's records show that you were not entitled to (specify Part A hospital insurance and/or Part B medical insurance) benefits when these services (item(s)) were furnished. Your "Medicare and You" Handbook explains the difference between Part A (hospital) and Part B (medical) insurance. The decision that you were not entitled to these benefits was made by the Social Security Administration, and not by (contractor name). Therefore, if you disagree with this decision or if you have any questions about your entitlement to Medicare benefits, contact your Social Security office. If you go to the Social Security office, take this letter with you.

20.2.3.3 - Recovery Where Beneficiary Is Deceased

(Rev. 5, 04-23-04)

When a beneficiary who is liable for an overpayment dies, the contractor attempts to recover from such sources as State welfare agencies, or private insurance plans (see MSP Manual, Chapter 7, Contractor MSP Recovery Rules), or withholds the overpayment from any underpayments due to the beneficiary's estate or due to a surviving relative.

If the entire overpayment cannot be recovered by the above methods, the contractor sends a letter (see sample below) addressed to the estate of the deceased at the address of the legal representative, if known, or to the last known address of the deceased. The contractor includes the basic information in §30.2.3, but does not mention the possibility of installment payments or the possibility of offset against monthly benefits.

The contractor does not direct recovery efforts against a person who answered a recovery letter concerning an overpayment unless it is known that the individual represents the beneficiary's estate. The contractor does not recover by offset against underpayments payable to a provider of services or to a person (other than the beneficiary's estate) who paid the bill.

If a refund is not received within 30 days after writing to the estate, the contractor refers the case to CMS according to the rules in the Medicare Financial Management Manual, Chapter 3, "Overpayments," §140. The contractor includes any information it has about the appointment of a legal representative, copies of any correspondence with survivors or others concerning the overpayment, and any instructions received for filing a claim against the estate. The contractor annotates item 13, Remarks, of the referral form (Form CMS-2382) as follows: "Expedite. Case involves deceased beneficiary." If the file contains instructions for filing a claim against the estate, the contractor mentions this also.

When forwarding the overpayment to CMS, the contractor notifies any party that responded to its recovery letter that the case is being transferred to the Social Security Administration and that further recovery action will be taken by the agency.

Model Refund Request to Estate of Deceased Beneficiary (Adapt to Fit the Situation)

Estate of (deceased beneficiary) (or, if known, Representative of the Estate of (deceased beneficiary)).

Dear Sir (or Dear Ms. _____ if estate representative's name is known):

On (date) we paid (provider's name and location) \$_____ more than was due for inpatient services provided to (deceased beneficiary) from _____ through _____. (Include a clear and complete explanation of how the overpayment arose (see §30.2 for some suggested explanations), the amount of the overpayment, how it was calculated, and why the payment was not correct.)

Add if applicable:

We have recovered \$_____ from (specify source). Thus, the total remaining overpayment is \$_____.

If other Medicare benefits become payable to the estate and you have not refunded the incorrect payment, we will withhold the amount owed from those benefits.

Under the Medicare law, the beneficiary is responsible for overpayments made on his behalf if the provider was not at fault in causing the overpayment. In this case, (provider's name) was not at fault. Therefore, the estate of (deceased beneficiary) is liable for the \$_____ incorrectly paid to (provider's name) for the services it furnished (deceased beneficiary).

Please send us a check or money order in the amount of \$_____ payable to (contractor name) in the enclosed, self-addressed envelope within 30 days.

If we do not hear from you within 30 days, we will be required to refer this matter to the Social Security Administration (or Railroad Retirement Board) for further recovery action.

NOTE: Contractors undertake notification of appeal rights in accordance with the appeals chapter in the Medicare Claims Processing Manual.

If you believe that (deceased beneficiary) was without fault in causing this overpayment and that recovery of the overpayment would be unfair, you may request that recovery of the overpayment be waived. Your request should include a brief statement of your reasons for requesting waiver.

20.3 – Surveys

(Rev. 11, Issued: 06-03-05, Effective: 07-05-05, Implementation: 07-05-05)

The CMS requires periodic surveys of customer service operations to be completed by each contractor within the time frames and in areas indicated on the specific notice. Examples include annual call center technology surveys, staffing profiles, training needs, etc.

20.4 - Customer Service Plans (CSP)(Activity Code 13004)

(Rev. 11, Issued: 06-03-05, Effective: 07-05-05, Implementation: 07-05-05)

Include Your Annual CSP and Costs for Customer Service Plan Activities in Your Budget Request.

Refer to the Activity Dictionary (Attachment 2 to the BPRs) for the lists of tasks for this activity.

FY 2005 national funding will continue at the same level as that for FY 2004. Individual contractor funding levels will be determined at the RO level. Contractors who wish to perform CSP activities for FY 2005 should submit an annual CSP to their Associate Regional Administrators for Beneficiary Services in accordance with current manual instructions. All remaining CSP contractor instructions remain in effect. There is no national format for the CSPs. Plans should be as innovative as possible and propose only

the effective education and outreach activities. For those contractors whose service areas cross CMS regional lines, contractors should not restrict their CSP activities to the local area. Within their CSP budget, these contractors should include activities that would have the greatest impact for beneficiaries in their entire geographic service area. Each regional office will decide the CSP funding level for their contractors.

Those contractors receiving funding should utilize their resources in the following beneficiary efforts including, but not limited to:

- Establish partnerships and collaborate with local and national coalitions and beneficiary counseling and assistance groups;
- Provide service to areas with high concentrations of non-English speaking populations and for special populations such as: Blind, deaf, disabled, and any other vulnerable population of Medicare beneficiaries; and
- Work with appropriate Congressional staffs to resolve beneficiary issues with Medicare.

Due to the diversity of the Medicare population, these activities have not been prioritized. Be prepared to discuss this plan with your regional office.

20.5 – Beneficiary Internet Web Sites

(Rev. 11, Issued: 06-03-05, Effective: 07-05-05, Implementation: 07-05-05)

Contractors that maintain a web site for Medicare beneficiaries on the Internet shall ensure that information posted is current and does not duplicate information posted on the Medicare.gov website maintained by CMS.

30 - Disclosure Desk Reference Guide for Call Centers (AB-03-077)

(Rev. 5, 04-23-04)

DISCLOSURE OF BENEFICIARY-SPECIFIC INFORMATION OVER THE TELEPHONE

IF THE CONTACT IS:	AND:	YOU MUST:	THEN YOU CAN:	REFERENCE
1. The beneficiary		Verify it is the beneficiary by asking for his/her: <ul style="list-style-type: none"> • Full name; • Date of birth; • HIC number; and • One additional piece of information such as SSN, address, phone number, effective date(s), whether 	Release any entitlement and claim information and answer any questions pertaining to the beneficiary's Medicare coverage.	Medicare Carriers Manual (MCM) Part 2 §5104 A. 7-9 MCM Part 3 §10010 Medicare Intermediary Manual (MIM) Part 2 §2958 A. 7-9

		he/she has Part A and/or Part B coverage.		MIM Part 3 §3763 45 CFR 164.524
2. The beneficiary	<p>The beneficiary makes a mistake on the information (name, date of birth, HIC number or additional piece of information) used to verify his/her identity.</p> <p>NOTE: There is a two-year tolerance for the year of birth. (For example, for a beneficiary born on 3/12/31, you may accept the year of birth as 1929, 1930, 1931, 1932, or 1933 – two years prior and two years after the correct year of birth. The month and date, however, must match exactly.)</p>	<p>Explain to the beneficiary that the information does not match the information in your records. Ask him/her to repeat the information, and if still incorrect, suggest that the beneficiary look at his/her Medicare paperwork to find the correct information or ask someone (family or friend) to help him/her with this information.</p> <p>The CSR may advise the beneficiary to contact SSA to discuss the DOB SSA established.</p>	<p>If the beneficiary is able to provide the correct information, release per the instructions above.</p> <p>If the beneficiary is unable to provide the correct information, YOU MAY NOT release any entitlement or claim information or answer any questions pertaining to the beneficiary.</p> <p>Advise the beneficiary that the information is protected under the Privacy Act and the HIPAA Privacy Rule and it is for the beneficiary's protection that we will not release the information.</p>	<p>45 CFR Subtitle A 5b.5(b)(v)</p> <p>MCM Part 3 §10010</p> <p>MIM Part 3 §3763</p> <p>Program Operation Manual System (POMS) GN 03360.005 – Releasing Information by Telephone</p> <p>45 CFR 164.524</p>

IF THE CONTACT IS:	AND:	YOU MUST:	THEN YOU CAN:	REFERENCE
3. Parent of a minor child	<p>Generally, a parent may have access to the child's information as his/her personal representative when such access is not inconsistent with State or other law.</p> <p>The parent would no longer be the personal representative of the child when the child reaches the age of majority or becomes emancipated, unless the child elects to have the parent continue as a personal representative.</p>	<p>Verify the identity of the minor child by asking for his/her:</p> <ul style="list-style-type: none"> • Full name; • Date of birth; • HIC number; and • One additional piece of information such as SSN, address, phone number, effective date(s), whether he/she has Part A and/or Part B coverage. <p>Verify that there is nothing listed in your files that would</p>	<p>Release any entitlement and claim information and answer any questions pertaining to the issue in question.</p>	<p>MCM Part 3 §10020 B</p> <p>MIM Part 3 §3766 B</p> <p>POMS GN 03360.005 – Releasing Information by Telephone</p> <p>45 CFR 164.502(g)(2)(3)</p>

		preclude sharing information with the parent calling, (e.g., a copy of a court order).		
<p>4. SSA-Appointed Representative Payee</p> <p><u>Or</u></p> <p>A legal guardian of any individual who has been declared incompetent by the court</p>	<p>To answer any questions via the telephone, you must have proof of the arrangement for services on file or the representative's name must appear on the system (e.g., Master Beneficiary Record (MBR), Supplemental Security Income Record (SSR), Health Insurance Master Record (HIMR) or Inquiry Response Numident Identification screen (QRID)).</p>	<p>Verify that the caller's name matches the representative payee or legal guardian's name in your files.</p> <p>Have the representative payee or legal guardian provide the beneficiary's:</p> <ul style="list-style-type: none"> • Full name; • Date of birth; • HIC number; and • One additional piece of information such as SSN, address, phone number, effective date(s), whether he/she has Part A and/or Part B coverage. 	<p>Release any entitlement and claim information and answer any questions pertaining to the issue in question.</p>	<p>MCM Part 3 §10020 E.1.b</p> <p>MIM Part 3 §3766 E.1.b</p> <p>SSA training module – Title II Claims Representative Basic Training Course (CR-02) <u>Disclosure/Confidentiality/Privacy Act/ Freedom of Information</u></p> <p>POMS GN 03360.005 – Releasing Information by Telephone</p> <p>45 CFR 164.502(g)(1)</p>

IF THE CONTACT IS:	AND:	YOU MUST:	THEN YOU CAN:	REFERENCE
<p>5. Legal representative as defined by the State.</p>	<p>Initially, these types of requests must come in as written requests in order to verify the relationship.</p> <p>To answer any questions via the telephone, you must have proof of the arrangement for services on file or the representative's name must appear on the system (e.g., Master Beneficiary Record (MBR), Supplemental Security Income Record (SSR) or Inquiry Response Numident Identification screen (QRID)).</p> <p>The representative's name must match the name of the representative that is on file.</p>	<p>Verify the identity of the beneficiary by asking for his/her:</p> <ul style="list-style-type: none"> • Full name; • Date of birth; • HIC number; and • One additional piece of information such as SSN, address, phone number, effective date(s), whether he/she has Part A and/or Part B coverage. <p>Verify that the caller's name matches the representative's name in your files.</p>	<p>Release information to legal representatives (such as an attorney) pertaining to the matter for which they have been appointed as representative. You may assume the legal representative can receive any entitlement and claim information on behalf of the beneficiary unless it is evident by the documentation that they represent the beneficiary for limited services (i.e., financial representative only).</p>	<p>SSA training module – Title II Claims Representative Basic Training Course (CR-02) <u>Disclosure/Confidentiality/Privacy Act/ Freedom of Information</u></p> <p>POMS GN 03360.005 – Releasing Information by Telephone</p> <p>45 CFR 164.502(g)(1)</p>

IF THE CONTACT IS:	AND:	YOU MUST:	THEN YOU CAN:	REFERENCE
6. A beneficiary's spouse, relative, friend or advocacy group (<u>excluding</u> State Health Insurance Assistance Program (SHIP) employees and volunteers)	<p>The beneficiary gives verbal authorization for you to speak with the caller.</p> <p>(The beneficiary does not have to remain on the line during the conversation, or even be at the same place as the caller – you may obtain the beneficiary's authorization to speak with the caller via another line or three way calling.)</p>	<p>Verify the identity of the beneficiary by asking the beneficiary for his/her:</p> <ul style="list-style-type: none"> • Full name; • Date of birth; • HIC number; and • One additional piece of information such as SSN, address, phone number, effective date(s), whether he/she has Part A and/or Part B coverage. <p>A verbal authorization on file is good for 14 days. The CSR may advise the beneficiary and the caller that if the beneficiary wants the caller to receive information for more than 14 days, the beneficiary should send in a written authorization.</p>	Release any entitlement and claim information and answer any questions pertaining to the issue in question.	<p>MCM Part 2 §5104 A. 7-9</p> <p>MIM Part 2 §2958 A. 7-9</p> <p>45 CFR 164.510(b)</p>

IF THE CONTACT IS:	AND:	YOU MUST:	THEN YOU CAN:	REFERENCE
7. A beneficiary's spouse, relative, friend or advocacy group (<u>excluding</u> State Health Insurance Assistance Program (SHIP) employees and volunteers)	The beneficiary is not available to verbally authorize you to speak with the caller and there is no written authorization on file.	<p>Advise the caller that you may not give out any information without the beneficiary's authorization.</p> <p>The caller may call back at a later time when the beneficiary is available to give authorization.</p> <p style="text-align: center;">-Or-</p> <p>The beneficiary could provide</p>	<p>YOU MAY NOT release any claim information or answer any questions pertaining to the beneficiary.</p> <p>Advise the caller that the information is protected under the Privacy Act and the HIPAA Privacy Rule and it is for the beneficiary's protection that we will not</p>	<p>MCM Part 2 §5104 A. 7-9</p> <p>MIM Part 2§2958 A. 7-9</p> <p>MCM Part 3 §10010</p> <p>MIM Part 3 §3763</p>

		written authorization to allow the caller to obtain information about his or her record.	release the information.	45 CFR 164.510(b)
8. A beneficiary's spouse, relative, friend or advocacy group (excluding State Health Insurance Assistance Program (SHIP) employees and volunteers)	<p>You have written authorization on file that allows you to give beneficiary-specific information to the caller.</p> <p>See Notes at end of chart for information regarding written authorization.</p>	<p>The caller must provide the beneficiary's:</p> <ul style="list-style-type: none"> • Full name; • Date of birth; • HIC number; and • One additional piece of information such as SSN, address, phone number, effective date(s), whether he/she has Part A and/or Part B coverage. <p>Ensure that the caller is the authorized individual, and within the authorized time period (if specified).</p>	Only discuss information authorized by the written authorization.	<p>MCM Part 2 §5104 A. 7-9</p> <p>MIM Part 2 §2958 A. 7-9</p> <p>45 CFR 164.510(b)</p>

IF THE CONTACT IS:	AND:	YOU MUST:	THEN YOU CAN:	REFERENCE
<p>9. A beneficiary's spouse, relative, friend or advocacy group (<u>excluding</u> State Health Insurance Assistance Program (SHIP) employees and volunteers)</p>	<p>Previous written authorization has expired.</p>	<p>In order to access the beneficiary's record, the caller must provide the beneficiary's:</p> <ul style="list-style-type: none"> • Full name; • Date of birth; • HIC number; and • One additional piece of information such as SSN, address, phone number, effective date(s), whether he/she has Part A and/or Part B coverage. <p>Advise the caller that the written authorization has expired.</p> <p>Obtain the beneficiary's verbal authorization and/or develop for a new written authorization.</p>	<p>Unless you receive a verbal authorization, YOU MAY NOT release any claim information or answer any questions pertaining to the beneficiary.</p> <p>Advise the caller that the information is protected under the Privacy Act and the HIPAA Privacy Rule and it is for the beneficiary's protection that we will not release the information.</p> <p>However, if the caller has a question about a specific claim, see the instructions regarding release of information on a specific claim.</p>	<p>MCM Part 2 §5104 A. 7-9</p> <p>MIM Part 2 §2958 A. 7-9</p> <p>45 CFR 164.510(b)</p>

IF THE CONTACT IS:	AND:	YOU MUST:	THEN YOU CAN:	REFERENCE
<p>10. A beneficiary's spouse, relative, friend or advocacy group (<u>excluding</u> State Health Insurance Assistance Program (SHIP) employees and volunteers) requesting information on a specific claim</p> <p>(No MSN/EOMB)</p>	<p>The beneficiary is not available to verbally authorize you to speak with the caller, there is no written authorization on file, and the caller does not have a copy of the MSN/EOMB, however the caller has the beneficiary's:</p> <ul style="list-style-type: none"> • Full name; • Date of birth; • HIC number; and • Information on a specific claim (e.g., date of service, physician name, procedure). 	<p>The CSR may suggest that the caller have the beneficiary forward written authorization to the call center if he/she anticipates any need for future telephone contacts.</p>	<p>Release information only:</p> <ul style="list-style-type: none"> • On whether or not the claim has been received or processed, and • The date the beneficiary can expect to receive the EOMB or MSN. 	<p>MCM Part 2 §5104 A. 7-9</p> <p>MIM Part 2 §2958 A. 7-9</p> <p>45 CFR 164.510(b)</p>
<p>11. A beneficiary's spouse, relative, friend or advocacy group (<u>excluding</u> State Health Insurance Assistance Program (SHIP) employees and volunteers) requesting information on a specific claim</p> <p>(Has MSN/EOMB)</p>	<p>The beneficiary is not available to verbally authorize you to speak with the caller and there is no written authorization on file, however the caller has the beneficiary's:</p> <ul style="list-style-type: none"> • Full name; • Date of birth; • HIC number; and • Copy of the MSN or EOMB. 	<p>The CSR may suggest that the caller have the beneficiary forward written authorization to the call center if he/she anticipates any need for future telephone contacts.</p>	<p>Only release information for the service(s) that appear on the MSN or EOMB.</p>	<p>MCM Part 2 §5104 A. 7-9</p> <p>MIM Part 2 §2958 A. 7-9</p> <p>45 CFR 164.510(b)</p>

IF THE CONTACT IS:	AND:	YOU MUST:	THEN YOU CAN:	REFERENCE
<p>12. A beneficiary's spouse, relative, friend or advocacy group (<u>excluding</u> State Health Insurance Assistance Program (SHIP) employees and volunteers)</p>	<p>The caller states that the beneficiary is deceased.</p>	<p>In order to access the beneficiary's record, the caller must provide the beneficiary's:</p> <ul style="list-style-type: none"> • Full name; • Date of birth; • HIC number; and • One additional piece of information such as SSN, address, phone number, effective date(s), whether he/she has Part A and/or Part B coverage. <p>If you DO NOT have proof of death (i.e., date of death shown on Common Working File (CWF), Master Beneficiary Record (MBR), advise the caller to notify SSA at 1-800-772-1213 that beneficiary is deceased.</p>	<p>YOU MAY NOT release any claim information or answer any questions pertaining to the beneficiary</p> <p>Advise the contact that the information is protected under the Privacy Act and the HIPAA Privacy Rule and it is for the beneficiary's protection that we will not release the information. Advise the caller that the request should be in writing, include the authority under which the caller is making the request (e.g., executor, next of kin) and must state why the information is sought.</p> <p>However, if the caller has a question about a specific claim, see the instructions regarding release of information on a specific claim. (See #10 or #11.)</p>	<p>MCM Part 3 §10022</p> <p>MIM Part 3 §3767</p> <p>45 CFR 164.502(g)(4)</p>

IF THE CONTACT IS:	AND:	YOU MUST:	THEN YOU CAN:	REFERENCE
13. A State Health Insurance Assistance Program (SHIP) employee or volunteer	One of the following applies: <ul style="list-style-type: none"> • You have a verbal or written authorization allowing you to speak with the SHIP employee or volunteer; or • The SHIP employee or volunteer is listed on the SHIP roster as an approved contact. 	In order to access the beneficiary's record, the caller must provide the beneficiary's: <ul style="list-style-type: none"> • Full name; • Date of birth; • HIC number; and • One additional piece of information such as SSN, address, phone number, effective date(s), whether he/she has Part A and/or Part B coverage. 	Release any entitlement and claim information and answer any questions pertaining to the issue in question.	MCM Part 2 §5104 A. 7-9 MIM Part 2 §2958 A. 7-9 45 CFR 164.510(b)
14. A State Health Insurance Assistance Program (SHIP) employee or volunteer	The beneficiary is not available to verbally authorize you to speak with the caller and there is no written authorization on file and the caller is NOT listed on the SHIP roster as an approved contact.	Advise the caller that you may not give out any information without the beneficiary's authorization. The caller may call back at a later time with the beneficiary present to give authorization -Or- The beneficiary could provide written authorization to allow the caller to obtain information about his or her record.	YOU MAY NOT release any claim information or answer any questions pertaining to the beneficiary. Advise the caller that the information is protected under the Privacy Act and the HIPAA Privacy Rule and it is for the beneficiary's protection that we will not release the information.	MCM Part 2 §5104 A. 7-9 MIM Part 2§2958 A. 7-9 MCM Part 3 §10010 MIM Part 3 §3763 45 CFR 164.510(b)

IF THE CONTACT IS:	AND:	YOU MUST:	THEN YOU CAN:	REFERENCE
15. Congressional Office	The Congressional staff member states that he/she is calling at the request of the beneficiary (and not on behalf of someone else about the beneficiary).	<p>In order to access the beneficiary's record, the caller must provide the beneficiary's:</p> <ul style="list-style-type: none"> • Full name; • Date of birth; • HIC number; and • One additional piece of information such as SSN, address, phone number, effective date(s), whether he/she has Part A and/or Part B coverage. <p>Document the name and title of the caller.</p>	Release any entitlement and claim information and answer any questions pertaining to the issue in question.	<p>MCM Part 3 §10020 E 1a</p> <p>MIM Part 3 §3763 E 1a</p> <p>45 CFR 164.510(b)</p>

IF THE CONTACT IS:	AND:	YOU MUST:	THEN YOU CAN:	REFERENCE
16. A CMS employee	<p>The CMS employee provides the following information in order to identify the beneficiary in question.</p> <ul style="list-style-type: none"> • Full name • Date of birth • HIC number • One additional piece of information such as SSN, address, phone number, effective date(s), whether he/she has Part A and/or Part B coverage. 	<p>There are three ways that a CSR may verify that he/she is speaking with a CMS employee.</p> <ul style="list-style-type: none"> • Both parties on the call look at the CWF or MBR record (or other beneficiary record to which they both have access). The CSR or CMS employee can name a field on the CWF or MBR and ask that the other party identify what is in that particular field. <p>OR</p> <ul style="list-style-type: none"> • The CSR should ask for the CMS employee's phone number and call him/her back, making sure that the area code and exchange is correct 	If the CSR is reasonably certain that he/she is speaking to a CMS employee, the CSR may release any claim information and answer any questions pertaining to the issue in question.	<p>45 CFR Subtitle A 5b.5 (v)</p> <p>MCM Part 3 §10020 E 2</p> <p>MIM Part 3 §3764 E 2</p> <p>POMS GN 03310.005</p> <p>45 CFR 164.506</p>

		<p>for the CO or RO location;</p> <p>NOTE: Caller ID or similar service may be used to verify the area code and exchange in lieu of a callback.</p> <p><u>OR</u></p> <ul style="list-style-type: none"> The CSR should take the name and number of the agency employee, the name and number of his/her supervisor, the date and reason for the inquiry, and post this information to the "NOTES" screen. 		
IF THE CONTACT IS:	AND:	YOU MUST:	THEN YOU CAN:	REFERENCE
<p>17. An employee of another Federal agency (e.g., SSA, RRB, VA, DoD) who needs the information to perform duties on behalf of that agency</p>	<p>The employee of the other agency provides the following information in order to identify the beneficiary in question:</p> <ul style="list-style-type: none"> Full name; Date of birth; HIC number; and One additional piece of information such as SSN, address, phone number, effective date(s), whether he/she has Part A and/or Part B coverage. <p>Ensure that the reason for the inquiry is related to the administration of that agency's program.</p>	<p>There are three ways that a CSR may verify that he/she is speaking with an employee of another agency.</p> <ul style="list-style-type: none"> Both parties on the call look at the MBR record (or other beneficiary record to which they both have access). The CSR can name a field on the MBR and ask that the other agency's employee identify what is in that particular field. <p><u>OR</u></p> <ul style="list-style-type: none"> The CSR should ask for the employee's phone number and call him/her back, making sure that the area code and exchange matches a listed phone number for that agency; <p>NOTE: Caller ID or similar service may be used to verify the area code and exchange in lieu of a callback.</p> <p><u>OR</u></p>	<p>If the CSR is reasonably certain that he/she is speaking to the other agency's employee, the CSR may release any claim information and answer any questions related to the administration of that agency's program.</p>	<p>MCM Part 3 §10013</p> <p>MIM Part 3 §3765</p> <p>MCM Part 3 §10020 E 2</p> <p>MIM Part 3 §3764 E 2</p> <p>MCM Part 3 §10037</p> <p>MIM Part 3 §3772</p> <p>POMS GN 03310.015</p> <p>45 CFR 164.506</p>

		<ul style="list-style-type: none"> The CSR should take the name and number of the agency employee, the name and number of his/her supervisor, the date and reason for the inquiry, and post this information to the "NOTES" screen. 		
IF THE CONTACT IS:	AND:	YOU MUST:	THEN YOU CAN:	REFERENCE
<p>18. State Agencies administering Medicaid</p> <p>Inform the caller that State agencies must get this information through the channels formerly referred to as BEST/CASF.</p> <p>Advise the caller that instructions on the process can be found at http://www.cms.hhs.gov/state/letters/</p>	<p>If the caller has an issue that cannot be resolved using the instructions found at http://www.cms.hhs.gov/state/letters/, the CSR may resolve the issue after verifying that the caller is an employee of the State Medicaid agency.</p> <p>The employee of the State Medicaid agency provides the following information in order to identify the beneficiary in question:</p> <ul style="list-style-type: none"> Full name; Date of birth; HIC number; and One additional piece of information such as SSN, address, phone number, effective date(s), whether he/she has Part A and/or Part B coverage. <p>Ensure that the reason for the inquiry is related to the administration of that agency's program.</p>	<p>There are three ways that a CSR may verify that he/she is speaking with an employee of State Medicaid agency.</p> <ul style="list-style-type: none"> Both parties on the call look at the MBR record (or other beneficiary record to which they both have access). The CSR can name a field on MBR and ask that the other agency's employee identify what is in that particular field. <p>OR</p> <ul style="list-style-type: none"> The CSR should ask for the employee's phone number and call him/her back, making sure that the area code and exchange matches a listed phone number for that agency; <p>NOTE: Caller ID or similar service may be used to verify the area code and exchange in lieu of a callback.</p> <p>OR</p> <ul style="list-style-type: none"> The CSR should take the name and number of the agency employee, the name and number of his/her supervisor, the date and reason for the inquiry, and post this information to the "NOTES" screen. 	<p>The CSR may release any claim information and answer any questions related to the administration of State Medicaid agency's program.</p>	<p>MCM Part 3 §10031 A</p> <p>MIM Part 3 §3770</p> <p>http://www.cms.hhs.gov/state/letters/</p> <p>45 CFR 164.506</p>

IF THE CONTACT IS:	AND:	YOU MUST:	THEN YOU CAN:	REFERENCE
19. Complementary health insurance (Medigap, complementary crossover, supplemental)	The beneficiary has signed an agreement with the complementary health insurer granting that company the authorization to receive Medicare claim information.	<p>Verify the complementary health insurer is identified on the beneficiary's file.</p> <p>Verify the identity of the beneficiary in question by asking for his/her:</p> <ul style="list-style-type: none"> • Full name; • Date of birth; • HIC number; and • One additional piece of information such as SSN, address, phone number, effective date(s), whether he/she has Part A and/or Part B coverage. 	Answer any question pertaining to the beneficiary's claims that should have crossed over to the complementary insurer.	45 CFR 164.506
IF THE CONTACT IS:	AND:	YOU MUST:	THEN YOU CAN:	REFERENCE
20. Medicare Contractor (Fiscal Intermediary/Carrier/DMERC/RHHI)	<p>The Medicare Contractor being contacted processed the claim in question.</p> <p>Verify the identity of the beneficiary in question by asking for his/her:</p> <ul style="list-style-type: none"> • Full name; • Date of birth; • HIC number; and • One additional piece of information such as SSN, address, phone number, effective date(s), whether he/she has Part A and/or Part B coverage. 	<p>There are three ways that a CSR may verify that he/she is speaking with an employee of another agency.</p> <ul style="list-style-type: none"> • Both parties on the call look at the MBR record (or other beneficiary record to which they both have access). The CSR can name a field on MBR and ask that the other agency's employee identify what is in that particular field. <p>OR</p> <ul style="list-style-type: none"> • The CSR should ask for the employee's phone number and call him/her back, making sure that the area code and exchange matches a listed phone number for that agency; <p>NOTE: Caller ID or</p>	If the CSR is reasonably certain that he/she is speaking to the other contractor's employee, the CSR may release any claim information and answer any questions pertaining to the beneficiary's claims that were processed by the Medicare Contractor being contacted.	45 CFR 164.506

		<p>similar service may be used to verify the area code and exchange in lieu of a callback.</p> <p>OR</p> <ul style="list-style-type: none"> The CSR should take the name and number of the agency employee, the name and number of his/her supervisor, the date and reason for the inquiry, and post this information to the "NOTES" screen. 		
IF THE CONTACT IS:	AND:	YOU MUST:	THEN YOU CAN:	REFERENCE
21. Other Health Insurer (MSP involved)	The beneficiary has signed an agreement with the other health insurer granting that company the authorization to receive Medicare claim information.	<p>Verify the identity of the beneficiary in question by asking for his/her:</p> <ul style="list-style-type: none"> Full name; Date of birth; HIC number; and One additional piece of information such as SSN, address, phone number, effective date(s), whether he/she has Part A and/or Part B coverage. <p>Refer the caller to the Coordination of Benefits (COB) Contractor for all Medicare Secondary Payer (MSP) inquiries (<u>except claims-related questions and termination of MSP situations related to an accident, illness or injury</u>) including:</p> <ul style="list-style-type: none"> The reporting of potential MSP situations Changes in a beneficiary's insurance coverage Changes in employment, End Stage Renal Disease (ESRD) entitlement 	You may answer any questions pertaining to the beneficiary's file that are necessary to coordinate benefits.	<p>MCM Part 3 10025 C</p> <p>MIM Part 3 3768 C</p> <p>Program Memorandum Intermediaries/Carriers Transmittal AB-00-129, Change Request 1460, Dated 12/19/00</p> <p>45 CFR 164.506</p>

		<p>issues,</p> <ul style="list-style-type: none">• All other general MSP questions. <p>Please note that questions about eligibility to the Medicare Program are NOT to be referred to the COB Contractor, whose main task is to ensure that the Medicare Program has current, accurate data about other insurance that Medicare beneficiaries have that may be primary to Medicare. The COB Contractor does not make Medicare eligibility determinations.</p> <p>COB Contractor Number 1-800-999-1118</p> <p>TTY/TDD 1-800-318-8782</p> <p>CSRs are available 8 am to 8 pm (Eastern Time)</p>		
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DEFINITIONS:

ACCESS – Releasing information in a Medicare record directly to the beneficiary to whom it pertains. A natural or adoptive parent of a minor child or a legal guardian can also have access when acting on behalf of the individual. A minor child may access his/her own record. Any person may have access to information maintained in his/her own record after identifying his/herself.

DISCLOSURE – Releasing information in a Medicare record to anyone other than the subject individual, legal guardian or parent of minor. The individual to whom the information pertains must authorize (either verbally or in writing) the disclosure of his/her personal information to the third party.

A REPRESENTATIVE PAYEE is a person or organization appointed by the Social Security Administration when it is determined that the beneficiary is unable (due to mental or physical incapability) to handle, manage or direct someone else to manage his/her own benefits, and it is determined to be in the best interest of the beneficiary to appoint a payee. The beneficiary does not have to be declared legally incompetent in order to use a representative payee. However, if a beneficiary is judged legally incompetent, they must have a payee. The representative payee may make any request or give any notice on behalf of the beneficiary. He/she may give or draw out evidence of information, get information, and receive any notice in connection with a pending claim or asserted rights. The payee has the responsibility to handle all matters related to Social Security and Medicare on behalf of the beneficiary.

A LEGAL REPRESENTATIVE is appointed by the beneficiary to handle specific areas of concern on his/her behalf. The legal representative may only receive information related to the reason he/she was appointed (e.g., health care decisions, financial matters). The beneficiary does not have to be unable to handle his/her affairs.

Certain individuals are entitled to Medicare, but not entitled to Social Security benefits and are directly billed for the Medicare premium payments. If SSA determines that an individual is not capable of handling his/her premium payments, or at the individual's request, SSA will appoint a PREMIUM PAYER. A premium payer is similar to a representative payee and can be given information related to Medicare claims.

A RELATIONSHIP exists when a provider/physician/supplier has rendered, or is rendering, health services to a beneficiary.

The DATE OF SERVICE is the date on which the beneficiary received health services from a provider, physician or supplier.

GENERAL NOTES:

Prior versions of this Disclosure Desk Reference for Call Centers specifically excluded the State Health Insurance Assistance Program (SHIP) employees and volunteers. This version includes a new category for SHIP employees and volunteers. Specific disclosure instructions on the process of validating the identity of the SHIP employees and volunteers via the use of rosters will be addressed in separate guidelines to be issued shortly. Continue your current practice until such instructions are published.

Blended call centers (those that answer both beneficiary and provider calls at the same place) may choose to answer provider calls regarding eligibility inquiries and claims issues on the beneficiary line if they have the ability to track the calls appropriately. Otherwise, they should refer the contact to the appropriate provider inquiry number.

An individual who makes a request by telephone must verify his/her identity by providing identifying particulars, which parallel the record to which notification or access is being sought. If the CSR determines that the particulars provided by telephone are insufficient, the requestor will be required to submit the request in writing or in person. Telephone requests will not be accepted where an individual is requesting notification of, or access to, sensitive records such as medical records.

Always remember that access and disclosure involve looking at a Medicare record and giving out information. If you do not have to look at a record (for example, in explaining a letter), access and disclosure rules are not involved. General (that is, non beneficiary-specific) information may be discussed at any time with any caller.

Medicare Customer Service Center (MCSC) employees must follow the MCSC rules governing disclosure which require CSRs to obtain at least four items of information to identify the beneficiary for claims information and six items when accessing the MBR or EDB. For consistency among contractors, we recommend that three of those items are the beneficiary's name, HIC number, and date of birth.

On all Medicare Customer Service Center (MCSC) calls dealing with Managed Care issues other than enrollment/disenrollment issues and dates, refer the contact to the Managed Care organization. You may not release any Managed Care claims information.

NOTE: Representative payees are not authorized to enroll or disenroll beneficiaries in Managed Care Organizations, unless the representative payee has that authority under State law.

The written authorization must:

- Include the beneficiary's name, and HIC;
- Specify the individual, organizational unit, class of individuals or organizational units who may make the disclosure;
- Specify the individual, organizational unit, class of individuals or organizational units to which the information may be disclosed;
- Specify the records, information, or types of information that may be disclosed;
- A description of the purpose of the requested use or disclosure (if the beneficiary does not want to provide a statement of the purpose, he/she can describe the use as "at the request of the individual");
- Indicate whether the authorization is for a one-time disclosure, or give an expiration date or event that relates to the individual or the purpose of the use or disclosure (e.g., for the duration of the beneficiary's enrollment in the health plan);

- Be signed and dated by the beneficiary or his/her authorized representative. If signed by the representative, a description of the representative's authority to act for the individual must also be provided; and
- A statement describing the individual's right to revoke the authorization along with a description of the process to revoke the authorization;
- A statement describing the inability to condition treatment, payment, enrollment or eligibility for benefits on whether or not the beneficiary signs the authorization;
- A statement informing the beneficiary that information disclosed pursuant to the authorization may be redisclosed by the recipient and may no longer be protected.

For non-English speaking beneficiaries, you must obtain the beneficiary's identifying information and verbal consent (via the AT&T language line or similar service, or other interpreter) prior to speaking with the friend, relative, etc.

If the Automated Voice Response (ARU) or Interactive Voice Response (IVR) system obtains the beneficiary's name, HIC number and DOB and one additional piece of information (such as SSN, address, phone number, effective date(s), whether they have Part A and/or Part B coverage) prior to the CSR answering, and this is evident to the CSR, it is not necessary to obtain that information again. The CSR should ask to whom they are speaking just to ascertain if it is the beneficiary or someone acting on the beneficiary's behalf.

If the ARU or IVR system is not currently programmed to obtain all of the disclosure elements, and it is necessary for the CSR to answer the call, the CSR should obtain the required data elements before disclosing any identifiable information.

These instructions do not change any requirements for contractors regarding the use of ARU/IVR systems. You are not authorized to reprogram the ARU or IVR at this time.

You can discuss diagnosis denials such as medical necessity, MSP and routine diagnosis services in order to explain the reason the claim was denied. Assist the caller if the diagnosis is in dispute.

EXAMPLE 1: The patient's claim denied for a routine physical exam (program exclusion). The CSR explains the reason the claim was denied was because of the routine diagnosis submitted on the claim. The patient explains that he/she was seeing the doctor for back pain. The CSR needs to advise the caller to contact the physician to discuss the reported diagnosis.

EXAMPLE 2: After receiving an auto/liability questionnaire, the beneficiary calls to report a service noted was not related to an accident/injury. The CSR should check the claims history to verify the presence of an open MSP auto/liability segment with an unrelated diagnosis. If an open MSP segment and an unrelated diagnosis are present on the claim, the CSR should follow established procedure for overriding the edit and adjusting the claim. This may include contacting the provider office first to confirm whether an erroneous unrelated diagnosis was reported. If an unrelated diagnosis was erroneously reported, the CSR may initiate an adjustment after receiving confirmation of the incorrect reporting from the provider office.

For situations not specifically addressed here, the CSR should use his/her discretion, taking care to protect the beneficiary's privacy and confidentiality. Refer situations in which the CSR is unsure of whether or not to release information to his/her supervisor or to the organization's privacy official.

Frequently Asked Questions on this topic may be found at <http://www.cms.hhs.gov/callcenters/QandA.asp>

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
R12COM	07/15/2005	Next Generation Desktop (NGD) Testing Requirements	08/15/2005	3493
R11COM	06/03/2005	FY 2005Beneficiary Telephone Customer Services Replaced by Transmittal 11	07/05/2005	3737
R10COM	05/27/2005	FY 2005Beneficiary Telephone Customer Services Replaced by Transmittal 11	06/27/2005	3737
R08COM	02/18/2005	Medicare Beneficiary Call Centers Will Begin Offering Preventive Services Information	03/14/2005	3706
R05COM	04/23/2004	Manual Instruction for Update Beneficiary Services Sections 5104 (MCM) and 2958 (MIM), and Beneficiary Services Section 20 of the Internet-Only Manual (IOM)	05/24/2004	3097
R03COM	12/09/2003	Renumbering Chapters 2 through 5 and Revision of Chapter 4	N/A	N/A
R01COM	10/01/2003	Initial Issuance of Chapters 1 through 5	N/A	N/A

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