CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-09 Medicare Contract Beneficiary and Provider Communications	Centers for Medicare & Medicaid Services (CMS)
Transmittal 26	**Date: August 7, 2009**
	Change Request 6482

NOTE: This instruction is being re-communicated to add the revision reference to section 30.3.8.1, Provider Customer Service statement and revision indicator on transmittal page that was inadvertently omitted. The revision reference of the section has been revised. The Transmittal Number, Date Issued and all other information will remain the same.

Subject: Provider Customer Service Program Updates

I. SUMMARY OF CHANGES: This change request reorganizes and updates chapter 6 and deletes chapter 3 in Pub.100-09, Medicare Contractor Beneficiary and Provider Communications Manual. Updates and clarifications are given concerning the guidelines applicable to the Provider Customer Service Program.

New / Revised Material
Effective Date: September 1, 2009
Implementation Date: September 8, 2009

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

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	Chapter / Section / Subsection / Title
D	3/Provider Inquiries
R	6/Table of Contents
R	Provider Customer Service Program Statement
R	6/10/Introduction to the Provider Customer Service Program (PCSP)
R	6/10.1/PCSP Listservs
N	6/10.2/PCUG Call
N	6/10.3/Integration of POE, PCC and PSS Activities in the PCSP
R	6/20/Provider Outreach and Education (POE)
R	6/20.1/Internal Development of Provider Issues

D	6/20.1.1/Internal Development of Provider Issues
D	6/20.1.2/Partnering With External Entities
R	6/20.2/Partnering with External Entities
D	6/20.2.1/Error Rate Reduction Data
D	6/20.2.2/Inquiry Analysis
D	6/20.2.3/Claims Submission Errors
D	6/20.2.4/Coordination with Medical Review
R	6/20.3/Data Analysis
R	6/20.3.1/Error Rate Reduction Data
R	6/20.3.2/Inquiry Analysis
R	6/20.3.3/Claims Submission Errors
R	6/20.3.4/Medical Review Referrals
D	6/20.3.4.1/Local Coverage Determinations
D	6/20.3.4.2/Education Resulting From Medical Review Referrals
D	6/20.3.4.3/Medicare Preventive Service Benefits
D	6/20.3.4.4/Electronic Claims Submissions
D	6/20.3.4.5/Remittance Advice
D	6/20.3.4.6/"Ask-the-Contractor" Teleconferences
R	6/20.4/Provider Education
N	6/20.4.1/Provider Bulletins/Newsletters
N	6/20.4.1.1/Alternative Distribution Methods
N	6/20.4.2/Direct Mailings
N	6/20.4.3/Training for New Medicare Providers
N	6/20.4.4/Training Tailored for Small Providers
N	6/20.4.5/Educational Topics
N	6/20.4.5.1/Local Coverage Determinations (LCDs)
N	6/20.4.5.2/Education Resulting from Medical Review Referrals
N	6/20.4.5.3/Medicare Preventive Service Benefits
N	6/20.4.5.4/Electronic Claims Submissions
N	6/20.4.5.5/Remittance Advice (RA)
R	6/20.5/POE Materials
D	6/20.5.1/Provider Service Plan (PSP)
D	6/20.5.2/Education Activity Report (EAR)

D	6/20.5.3/Error Rate Reduction Plan (ERRP)
R	6/20.6/Regular Meetings
R	6/20.6.1/POE Advisory Groups
R	6/20.6.2/"Ask-the-Contractor" Teleconferences (ACTs)
D	6/20.6.3/Considerations and Record Keeping for Fee Collection
D	6/20.6.4/Excess Revenues from Participant Fees
D	6/20.6.5/Refunds/Credits for Cancellation of Events
D	6/20.6.6/Recording of Training Events
N	6/20.7/POE Reporting
N	6/20.7.1/Provider Service Plan (PSP)
N	6/20.7.2/Education Activity Report (EAR)
N	6/20.7.3/Error Rate Reduction Plan (ERRP)
N	6/20.8/Charging Fees to Providers for Medicare Education and Training Activities
N	6/20.8.1/No Charge
N	6/20.8.2/Fair and Reasonable Fees
N	6/20.8.2.1/Materials
N	6/20.8.2.2/Education and Training Events
N	6/20.8.2.2.1/Reimbursement from Providers
N	6/20.8.3/Considerations and Record Keeping for Fee Collection
N	6/20.8.4/Excess Revenues from Participant Fees
N	6/20.8.5/Refunds/Credits for Cancellation of Events
N	6/20.8.6/Recording of Training Events
R	6/30/Provider Contact Center (PCC)
R	6/30.1/Inquiry Triage Process
N	6/30.1.1/Responding to Coding Questions
R	6/30.2/Provider Telephone Inquiries
R	6/30.2.1/General Inquiries Line
R	6/30.2.2/Teletypewriter (TTY) Lines
R	6/30.2.3/Inbound Calls
D	6/30.2.3.1/Providing Busy Signals
D	6/30.2.3.2/Queue Message
D	6/30.2.3.3/General Inquiries Line

R	6/30.2.4/Troubleshooting Problems
D	30.2.4.1/CSR Equipment Requirements
D	30.2.4.2/Sign-In Policy
D	30.2.4.3/CSR Identification to Callers
R	6/30.2.5/Requesting Changes to Telephone Configurations
R	6/30.2.6/Hours of Operation
R	6/30.2.7/Contact Center Closures
R	6/30.2.7.1/Pre-Approved Closures
R	6/30.2.7.2/Other Than Pre-Approved Closures
N	6/30.2.8/Providing Busy Signals
N	6/30.2.9/Queue Message
N	6/30.2.10/Contact Center Staffing
N	6/30.2.10.1/CSR Equipment Requirements
N	6/30.2.10.2/CSR Sign-in Policy
N	6/30.2.10.3/CSR Identification to Callers
N	6/30.2.11/Remote Monitoring Access
N	6/30.2.12/Contingency Plans
N	6/30.2.13/Guidelines for High Quality Responses to Telephone Inquires
N	6/30.2.13.1/Telephone Inquiries Quality Monitoring Program
N	6/30.2.13.2/Quality Call Monitoring Program Minimum Requirements
N	6/30.2.13.3/Recording Calls
N	6/30.2.13.4/QCM Calibration
N	6/30.2.14/CMS Monitoring
R	6/30.3/Provider Written Inquiries
R	6/30.3.1/Controlling Written Inquiries
R	6/30.3.2/Written Inquiry Storage
R	6/30.3.3/Telephone Responses
R	6/30.3.4/E-mail and Fax Responses
R	6/30.3.5/Check Off Letters
R	6/30.3.6/Quality Guidelines for Written Responses
D	6/30.3.6.1/Quality Written Correspondence Monitoring (QWCM) Program

D	6/30.3.6.2/QWCM Calibration
N	6/30.3.7/Stock Language/Form Letters
N	6/30.3.8/Written Inquiries Quality Monitoring Program
N	6/30.3.8.1/Quality Written Monitoring Program Minimum Requirements
N	6/30.3.8.2/QWCM Calibration
N	6/30.3.9/Replying to Correspondence from Members of Congress
R	6/30.4/Walk-In Inquiries
R	6/30.4.1/Guidelines for Walk-In Service
R	6/30.5/Provider Relations Research Specialists (PRRS)
R	6/30.5.1/Complex Provider Inquiries
R	6/30.5.2/Complex Beneficiary Inquiries
R	6/30.6/Inquiry Tracking
R	6/30.6.1/Updates to the CMS Standardized Provider Inquiry Chart
R	6/30.7/Fraud and Abuse
R	6/30.8/Surveys
N	6/30.8.1/Medicare Contractor Provider Satisfaction Survey (MCPSS)
N	6/30.8.2/Telephone Satisfaction Survey
N	6/30.8.3/Web Site Satisfaction Survey
D	6/30.9/Surveys
D	6/30.9.1/Customer Service Operations Surveys
D	6/30.9.2/Provider Satisfaction Surveys
D	6/30.9.2.1/Contractor Activities Related to the Medicare Contractor Provider Satisfaction Survey (MCPSS)
R	6/40/PCSP Staff Development and Education
R	6/40.1/POE Staff Training
R	6/40.2/PCC Staff Development and Training
R	6/40.2.1/Required Training
R	6/40.2.2/Provider Contact Centers Training Program
N	6/40.2.2.1/Closure Determinations
N	6/40.2.2.2/Provider Complaints
N	6/40.2.2.3/Training Schedule
N	6/40.2.2.4/Training Closures for More Than Four Hours

N	6/40.2.2.5/Provider Notifications
N	6/40.2.2.6/CSR and Correspondent Feedback
N	6/40.2.2.7/Training Information Reporting
D	6/40.2.3/Closure Determination
D	6/40.2.4/Provider Complaints
D	6/40.2.5/Training Schedule
D	6/40.2.6/Training Closures for More Than Four Hours
D	6/40.2.7/Provider Notifications
D	6/40.2.8/CSR Feedback
D	6/40.2.9/Reports
D	6/40.2.10/CMS Monitoring
R	6/40.3/PRRS Staff Training
R	6/50/Provider Self Service Technology
R	6/50.1/Interactive Voice Response System (IVR)
R	6/50.2/Provider Web Site
R	6/50.2.1/General Requirements
R	6/50.2.2/Webmaster and Attestation Requirements
R	6/50.2.3/Feedback Mechanism
R	6/50.2.4/Contents
R	6/50.2.4.1/Information from CMS
R	6/50.2.4.2/FAQs
R	6/50.2.5/Web Site Promotion
R	6/50.3/Electronic Mailing List/Listserv
R	6/50.3.2/Listserv Promotion
R	6/60/PCSP Performance Management
R	6/60.1/POE Listserv Membership
R	6/60.2.2/Call Completion
R	6/60.2.5/Callbacks
R	6/60.2.6/QCM Performance Standards
R	6/60.3.1/QWCM Performance Standards
R	6/60.3.2/Written Inquiries Timeliness
N	6/60.3.2.1/General Inquiries Timeliness
N	6/60.3.2.2/PRRS Timeliness - Provider Inquiries

N	6/60.3.2.3/PRRS Timeliness - Complex Beneficiary Inquiries (MAC Only)
N	6/60.3.2.4/Congressional Inquiries Timeliness
D	60.4/PRRS Timeliness
R	6/70/PCSP Data Reporting
R	6/70.1/Provider Inquiries Evaluation System (PIES) and Customer Service Assessment and Management System (CSAMS)
N	6/70.1.1/Access to PIES
N	6/70.1.2/Due Date for Data Submission
N	6/70.1.3/Data To Be Reported Monthly
R	6/70.2/Provider Customer Service Program Contractor Information Database (PCID)
N	6/70.2.1/Access to PCID
N	6/70.2.2/Contract Data to Be Reported in PCID
N	6/70.2.3/Inquiry Tracking Data to Be Reported in PCID
R	6/80.3.4/Requests for Information Available on the Remittance Advice
R	6/80.5.4/Authentication of Beneficiary Elements
R	6/90/Provider Inquiry Standardized Categories

III. FUNDING:
SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

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

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

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

Attachment - Business Requirements

Pub. 100-09	Transmittal: 26	Date: August 7, 2009	Change Request: 6482

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SUBJECT: Provider Customer Service Program Updates

Effective Date: September 1, 2009

Implementation Date: September 8, 2009

I. GENERAL INFORMATION

A. Background:

This change request reorganizes and updates chapter 6 and deletes chapter 3 in Pub 100-09, Medicare Contractor Beneficiary and Provider Communications Manual. Updates and clarifications are given concerning the guidelines applicable to telephone and written inquiries, as well as the Disclosure Desk Reference.

B. Policy:

Sections 1816 and 1874 of the Social Security Act require that Medicare contractors serve as a channel of communications for information to and from providers/suppliers. Medicare contractors are required by CMS to have Medicare provider (or supplier) communications and inquiries programs.

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6482.1	Contractors shall have staff from their Provider Outreach and Education (POE) function attend the monthly Provider Customer Service Program Contractor User Group (PCUG) teleconferences.	X	X	X	X	X					RRB
6482.2	Contractors shall regularly review their POE, Provider Contact Center (PCC) and Provider Self-Service (PSS) operations for ways that these activities can be integrated and existing resources leveraged to provide a comprehensive Provider Customer Service Program (PCSP) for providers.	X	X	X	X	X					RRB
6482.3	At CMS' request contractors shall provide CMS with	X	X	X	X	X					RRB

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	documentation of internal meetings and activities aimed at identifying issues within the contractor that warrant education and training.										
6482.4	Contractors shall use their discretion to determine if there are data sources other than those listed in the manual that should be analyzed to determine where provider education is needed.	X	X	X	X	X					RRB
6482.5	Contractors shall use inpatient claims error rate data as part of their error rate reduction efforts.	X		X	X	X					RRB
6482.6	Contractors shall also use the results of their inquiry analysis program to develop and deliver training to their contact center staff.	X	X	X	X	X					RRB
6482.7	To the extent possible, contractors shall use MLN products in their entirety and as published. If, on the occasion that MLN product information is simply "excerpted," contractors shall always indicate the "source" of the information on the excerpted material; i.e., all material shall be prefaced with the language "From the Medicare Learning Network…" and the material shall also include the official MLN logo. Additionally, if a contractor adds information pertinent to its jurisdiction to any MLN product or information, this language shall be clearly distinguished as an addition by the contractor and should not be attributed to the MLN.	X	X	X	X	X					RRB
6482.8	Medicare contractors bidding on MAC contracts shall not assume that their alternative distribution plan is automatically approved by CMS, even if their approach was previously accepted for a different Medicare contract.	X	X								
6482.9	Any new MAC who wishes to use an alternative distribution method shall submit a new proposal post award, and have it approved by CMS before using an alternative distribution method.	X	X								
6482.10	Contractors currently not approved for the alternative bulletin distribution process who wish to participate in the e-bulletin initiative shall submit a proposal that includes the following elements: **1.** Alternative distribution method (e.g. contractor Web site, CD-ROM); **2.** Documentation that electronic bulletins will contain the same information as paper bulletins;	X	X	X	X	X					RRB

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	3. Projected savings over paper distribution (person hours and/or dollars); **4.** Plans for use of projected savings; **5.** Estimated six months savings; and **6.** Total number of paper bulletins distributed during the previous six months.										
6482.11	At the request of CMS, contractors shall print and distribute hardcopy mailings to all or a subset of their active providers. Mailings shall be sent to the best address to reach the provider, not the billing agency used by the provider.	X	X	X	X	X					RRB
6482.12	Contractors shall establish and maintain a POE Advisory Group (POE AG).	X	X	X	X	X					RRB
6482.13	Each contractor shall have its own separate POE Advisory Group for each of its contracts.	X	X	X	X	X					RRB
6482.14	After each POE Advisory Group meeting, minutes shall be disseminated within 30 days to all group members, CMS and others who request them. These minutes shall also be posted on the contractor's website within 30 days.	X	X	X	X	X					RRB
6482.15	After each Ask-the-Contractor Teleconference (ACT), minutes or a question and answer document shall be disseminated within 30 days to CMS and others who request them. These minutes shall also be posted on the contractor's website within 30 days.	X	X	X	X	X					RRB
6482.16	The initial Error Rate Reduction Plan (ERRP) and the ERRP update shall follow the format required by CMS and shall describe how the contractor will utilize the CERT findings to develop and implement outreach and education efforts.	X	X	X	X	X					RRB
6482.17	There may be times when individual providers or provider associations offer to pay the travel costs for the contractor's POE staff so that this staff is able to attend and participate in provider meetings. In most instances contractor staff may accept the travel reimbursement if the event is being sponsored by a provider society/association. However, if the event is sponsored by an individual provider the contractor shall not accept	X	X	X	X	X					RRB

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	reimbursement.										
6482.18	Before accepting the provider association's offer, the contractor shall send their PO and Contract Specialist a copy of the event invitation letter, proposed agenda, and as applicable, issues upon which the contractor's staff is to give a presentation, or discuss as part of a panel or general question/answer discussion.	X	X								
6482.19	By the end of the first month of the contract year, each contact center shall appoint a primary provider inquiry contact person (i.e., the contact center manager or other designee.) The contact's name, business address, telephone number, and e-mail address shall be entered into the Provider Customer Service Program Contractor Information Database (PCID) system. If the contact person is replaced, the contractor shall submit the new contact information to PCID within 14 calendar days of the change.	X	X	X	X	X					RRB
6482.20	Contractors should have first level CSRs handle more complex inquiries.	X	X	X	X	X					RRB
6482.21	For workload reporting purposes, if a call is transferred between CSR levels, the inquiry shall remain open until it is fully resolved and shall only be counted once.	X	X	X	X	X					RRB
6482.22	Contractors shall be responsible for monitoring the adequacy of their telecommunications operations, and shall take the necessary action to quickly diagnose and correct any issues impacting their ability to provide telephone service to providers.	X	X	X	X	X					RRB
6482.23	Contractors shall inform CMS of any major interruptions to their telephone service. A major service interruption is defined as any incident lasting two or more hours that impacts the contact center's ability to receive calls or a total loss of service. The contractor shall send an e-mail to the service reports mailbox at servicereports@cms.hhs.gov with a copy to the PNS contractor's mailbox at pnstechsupport@flashpointis.com summarizing the problem and the steps taken to restore full service.	X	X	X	X	X					RRB
6482.24	Contractors who wish to adopt alternate hours of operation shall notify CMS by sending an email to the service reports mailbox at servicereports@cms.hhs.gov	X	X	X	X	X					RRB

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	within 30 days of the start of the contract year, or one month in advance of the anticipated change within a contract year.										
6482.25	Contractors shall notify CMS through PCID within 30 days of the start of the contract year about all pre-approved closures. Changes made to this schedule shall be updated in PCID within two weeks of the change.	X	X	X	X	X					RRB
6482.26	Contractors shall request permission to close the contact center on days other than those pre-approved by CMS through the service reports mailbox at servicereports@cms.hhs.gov at least three weeks before the date of the planned closure.	X	X	X	X	X					RRB
6482.27	Contact center staffing, including permanent and temporary staff, shall be based on the pattern of incoming calls per hour and day of the week, ensuring that adequate coverage of incoming calls is maintained throughout each workday for each geographic area serviced.	X	X	X	X	X					RRB
6482.28	Contractors shall provide CMS with remote access to their incoming provider inquiries toll free lines.	X	X	X	X	X					RRB
6482.29	Contractors shall enter the instructions and access codes to remotely monitor provider inquiry lines in PCID. Monthly changes to the codes shall be entered in PCID at least three days before the start of the next month.	X	X	X	X	X					RRB
6482.30	Contractors shall contact the Provider Network Services contractor at pnstechsupport@flashpointis.com if the contractor is unable to activate their disaster recovery message during a disruption of service.	X	X	X	X	X					RRB
6482.31	Contractors shall submit a Contingency Plan that includes all items outlined at http://www/cms.hhs.gov/FFSContReptMon. The plan shall also contain a Compliance Matrix that identifies where each item in the checklist can be found in the contractor's plan.	X	X	X	X	X					RRB
6482.32	Contractors shall ensure that all CSRs handling provider calls are monitored throughout the month. This includes calls handled by temporary employees, part-time employees, higher level CSRs and the Provider Relations Research Specialists (PRRS).	X	X	X	X	X					RRB
6482.33	Contractors who record calls for training and quality purposes shall notify providers that their call may be recorded.	X	X	X	X	X					RRB
6482.34	Contractors should request that a provider submit their inquiry in writing if the provider objects to having his	X	X	X	X	X					RRB

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	call recorded and the contractor cannot be stopped by an individual CSR.										
6482.35	On a quarterly basis, contractors shall submit to CMS five telephone calls for each line of business in their contract—Part A, Part B, HH+H and DME. These calls shall be actual provider inquiries responded to within the prior contract quarter. All calls submitted for calibration shall have been scored using the QCM tool and entered into the QCM database. All calls submitted via e-mail shall have all protected health information removed from the call. Calls are due on March 1st, June 1st, September 1st and December 1st.	X	X	X	X	X					RRB
6482.36	Every written inquiry shall receive a final response that accurately and completely addresses the issues contained in the incoming inquiry.	X	X	X	X	X					RRB
6482.37	For provider inquiry timeliness purposes, the date of receipt shall be counted as day one.	X	X	X	X	X					RRB
6482.38	By the end of the first month of the contract year contractors shall enter the physical address of where they store their provider written inquiries into PCID. This requirement only applies to those contractors who only maintain hard copy files. This requirement does not apply to contractors who maintain electronic versions of written inquiries. Any changes to this information shall be entered in PCID within 2 weeks of the change.	X	X	X	X	X					RRB
6482.39	Contractors shall allow CMS access to all written inquiries stored off site within 24 hours of notification to the contractor.	X	X	X	X	X					RRB
6482.40	Contractors shall use the CMS Writing Guide to assist them in preparing high-quality responses to provider written inquiries.	X	X	X	X	X					RRB
6482.41	Periodically CMS may request that contractor's submit their most frequently used stock language and/or form letters. CMS will review this language and provide suggestions on how the language can be improved. If CMS determines that the form letters and/or stock language contain accuracy errors or other errors that affect the readability and/or meaning of the response, contractors shall have 60 days from receipt of the information to make any necessary changes.	X	X	X	X	X					RRB
6482.42	Contractors shall include Congressional inquiries in the	X	X	X	X	X					RRB

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	universe of inquiries used to select the sample for Quality Written Correspondence Monitoring (QWCM).										
6482.43	On a quarterly basis, contractors shall submit to CMS five written inquiry cases for each line of business in their contract—Part A, Part B, HH+H and DME.. The cases shall be actual provider written inquiries responded to within the prior contract quarter. In addition, all cases must have been scored using the QWCM tool and entered into the QWCM database. Each case shall contain the incoming inquiry, response, screenshots showing any associated research done in order to supply the response, as well as a copy of the QWCM scorecard. Letters are due on March 1st, June 1st, September 1st and December 1st.	X	X	X	X	X					RRB
6482.44	PRRS staff shall identify provider education topics based on the complex inquiries received if the contractor determines that general provider education on these specific topics would be practical and useful to the provider community and reduce inquiries.	X	X	X	X	X					RRB
6482.45	A written inquiry that is transferred to the PRRS shall remain open and only be counted once.	X	X	X	X	X					RRB
6482.46	For Benefit Integrity Unit escalations, the contractor should consider the action complete and close the Complex Inquiry in NGD when the Benefit Integrity Unit referral is placed into the 2nd level screening work flow, and not when the 2nd level screening is complete.	X	X								
6482.47	Contractors shall report the number of telephone and written inquiries logged for each category and subcategory monthly. This data shall be entered in PCID within 15 days after the end of each month.	X	X	X	X	X					RRB
6482.48	Contractors shall use the MCPSS survey results and provider feedback to identify and implement process improvement initiatives, including activities for the PCC and POE.	X	X	X	X	X					RRB
6482.49	At the request of CMS, contractors shall work with CMS and CFI Group to implement the telephone satisfaction surveys, develop contractor specific custom questions for the telephone satisfaction surveys and participate in conference calls to discuss trends and enhancements related to the telephone satisfaction surveys.	X	X	X	X	X					RRB

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6482.50	At the request of CMS, contractors shall participate in the Web site Satisfaction Surveys.	X	X	X	X	X					RRB
6482.51	Contractors shall ensure that educational opportunities are afforded to all PCSP staff, and that staff are afforded promotion pathways through the design and implementation of the PCC and POE functions.	X	X	X	X	X					RRB
6482.52	Contractors shall have a training evaluation process in place for new hire and ongoing training to certify that the CSR or correspondent is ready to independently handle inquiries on the topics covered.	X	X	X	X	X					RRB
6482.53	Ongoing data analysis shall be used to determine training topics for PCC staff.	X	X	X	X	X					RRB
6482.54	Contractors shall train their CSRs and correspondents on the following topics at least once during the contract year: • Contractor's web site • CMS web site • MLN Matters Articles and Job Aids • Standardized Inquiry Chart • Privacy Act of 1974 and the Health Insurance Portability and Accountability Act	X	X	X	X	X					RRB
6482.55	Contractors who take advantage of the ability to close for up to 8 hours per month for training shall not use training time closures as the justification for poor performance.	X	X	X	X	X					RRB
6482.56	By the 10th of the next month, contractors shall report in PIES or CSAMS the number of hours closed for training during the month.	X	X	X	X	X					RRB
6482.57	Education and training opportunities shall provide PRRS staff with the knowledge and tools to enable them to answer the full range of complex beneficiary and provider inquiries while meeting CMS performance requirements and standards for PRRS.	X	X	X	X	X					RRB
6482.58	If approved by CMS, contractors should offer Internet technology for the transmission of and/or receipt of healthcare transactions.	X	X	X	X	X					RRB
6482.59	CSRs shall refer providers back to the IVR if they have questions about claims status or eligibility that can be handled by the IVR. CSRs may provide claims status and/or eligibility information if it is clear that the provider cannot access the information through the IVR because the IVR is not functioning.	X	X	X	X	X					RRB

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6482.60	As IVR functionality changes, the operating guide shall be updated timely and the revisions posted to the website.	X	X	X	X	X					RRB
6482.61	Webmasters shall pay close attention to the requirements for compliance with the requirements outlined in Section 508 of the Rehabilitation Act of 1973.	X	X	X	X	X					RRB
6482.62	If a Webmaster determines that the contractor's site is not in compliance with any of the CMS requirements, including the requirements outlined in Section 508, the contractor shall outline the steps it is taking to become compliant. This information shall be submitted with the attestation statement.	X	X	X	X	X					RRB
6482.63	Contractors shall provide the post office mailing address or e-mail address of their CMS Technical Monitor or PO as the referral point for feedback through their web site.	X	X	X	X	X					RRB
6482.64	Contractors should post the articles, information, or links that are relevant to their line of business (e.g. Part A, Part B HH+H or DME).	X	X	X	X	X					RRB
6482.65	If the an article, information or link has been revised, contractors shall ensure that the information posted on their Web site represents the most current instruction from CMS. Revised information shall be posted within seven calendar days after notification is sent. Contractors shall remove the article, information or link immediately if the accompanying change request has been cancelled or revised.	X	X	X	X	X					RRB
6482.66	Contractors shall determine if the PCC may also be an effective way to promote the contractor's provider education website.	X	X	X	X	X					RRB
6482.67	Subscriptions to the listserv shall also be promoted by the PCC.	X	X	X	X	X					RRB
6482.68	Contractors shall consider having CSRs register providers for their listserv during a call if the provider is not currently registered and the CSR believes the provider would benefit from the information provided through the listserv. Contractors shall also coordinate	X	X	X	X	X					RRB

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	with other areas of the contractor to encourage listserv registration.										
6482.69	MACs shall have their listserv population at 30 percent or higher of their active provider count one year after award. MACs who are awarded the same contract after a recomplete shall maintain the percentage of listserv registrants achieved in the last year of the previous contracting period during the first year of the new contract.	X	X	X	X	X					RRB
6482.70	MACs shall increase the percentage of active providers registered for their listserv by 5 percent per year.	X	X	X	X	X					RRB
6482.71	Any deviation from monitoring the required number of calls shall be documented by the contact center. Documentation shall be maintained in the event the number of calls monitored is questioned.	X	X	X	X	X					RRB
6482.72	Any deviation from monitoring the required number of written inquiries shall be documented by the contact center. Documentation shall be maintained in the event the number of calls monitored is questioned.	X	X	X	X	X					RRB
6482.73	When a contractor sends an interim response, the final response shall be sent within 5 business days after receipt of the needed information. Any interim responses sent to general inquiries will count toward the contractor's overall allowance of no more than 5 percent of interim responses for the universe of written inquiries.	X	X	X	X	X					RRB
6482.74	Any days the contractor is closed for business, including Federal holidays, shall not count as business days for purposes of calculating written timeliness.	X	X	X	X	X					RRB
6482.75	PRRS staff shall provide clear and accurate responses within 25 business days for at least 75 percent of cases referred by the BCC or the CMS ROs; and 45 business days for 100 percent of all cases.	X	X								
6482.76	When an interim response is sent to a complex beneficiary inquiry, the final response shall be sent within 5 business days after receipt of the needed information. Any interim responses for complex	X	X								

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	beneficiary inquiries will count toward the contractor's overall allowance of no more than 5 percent of interim responses for the universe of written inquiries. Responses to complex beneficiary inquiries shall be documented in the NGD.										
6482.77	All Congressional written inquiries shall be responded to in writing within 10 business days.	X	X	X	X	X					RRB
6482.78	For those Congressional inquiries that cannot be answered in final within 10 business days, contractors shall issue an interim response within 10 business days explaining the reason for the delay.	X	X	X	X	X					RRB
6482.79	When an interim response is sent to a Congressional inquiry, the final response shall be sent within 5 business days after receipt of the needed information. Any interim responses sent to Congressional inquiries will count toward the contractor's overall allowance of no more than 5 percent of interim responses for the universe of written inquiries.	X	X	X	X	X					RRB
6482.80	All MACs shall use the Provider Inquiries Evaluation System (PIES) to report telephone and written performance data.	X	X								
6482.81	Incoming MACs shall request access to PIES for at least one staff member within 30 days after contract award.	X	X								RRB
6482.82	Each contact center shall enter required contact center data elements into PIES or CSAMS between the 1st and 10th of each month for the prior month.	X	X	X	X	X					RRB
6482.83	To change data after the 10th of the month, users shall inform CO of the requested change via the appropriate resource mailbox. Changes to PIES data shall be submitted to pie-system@cms.hhs.gov. Changes to CSAMS data shall be submitted to csams@cms.hhs.gov.	X	X	X	X	X					RRB
6482.84	Incoming MACs shall request access to PCID for at least one staff member within 30 days after contract award.	X	X								RRB
6482.85	Contractors shall be responsible for entering and maintaining the following data elements in PCID: • Number of Active Providers Served • Approved Closures	X	X	X	X	X					RRB

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	• Number of Listserv Registrants • Remote Monitoring Procedures • IVR Information • Contractor Mailing Address • Contractor Web site Address • Location of Written Inquiries, if applicable • Emergency Contact Information • Contractor Points of Contact ▪ PCSP Program Manager (MAC only) ▪ POE Contact (Primary) ▪ Contact Center Contacts										
6482.86	Contractors shall populate the required data elements within 60 days after award. If the data is not available at that time, it shall be entered within 7 calendar days after it becomes available. Changes/updates to any of the data points maintained by contractors shall be made within 14 calendar days of the change. In addition, contractors shall review the data in the system at least monthly to determine if updates are necessary. Updates shall be entered by the 10th of the month for the prior month.	X	X	X	X	X					RRB
6482.87	Contractors shall report their monthly telephone and written inquiry tracking information in PCID within 15 calendar days after the end of the month.	X	X	X	X	X					RRB
6482.88	Contractors who enter data in the Contractor-Specific fields in PCID shall complete the Excel spreadsheet on the PCID site, under the Documentation link and submit it to the provider services mailbox at providerservices@cms.hhs.gov with the subject line "Contractor-Specific Subcategories Report.	X	X	X	X	X					RRB
6482.89	Any changes that need to be made to the inquiry tracking reports after the reporting period has closed shall be sent to the PCID mailbox at p-cid@cms.hhs.gov.	X	X	X	X	X					RRB
6482.90	During a call, the CSR/correspondent should take the opportunity to educate the inquirer on how to read the RA, in an effort to encourage the use of self-service. The CSR/correspondent should advise the inquirer that the RA is needed in order to answer any questions for which answers are available on the RA. Providers should also be advised that any billing staff or	X	X	X	X	X					RRB

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	representatives that make inquiries on his/her behalf will need a copy of the RA.										
6482.91	Contractors shall follow the authentication procedures in the Disclosure Desk Reference when calling a provider back with a response to an inquiry.	X	X	X	X	X					RRB
6482.92	If preventive services change before the Disclosure Desk Reference is updated, contractors shall use the most current list of preventive services when determining what information can be released.	X	X	X	X	X					RRB
6482.93	Contractors shall log calls using the correct categories and sub-categories on the Standardized Inquiry chart—including the new category for DME Competitive Bidding and the subcategories for PQRI and E-Prescribing.	X	X	X	X	X					RRB

III. PROVIDER EDUCATION TABLE

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

IV. SUPPORTING INFORMATION

None

V. CONTACTS

Pre-Implementation Contact(s): Amy Abel-Matkins, 410-786-1858, amy.abel-matkins@cms.hhs.gov

Post-Implementation Contact(s): Amy Abel-Matkins, 410-786-1858, amy.abel-matkins@cms.hhs.gov

VI. FUNDING

Section A:

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

Section B:

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

Medicare Contractor Beneficiary and Provider Communications Manual

Chapter 6 - Provider Customer Service Program

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(Rev.26, 08-07-09)

Provider Customer Service Program

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

Deliverable dates and/or requirements in a *Medicare Administrative Contractor (MAC)* Statement of Work supersede any such dates or requirements stated in this chapter, where the two documents conflict. *Unless stated otherwise, MACs shall continue to send contract deliverables to their appropriate deliverables mailbox.*

In this chapter, the term provider applies to all Medicare provider and supplier types and the term contractor applies to all intermediaries, carriers and MACs.

In this chapter, the contract year for legacy contractors is the fiscal year.

10 – Introduction to Provider Customer Service Program (PCSP)

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

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

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

10.1 – *PCSP Listservs*

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

1. *Provider Customer Service Program User Group (PCUG) Listserv - To receive important and timely information from CMS related to the PCSP, including Customer Service Representative (CSR) training materials, written and telephone provider inquiry job aids, and quality assurance program updates contractors shall join the CMS PCUG Listserv. To join this listserv, contractors shall send an email to pcug_listserv@cms.hhs.gov. The email shall include the names and e-mail addresses of the individuals who are registering for the listserv. At a minimum, contractor contact center managers and quality analysts shall register*

for the listserv; however, several contractor staff may register for the listserv. There is no limitation as to the number of registrants for any contractor.

2. *Contractor Listserv – to receive important and timely information to share with your provider community, including* updates to the CMS Web site, provider education material and copies of proposed and final regulations *contractors shall join the CMS Contractor Listserv. To join this listserv, contractors shall send an* email to learnresource-l@cms.hhs.gov. The email shall include the e-mail addresses of the individuals, as well as a permanent corporate / resource box, at the contractor who are registering for the listserv. Several contractor staff shall register for this listserv. There is no limitation as to the number of registrants for any contractor. At a minimum, contractor contact center managers and managers overseeing provider *outreach and* education activities shall register for the listserv.

10.2 – PCUG Call

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

The PCUG conference call is held monthly with staff from the contractor's PCSP functions. The call allows CMS to update contractors on issues, directives and policies impacting the PCSP and provides a forum for contractors to ask questions and share ideas. Contractors shall ensure that staff from their PCC and POE functions attend the monthly PCUG calls. Contractors may submit topics for consideration in agenda planning to the PCUG mailbox at pcug_listserv@cms.hhs.gov. Further information about the PCUG, including schedules, can be found at:
http://www.cms.hhs.gov/FFSProvCustSvcGen/

10.3 - Integration of POE, PCC and PSS Activities in the PCSP

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

Since the PCSP is an integration of POE, PCC and PSS activities, contractors shall regularly review their operations for ways that these activities can be integrated and existing resources leveraged to provide a comprehensive PCSP to providers in their jurisdiction. Contractors shall look at how POE activities can reduce the need for providers to call the PCC, how actions taken by CSRs in the PCCs can incorporate education resources into a call or written response without adding significant time to the call length and how the interactive voice response (IVR) system can be used to publicize the listserv or upcoming training, seminars, etc. Examples include providing upcoming education information available to CSRs, so that if they receive a question on a particular topic for which a provider training is scheduled or for which a computer based-training is available, they can give the inquirer information about the training and/or how to sign up for it or access it. Another example is to have CSRs or the IVR system convey information about how to sign up for the provider listserv or to publicize the contractor's provider education Web site while callers are on hold. Contractors are also encouraged to give POE staff and PCC staff, including CSRs, avenues to provide feedback to each other with the goal of coming up with ways that assist both areas with

accomplishing their respective tasks by working together. Such sessions could periodically be part of the regularly scheduled CSR training classes, so that no additional time is taken from PCC operations.

Contractors or even individual contractor staff may already be doing these types of activities. For example, individual CSRs may routinely guide an inquirer though the provider education Web site or suggest that a provider sign up for the listserv. If so, contractors are encouraged to continue and increase these efforts. If these activities are not currently happening, then contractors shall implement these types of efforts.

20 – Provider Outreach and Education (POE)

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

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

Medicare contractors shall utilize a variety of strategies and methods to offer Medicare providers a broad spectrum of information about the Medicare program through a variety of communication channels and mechanisms—including print, Internet, telephone, CD-ROM, educational messages on the general inquiries line and IVR, face-to-face instruction, web-based training and presentations in classrooms and other settings. POE education may be delivered by clinical and non-clinical staff to groups or to individuals. The type and size of education delivered is at the discretion of the contractor, with the goal of effectively and efficiently using the POE funding to reduce the error rate, the number of provider inquiries and the number of claims errors. The CMS encourages contractors to be innovative in their identification of provider educational priorities and the methods used to deliver this education, including leveraging PCC and PSS resources to identify educational opportunities and expand delivery methods.

20.1 - Internal Development of Provider Issues

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

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

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

20.2 – *Partnering with External Entities*

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

Contractors shall *establish and maintain* partnerships with external entities to help disseminate Medicare provider information. Whenever feasible, events and activities shall be coordinated with other Medicare contractors and entities, including quality improvement organizations (QIOs), State Health Insurance Assistance Programs (SHIPs), and End Stage Renal Disease (ESRD) networks as well as interested groups, organizations, and CMS partners. In addition, contractors shall routinely and directly notify other interested entities of their upcoming provider education events and activities. Partnership activities shall not take the place of contractor-led POE events but shall supplement them.

Partnering entities may be medical, professional or trade groups and associations, government organizations, educational institutions, trade and professional publications, specialty societies, and other interested or affected groups. By establishing collaborative information dissemination efforts, providers will be able to obtain Medicare program information through a variety of sources. Partnering or collaborative provider information and education efforts *may* include, *but not be limited to*:

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

20.3 - *Data Analysis*

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

The contractor shall analyze all available data, such as: *CERT error rates, RAC data*, telephone and written inquiries *data*, claims submission errors, appeals *data*, CSR feedback, as well as feedback from across the contractor, as it develops an education methodology. The contractor should also use referrals from medical review, as discussed below. *The data elements listed in this section shall not be construed as an all-inclusive list. Contractors shall use their discretion to determine if their PCSP would benefit from analysis of data not mentioned in this section.*

20.3.1 – *Error Rate Reduction Data*

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

The contractor shall implement a provider education plan that focuses on reducing the CERT error rate. Contractors shall focus on data from the CERT and RAC programs, as appropriate. Additionally, contractors shall use other data sources such as provider inquiry tracking data and claims submission error data *as part of the analysis in developing their error rate reduction plan.*

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

20.3.2 - *Inquiry Analysis*

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

For provider inquiry analysis, contractors shall maintain a systematic and reproducible provider inquiry analysis program that will produce a monthly list of the most frequently asked questions (FAQs) beyond claims status and eligibility for telephone inquiries and written inquiries. Contractors shall utilize information or instructions furnished by CMS to classify or categorize provider inquiries. Educational efforts shall be developed and implemented to address the needs of providers as identified by this program. *Contractors shall also use the results of their inquiry analysis program to develop and deliver training to their contact center staff.*

20.3.3 - *Claims Submission Errors*

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

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

20.3.4 - Medical Review Referrals
(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

In accordance with IOM 100-8, Chapter 1 and IOM Pub 100-8, Chapter 3, POE staff is responsible for providing education as a result of referrals from medical review. As part of this process, POE staff shall maintain information about referrals from medical review, requests for education from providers, follow-up communication with medical review, and disposition of problems referred from medical review, including type of education given. (See §20.4.5.2 for further information.)

POE staff shall use this information to look for trends in the universe of probe review letters and priority referrals to determine whether broader education to the provider community may be warranted. POE staff shall also evaluate the medical review referrals and work with medical review to determine whether there are topics that are appropriate for FAQs to be posted on the contractor's Web site (see §50.2.4.2).

20.4 - *Provider Education*
(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

Whenever possible, contractors shall use CMS-provided national education materials in *their* provider outreach and education activities; i.e., *Medicare Learning Network (MLN)* products. *The MLN is a brand name for official CMS national provider education products designed to promote national consistency of Medicare provider information developed for CMS initiatives. It uses a variety of mechanisms, such as the Internet, national educational articles, brochures, fact sheets, web-based training courses, and videos, to deliver a planned and coordinated provider education program. The MLN uses these different mechanisms to provide educational opportunities that accommodate the healthcare professional's busy schedule, with the least amount of disruption to their normal business functioning.*

To the extent possible, contractors shall use MLN products in their entirety and as published. If, on the occasion that MLN product information is simply "excerpted," contractors shall always indicate the "source" of the information on the excerpted material; i.e., all material shall be prefaced with the language "From the Medicare Learning Network…" and the material shall also include the official MLN logo. Additionally, if a contractor adds information pertinent to its jurisdiction to any MLN product or information, this language shall be clearly distinguished as an addition by the contractor and should not be attributed to the MLN. All official *MLN* educational products are branded and available at http://www.cms.hhs.gov/MLNGenInfo/01_Overview.asp#TopOfPage.

20.4.1 - Provider Bulletins/Newsletters
(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

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

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

Contractors shall encourage providers to obtain electronic copies of bulletins/newsletters and other notices through the *provider education* Web site. If providers are interested in obtaining additional paper copies on a regular basis, contractors are permitted to charge a fee for this *service*. The subscription fee should be "fair and reasonable" and based on the cost of producing and mailing the publication.

20.4.1.1 - Alternative Distribution Methods

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

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

All contractors, including *MACs*, interested in alternative distribution methods, or contractors that want to modify their approved approach shall develop a proposal and submit *it to the provider service mailbox at* providerservices@cms.hhs.gov for approval. *Medicare contractors bidding on MAC contracts shall not assume that their alternative distribution plan is automatically approved by CMS, even if their approach was previously accepted for a different Medicare contract. Any MAC who wishes to use an alternative distribution method shall submit a new proposal post award, and have it approved by CMS before using an alternative distribution method.*

The elements of the proposal *shall* include:

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

Contractors shall submit an evaluation of their alternative distribution method six months from its implementation date. Follow-up evaluations are required whenever the approach is modified. Contractors shall submit all evaluations electronically to *the provider service mailbox at* providerservices@cms.hhs.gov. At a minimum, the evaluation shall include:

1. *An a*nalysis of why paper bulletins were requested by providers/suppliers, and suggestions of ways to assist them in getting electronic bulletins;

2. *The t*otal number of providers/suppliers receiving paper bulletins after six months; and

3. *Any positive or negative feedback received from providers regarding the distribution method*

20.4.2 – Direct Mailings

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

At the request of CMS, contractors shall print and distribute hardcopy mailings to all or a subset of their active providers. Mailings shall be sent to the best address to reach the provider, not the billing agency used by the provider. As such, contractors should consider using the correspondence address in PECOS if it is available.

20.4.3 - Training for New Medicare Providers

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

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

20.4.4 - Training Tailored for Small Providers

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

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

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

20.4.5 – Educational Topics
(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

Contractors shall use their discretion in determining the educational topics most relevant to their provider population. Various sources of information, including provider feedback, policy and procedure changes and contractor data analysis should be used to determine these topics; however, at a minimum, contractors shall educate providers on the topics outlined in this section.

20.4.5.1 – Local Coverage Determinations (LCDs)
(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

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

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

20.4.5.2 - Education Resulting from Medical Review Referrals
(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

In accordance with IOM 100-8, Chapter 1 and IOM Pub 100-8, Chapter 3, the contractor's medical review area will analyze medical review data and make two types of education referrals to POE—referrals resulting from probe reviews and priority referrals.

Probe Review Referrals: When medical review staff performs a probe review, the provider is notified about the review. These notification letters may include an offer for provider education to address the issues found in the probe. If education is requested by a provider in response to these letters, POE staff shall be responsible for providing this education. The education can be of any type the contractor deems appropriate, including one-on-one training, referral of the provider to available web training, and upcoming workshops containing information on the topic. The contractor shall ensure that POE staff has ready access to copies of the probe notification letters should a provider contact POE staff to request education.

Priority Referrals: A priority referral~~,~~ results when medical review staff believes that education is important for a provider or small group of providers in order to prevent further errors and reduce fraud. POE staff should collaborate with medical review when evaluating these referrals to determine what type of education, if any, is appropriate and whether this education fits with the overall contractor strategy to reduce the error rate.

The contractor is under no obligation to provide specific education in response to all medical review referrals. The education provided as a result of medical review shall be determined in the context of the contractor's goal of reducing the error rate within the resources available. The type of education and the involvement of clinical staff are at the discretion of the contractors. Contractors shall not charge for this education (See § 20.8.1).

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

20.4.5.3 - Medicare Preventive Service Benefits
(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

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

20.4.5.4 - Electronic Claims Submissions
(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

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

20.4.5.5 - Remittance Advice (RA)
(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

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

Providers receive an RA, which is a notice of payment and adjustment, once a claim has been received and processed. An adjustment refers to any change that relates to how a

claim is paid differently from the original billing. Adjustments can include *a* denied claim, zero payment, partial payment, reduced payment, penalty applied, additional payment and supplemental payment. Two important non-medical code sets are used to communicate an adjustment, or why a claim (or service line) was paid differently than *the provider* billed. These code sets are Claim Adjustment Reason Codes and Remittance Advice Remark Codes. Descriptions for both of these code sets appear at: http://www.wpc-edi.com/products/codelists/alertservice.

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

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

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

20.5 – POE *Materials*

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

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

All materials developed by Medicare contractors using CMS funding as the principal source for its development are considered the property of CMS, and shall be made available to CMS upon request. If a contractor reproduces or uses material, in whole or

in part, originally developed by another Medicare contractor, that contractor shall be acknowledged either within the material, or on its cover, case or container.

20.6 – *Regular Meetings*

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

20.6.1 - *POE Advisory Groups*

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

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

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

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

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

Contractors shall consider having more than one POE Advisory Group when the breadth of its geographic service area, or range of the providers serviced, diminishes the practicality and effectiveness of having a single Advisory Group. *Each contractor shall have at least one separate group for each of its contracts (i.e.at least one POE AG for each Jurisdiction). In addition, contractors shall not share an Advisory Group with another contractor.*

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

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

Meeting *times and* agendas, which include discussion topics garnered from solicitation of group members, shall be distributed to all members of the group and *to CMS* prior to any meeting. After each meeting, minutes shall be *posted on the contractor's Web site within 30 days.*

20.6.2 - *"Ask-the-Contractor" Teleconferences (ACTs)*

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

"Ask-the-Contractor" Teleconferences provide a means for providers to ask their contractors specific questions concerning billing and Medicare policies or procedures. *ACTs also provide a method of sharing information, and function as a tool for listening to the contractor's provider community.*

Contractors shall organize toll-free *ACTs* to complement, but not replace, the work of the Advisory Group *(See § 20.6.1).* Contractors shall offer ACTs at least quarterly. In designing ACTs, contractors shall consider other technological approaches, such as web-chat capabilities. Contractors shall also invite CMS Central and Regional Office staff to listen to ACTs. *After each meeting, minutes or a question and answer document shall be posted to the contractor's Web site within 30 days. It is not acceptable for contractors to just post the audio recording of the ACT if there were questions asked during the call that could not be answered during the call.*

Contractors shall use their *Advisory Group(s)* to assist in establishing the timing, frequency, size, topics, and provider type(s) to be included in ACTs. Contractors *shall* also use other methods for ACT topic identification such as inquiry analysis, claims

submission error analysis, Medical Review data analysis, *input from PCC staff* and information gathered through partnerships.

20.7 - POE Reporting

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

20.7.1 - Provider Service Plan (PSP)

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

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

Contractors shall send the final PSP electronically in MS Word by the last day of the first month of their contract year to CMS Central Office using the *provider services mailbox at providerservices@cms.hhs.gov*. *MACs shall send the final PSP to the appropriate CMS deliverables mailbox.* Contractors shall adhere to the PSP template/format and instructions located on the CMS Web site at http://www.cms.hhs.gov/FFSProvCustSvcGen/40_Contractor_Reporting.asp#TopOfPage for its PSP submission. Contractors shall ensure that they are utilizing the most recent version of the PSP template/format. Contractors shall be notified of updated templates via *the* CMS *PCUG* listserv described in §10.

20.7.2 – Education Activity Report (EAR)

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

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

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

providerservices@cms.hhs.gov. *MACs shall send the EARs to their appropriate CMS deliverables mailbox.*

Contractors shall adhere to the EAR template/format and instructions located on the CMS Web site *at* http://www.cms.hhs.gov/FFSProvCustSvcGen/40_Contractor_Reporting.asp#TopOfPage for its EAR submission. Contractors shall ensure that they are utilizing the most recent version of the EAR template/format. Contractors shall be notified of updated templates via the CMS *PCUG* listserv described in §10.

20.7.3 – Error Rate Reduction Plan (ERRP)

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

Every November, CMS publishes a report on Medicare fee-for-service improper payments. The report includes national, contractor-type, and contractor-specific error rates. Each CERT participating Medicare contractor responsible for a jurisdiction that received a contractor-specific error rate shall develop and submit an Error Rate Reduction Plan. The ERRP shall describe the corrective actions the contractor plans to take in order to lower the error rate. The Initial ERRP is due 30 days after the release of the annual (November) improper payments report.

After the release of the mid-year improper payments report, each CERT participating Medicare contractor shall submit an updated plan informing CMS of the progress on the error rate reduction actions described in the initial plan. Any changes to the plan should be made directly to the body of the plan in database and then summarized in the revision history portion of the ERRP. The ERRP Update is due 30 days after the release of the mid-year (May) improper payments report.

The initial ERRP and the ERRP update shall follow the format required by CMS and shall describe how the contractor will utilize the CERT findings to develop and implement outreach and education efforts.

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

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

CMS expects that contractors shall not charge for the development and presentation of provider education and training and provider education materials. However, there are some circumstances *for* which contractors may charge fair and reasonable fees to participants to offset or recover costs associated with educational activities.

20.8.1 – No Charge

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

Contractors shall not charge providers who are attending or participating in an educational event based upon a medical review identified need for education (See §*20.3.4* and §*20.4.5.2*).

20.8.2 – Fair and Reasonable Fees
(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

Note that "fair and reasonable" means that the fee charged is in line with the actual cost of the activity or item and is within the means of likely participants.

20.8.2.1 – Materials
(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

Contractors may charge a fair and reasonable fee for copies of information available on the contractor's Web site, including paper or other form (e.g., CD-ROM) sent directly to the provider (e.g., duplication costs, shipping and handling.)

20.8.2.2 – Education and Training Events
(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

Contractors may charge fair and reasonable fees in the following instances and/or for the following items to offset or recover the costs associated with the training or education activity or material*:*

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

20.8.2.2.1 – Reimbursement from Providers
(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

There may be times when individual providers or provider associations offer to pay the travel costs for the contractor's POE staff so that this staff is able to attend and participate in provider meetings. In most instances contractor staff may accept the travel reimbursement if the event is being sponsored by a provider society/association. However, if the event is sponsored by an individual provider the contractor shall not accept reimbursement.

Before accepting the provider association's offer, the contractor shall send their Project Officer (PO) and Contract Specialist a copy of the event invitation letter, proposed

agenda, and as applicable, issues upon which the contractor's staff is to give a presentation, or discuss as part of a panel or general question/answer discussion.

In all cases, contractors shall not accept speakers' fees*, but they may accept small gifts* such as pens engraved with the host logo, coffee mugs, plaques, flowers, etc. *C*ontractors are not permitted to accept and/or use substantive gifts or donations associated with participation in education and training activities absent specific authority from CMS.

20.8.3 - Considerations and Record Keeping for Fee Collection
(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

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

For each contract year, contractors shall keep records of the actual costs incurred for each event held. *Where applicable, these records shall contain information on the actual costs related to the following: facility rental, audio/visual equipment, light refreshments, development and/or duplication of materials. In addition, contractors shall keep records of all fees charged to, and collected from, registrants. These records shall be kept for at least one year from the date of the educational event and shall document actual costs used to support the fees charged.*

20.8.4 - Excess Revenues from Participant Fees
(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

Excess revenues from participant fees may occur when the total of the fees collected exceeds the total of the allowable costs. Contractors may use one of the following methodologies *to determine how to handle* any excess revenues collected from fee-associated provider education events:

Per event: The total fees *collected* for any event should not exceed the actual costs incurred for the event by more than 10 *percent*. If *the total collected is* less than 10 percent, the contractor may incorporate the excess revenue into its POE program. If *the total collected* exceeds 10 *percent*, the contractor shall *evenly* refund the entire excess amount collected to all registrants who paid a fee for *attending the* event. For example, the *contractor charged 250 participants a $50 registration fee for an event that cost the contractor $10,000 (for light refreshments, meeting facility, and equipment rental). Therefore, the contractor collects $12,500. Since the amount collected exceeds the cost of the event by more than 10 percent, the entire excess amount collected ($2,500) shall be equally disbursed back to all paying registrants.*

Per year: *At the end of the ninth month of the contract year,* the contractor shall total the fees collected to attend completed fee-associated provider education and training events for that year. *To that amount, the contractor shall add the estimated fees the contractor anticipates collecting* from all remaining scheduled *fee-associated* events. *The*

contractor shall subtract from this amount the total actual and anticipated costs for all past and future fee-associated education events for the contract year. The total remaining should not exceed the actual and expected costs incurred for the year by more than 25 percent. If the amount collected is 25 percent or less of total costs, the contractor shall note that amount in their 2nd EAR, and incorporate the excess revenue into its POE program. If the amount collected exceeds 25 percent of the total costs, the contractor shall send a message by the end of the tenth month of its contract year to the service reports mailbox at servicereports@cms.hhs.gov listing the amount of excess revenue collected and the contractor's plan to equally refund the entire excess revenue to everyone who attended any of the contractor's fee-based training events.

20.8.5 - Refunds/Credits for Cancellation of Events
(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

Contractors shall develop and implement a refund policy and apply it to any event for which they charge a fee. Contractors shall ensure event registrants are aware of the refund policy by including the policy, or a reference to it, on event registration *material* or advertising.

The CMS understands that in order to secure accommodations and services for planned provider training events, the contractor may have to make commitments under which it will incur contractual expenses. Contractors may take this into consideration when determining their refund/credit policy. The policy must, at a minimum, adhere to the following guidelines:

- *Contractors* shall make full or partial refunds/credits to providers who register for an event, *but* cancel before the event, or do not attend the event, and notify the contractor before the event

- *Contractors shall make full refunds i*f the contractor cancels the event

20.8.6 - Recording of Training Events
(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

Entities not employed by CMS, or under contractual arrangement are not permitted to videotape or otherwise record training events for profit-making purposes. If a contractor records a training event, then the contractor may charge a fee for the duplication and mailing of the videotapes or other records upon request.

30 - Provider Contact Center (PCC)
(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

CMS strives to continuously improve Medicare customer satisfaction through the delivery of high quality and cost-effective customer service. High quality customer service is accurate, convenient and accessible, courteous and professional, and responsive to the needs of diverse groups. It is important that all communication be coordinated to ensure

consistent responses, due to the various communication channels available to providers today. Medicare contractors shall develop a *PCC* offering a range of Medicare expertise to respond to telephone, written (letters, e-mail, *and* fax) and walk-in inquiries. The PCC assures a positive business relationship with Medicare providers through its responsiveness to provider's verbal and written inquiries. The PCC includes the provider *telephone inquiries staff*, the general written inquiries unit, and walk-in inquiries staff.

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

By the end of the first month of the contract year, each contact center shall appoint a primary provider inquiry contact person (i.e., the contact center manager or other designee.) The contact's name, business address, telephone number, and e-mail *address* shall be *entered into the Provider Customer Service Program Contractor Information Database (PCID) system*. If the contact person is replaced, the contractor shall submit the new contact information to *PCID within 14 calendar days* of the change. Contact centers shall also submit a high-level organizational chart for their provider inquiry function to servicereports@cms.hhs.gov.

30.1 - Inquiry Triage Process

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

Provider inquiries may require varying degrees of expertise to answer. Using a triage mechanism, the contact center shall be able to route general inquiries within the PCC to the system or person best equipped to respond, with a minimal degree of transfer. The triage procedures shall be used for telephone inquiries, but a contractor may choose to employ a similar mechanism to triage general written inquiries as well. Contractors should develop mechanisms to quickly identify complex written inquiries needing referral to the *Provider Relations Research Specialists (PRRS)*. Figure 1 illustrates the levels of complexity and the corresponding provider inquiry volume.

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

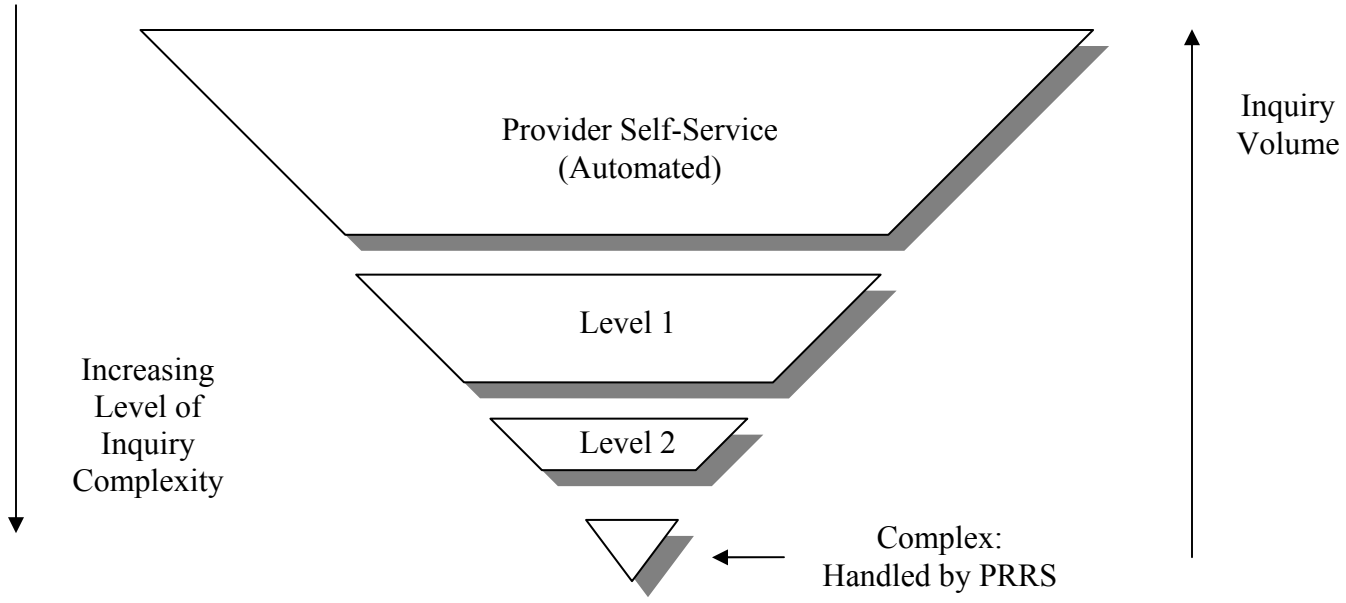
First level CSRs shall answer a wide range of basic questions that cannot be answered by the IVR or other interactive self-service technology. At a minimum, these CSRs shall handle questions that do not require substantial research and can easily be answered

during the initial call*; however, contractors may choose to have first level CSRs also handle more complex inquiries. In the event that a fist level CSR cannot answer an inquiry, they* shall have the authority to refer more complex questions to second level CSRs.

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

For workload reporting purposes, if a call is transferred between CSR levels, the inquiry shall remain open until it is fully resolved and shall only be counted once.

Figure 1



30.1.1- Responding to Coding Questions

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

Providers are responsible for determining the correct diagnostic and procedural coding for the services they furnish to Medicare beneficiaries. CSRs shall not make determinations about the proper use of codes for the provider. When providers inquire about interpretation of procedural and diagnostic coding they shall be referred to the entities that have responsibility for those coding sets. There are four places that CSRs shall refer callers *with* questions about coding.

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

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

3. Level II Healthcare Common Procedure Coding System (HCPCS) codes related to Durable Medical Equipment or prosthetics, orthotics, and supplies are answered by the *Pricing, Data Analysis and Coding (PDAC) Contractor*. *Information about the PDAC and the services it provides can be found at* https://www.dmepdac.com/.

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

30.2 – *Provider* Telephone *Inquiries*

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

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

30.2.1 – *General Inquiries Line*

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

The provider toll free numbers installed for *fee-for-service* claims processing contractors general provider inquiry traffic shall not be used for other applications (e.g., MSP, reviews, EDI, provider enrollment, and other non-claim related provider inquiries) beyond answering general questions for each application. At a minimum, these general

lines shall be used to handle questions related to billing, claims, eligibility, and payment. If contractors need new service for other Medicare applications currently being handled on the provider claims inquiry numbers, they shall follow the established process for adding additional toll free numbers. CMS will consider all requests for additional toll free numbers.

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

30.2.2 – *Teletypewriter (TTY) Lines*

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

In accordance with Section 508 of the Rehabilitation Act of 1973 and the Workforce Investment Act of 1998, all contact centers shall provide the ability for deaf, hard of hearing or speech-impaired providers to communicate via *TTY* equipment. A TTY is a special device permitting hard of hearing or speech-impaired individuals to use the telephone by allowing them to type messages back and forth to one another instead of talking and listening. (A TTY is required at both ends of the conversation in order to communicate.) Contractors shall publicize the TTY line on their web sites. This TTY shall also be applicable to beneficiary complex inquiries.

30.2.3 – *Inbound Calls*

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

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

30.2.4 - *Troubleshooting Problems*

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

Contractors shall be responsible for monitoring the adequacy of their telecommunications operations, and shall take the necessary action to quickly diagnose and correct any issues impacting their ability to provide telephone service to providers. To monitor and report a problem, contractors shall follow these steps:

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

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

    - External or Network Service Problem - *Contractors shall report the problem to the toll free carrier and also report to CMS per the steps below.*

2. Involve personnel from the *Provider Network Services (PNS) contractor*, if needed, to answer technical questions, *to escalate issues for resolution* or to facilitate discussions with the *toll free carrier's* Help Desk. *The PNS contractor can be contacted by sending an e-mail to pnstechsupport@flashpointis.com.*

3. File an incident report with *CMS and* the *PNS contractor* for major interruptions of service. *A* major *service* interruption is defined as any incident *lasting two or more hours that impacts the contact center's ability to receive calls* or a total loss of service. The contractor shall send an e-mail to *the service reports mailbox at* servicereports@cms.hhs.gov *with a copy to the PNS contractor's mailbox at* pnstechsupport@flashpointis.com *summarizing* the problem and the steps taken to restore full service. The contractor shall send a follow-up e-mail *to the service reports mailbox* when the problem has been resolved.

4. Use *the toll free carrier's online system* to review documentation *and* track trouble tickets online.

5. File a monthly report with CMS through *the service reports mailbox at* servicereports@cms.hhs.gov *regarding all service interruptions*.

30.2.5 – *Requesting Changes to Telephone Configurations*

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

The ongoing management of the entire provider toll free system requires a process for making changes, which may be initiated by either the contractor or CMS. All change requests associated with the *toll free* network (e.g., adding or removing channels or T1s, office moves, routing changes), shall be processed through *the PNS contractor*. Any CMS-initiated changes (i.e., adding lines, removing lines, reconfiguring trunk groups) will be based upon an analysis of *telephone performance data* and traffic reports. CMS reserves the right to initiate changes based on this information.

If a contractor requests *a change* they shall *send the request and* an analysis of their current telephone environment (including a detailed traffic report) specific to the service being requested that shows the need for changes to their phone system (e.g., additional lines, trunk group reconfiguration). *This information shall be sent to the service reports mailbox at* servicereports@cms.hhs.gov. This information shall be gathered through the

contractor's switch and through the *toll free carrier's* reports. Based on technical merit and availability of funds, CO will review the recommendation and make a determination. In cases where the request is approved, CO will forward *the* approved requests to the designated agency representative for order issuance.

30.2.6 – *Hours of Operation*

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

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

Normal business hours for live telephone service are defined as 8:00 a.m. through 4:00 p.m. for all time zones of the geographical area serviced, Monday through Friday. Where provider call volume supports it, the normal business hours may be shifted to 8:30 – 4:30 *p.m.* for all time zones. Contractors adopting these *alternate* hours shall notify CMS by sending an email to *the service reports mailbox at* servicereports@cms.hhs.gov *within 30 days of the start of the contract year*, or one month in advance of *the* anticipated change within a contract year.

30.2.7 – *Contact Center Closures*

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

Contractors shall report to CMS planned and unplanned closures of the PCC as required in the following paragraphs.

30.2.7.1 – *Pre-Approved Closures*

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

Including the ten Federal holidays, CMS allows contractors to close their contact centers on the following days without requesting approval:

- *New Year's Day*
- *Martin Luther King's Day*
- *President's Day*
- *Good Friday*
- *Memorial Day*
- *Independence Day*
- *Labor Day*
- *Columbus Day*
- *Veteran's Day*
- *Thanksgiving Day*
- *Day After Thanksgiving*
- *Christmas Eve*
- *Christmas Day*

- *Day After Christmas*

Contractors shall notify CMS through *PCID within 30 days of the start* of the contract year about *all* planned closures. Changes made to this schedule shall be *updated in PCID within two weeks of the change*. Contact centers shall notify the provider community of the planned closure at least two weeks in advance of closure.

30.2.7.2 – *Other Than Pre-Approved Closures*
(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

Contractors shall *request permission to close the contact center on days other than those pre-approved by CMS through the service reports mailbox at* servicereports@cms.hhs.gov at least three weeks before the *date of the* planned closure. If CMS *approves* the closure the contractor shall notify the provider community at least two weeks in advance of the closure.

30.2.8 - Providing Busy Signals
(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

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

30.2.9 - Queue Message
(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

Contractors shall provide a recorded message that provides the following information while callers are waiting in queue to speak to an available CSR:

- Anticipated time until the call will be answered including any temporary delays the provider may experience while waiting in queue
- Non-peak times for callers to call back when the contact center is less busy
- Information the provider should have available before speaking with a CSR
- Educational information on issues identified by the contractor (See § 20).

30.2.10 – Contact Center Staffing
(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

Contact center staffing, including permanent and temporary staff, shall be based on the pattern of incoming calls per hour and day of the week, ensuring that adequate coverage of incoming calls is maintained throughout each workday for each geographic area serviced. In order to provide adequate coverage of incoming calls throughout the day, contact centers have the discretion to end a telephone inquiry if the CSR is placed on hold for two minutes or longer. Contractors shall not disconnect a call prior to two minutes. Contractors shall, if possible, give prior notice to the caller that the CSR may disconnect if the CSR is placed on hold for two minutes.

30.2.10.1 – CSR Equipment Requirements
(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

To ensure that inquiries receive accurate and timely handling, contractors shall provide *each CSR with the following*:

- Online access to a computer terminal for each CSR responsible for claims-related inquiries. The computer terminal shall be physically located so that representatives can research data without leaving their desks/seats
- Access to the contractor's web site
- *Access to CMS' Web site*
- An outgoing line for callbacks

30.2.10.2 – CSR Sign-in Policy
(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

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

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

30.2.10.3 - CSR Identification to Callers
(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

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

30.2.11 - Remote Monitoring Access
(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

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

Contractors shall *enter* the instructions, *access codes and CSR IDs, when applicable,* to remotely monitor their provider inquiry toll free lines *in PCID*. If the contractor monitoring system requires changes in its access codes or other parts of the instructions from what was previously submitted, the contractor shall *enter* the revised instructions or access codes *in PCID* at least 3 business days before the beginning of the affected month.

30.2.12 – Contingency Plans
(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

When a contact center is faced with a situation that results in a major disruption of service, the contact center shall take the necessary action to ensure that callers are made aware of the situation. This is intended to supplement the contractor's existing contingency plans. Whenever possible, the contact center is responsible for activating its own emergency messages or re-routing calls. However, when this is not possible and providers are unable to reach the contact center switch, the contact center shall contact the *PNS contractor at pnstechsupport@flashpointis.com.* For all other *telecommunications* support requests, provider contact centers shall follow their normal procedures.

By the end of the third month of the contract year, contact centers shall submit to CMS their current written contingency plan describing how the Medicare provider telecommunications operations will be maintained or continued in the event of manmade or natural disasters. *The plan shall cover, at a minimum, all items outlined in the Contingency Plan Checklist located at* http://www.cms.hhs.gov/FFSContReptMon/Downloads/Contingency_Plan_Checklist.pdf *The plan shall also contain a Compliance Matrix that identifies where each item in the checklist can be found in the contractor's plan.* The plan may include arrangements with one or more other contractors to assist in telephone workload management during the time the contact center is unable to receive provider phone calls. Plans shall be submitted to the service reports mailbox at servicereports@cms.hhs.gov or via postal mail.

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

30.2.13 - Guidelines for High Quality Responses to Telephone Inquiries

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

30.2.13.1 – Telephone Inquiries Quality Monitoring Program

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

Contractors shall have a monitoring program in place to ensure the quality of telephone inquiries responses. The *monitoring program applies* to contractors' general provider inquiry telephone numbers. The standards shall not apply to those *telephone* inquiries handled by other units within the contractor (e.g., appeals, fraud, MSP).

As contractors are ultimately responsible for their responses to provider inquiries, contractors shall use the results of their *quality* program to identify, and act upon, areas of needed improvement, both for the PCC as a whole and for individual PCC staff. Contractors shall document their monitoring efforts and corrective action plans as applicable, and provide such information to CMS upon request.

30.2.13.2 - Quality Call Monitoring Program Minimum Requirements

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

The contractor's monitoring program shall, at a minimum, follow the requirements and performance standards as set forth in the Quality Call Monitoring (QCM) program. Copies of the *official* QCM *scorecard*, *User G*uide, *Handbook*, and *Scoring Chart* can be obtained through the QCM database web site at https://www.qcmscores.com/. *A detailed description of each evaluation criteria can be found on the official QCM scoring chart and Handbook. In addition, the contractor's telephone inquiries monitoring program shall ensure that:*

1. *All CSRs handling provider calls are monitored throughout the month. This includes calls handled by temporary employees, part-time employees, higher level CSRs and the PRRS.*

2. Calls monitored are from providers and are of the type that the CSR's level typically handles (Level 1, Level 2, *PRRS*)

3. Responses monitored are sampled randomly so as to be representative of varying days of the week, weeks of the month, and monitors/auditors.

4. Monitoring *is done* using the official QCM scorecard and *Scoring C*hart and *recorded in* the QCM database.

5. *All responses are evaluated* and scores are entered into the QCM database by the *tenth day* of the following month. For example, responses scored in December shall be entered into the QCM database by January 10th.

6. CSR trainees and new CSRs are adequately monitored. However, scores for CSR trainees will be excluded from QCM performance for one 30-day period following the end of their formal classroom training.

7. Monitoring is done in a way that is conducive to the success of the monitoring program.

8. *Timely feedback is* provided to CSRs.

9. PCC staff *is* properly educated about the program and its use; *and all CSRs, Reviewers, and Supervisors have copies of the official QCM scorecard, Scoring Chart, and Handbook.*

10. The QCM Handbook is *followed*.

30.2.13.3 – Recording Calls

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

Contractors may record calls as part of their contract with CMS to ensure the quality of telephone inquiries. If a contractor chooses to record calls, they shall provide verbal notification at the beginning of the call announcing that the call may be monitored or recorded for training purposes. If a provider objects to having their conversation recorded, the CSR may inform the provider that they record calls for the sole purpose of quality assurance and training and the recording system can not be stopped by an individual CSR. If the provider still objects and does not want to continue with the recorded call the CSR may inform the provider that they may send in their inquiry in writing. The contractor shall then provide the appropriate address for written correspondence.

Contractors *who* record calls for QCM purposes shall maintain recordings for an ongoing 90-day period during the year. All recordings shall be clearly identified by date and filed in a manner that *allows* for easy selection for review. Contractors shall dispose of any recordings that are no longer used in a manner that would prohibit someone from obtaining any personally identifiable information *from the recordings*.

30.2.13.4 – QCM Calibration

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

Calibration is a process to help maintain fairness, objectivity and consistency in scoring calls by staff within one or more contact centers.

Contractors shall participate in all national QCM calibration sessions organized by CMS. National sessions are held once per quarter. Appointments will be sent to all provider contact centers via the PCUG listserv (see §10).

Contractors with more than one contact center shall conduct monthly calibration sessions among multiple centers. Contact centers with more than one reviewer shall conduct monthly calibration sessions within the contact center. Contact centers shall keep written records of their internal calibration meetings, including attendance lists. These records shall be provided to CMS upon request.

On a quarterly basis, contractors shall submit to CMS two telephone calls for each line of business in their contract—Part A, Part B, HH+H and DME. Calls shall be submitted by the following dates:

- *March 1st*
- *June 1st*
- *September 1st*
- *December 1st*

These calls shall be actual provider inquiries responded to within the prior contract quarter. Rather than looking for perfect calls, CMS would prefer calls that generate discussion among the contractor sites. This includes calls where CSRs demonstrate exceptional or unacceptable behavior.

All calls submitted for consideration for calibration shall have been scored using the QCM tool and entered into the QCM database. All calls submitted shall have a copy of the QCM scorecard attached. Calls may be submitted electronically or through postal mail. All calls submitted through e-mail shall have all PHI removed from the call. Regardless of the method of submission, all calls shall be submitted in the .wav format and shall be under 10MB per call. E-mail submissions shall be sent to the QCMScores mailbox at qwcmscores@cms.hhs.gov. All postal submissions shall be mailed to the following address:

Centers for Medicare & Medicaid Services

7500 Security Boulevard
Mail Stop: C4-13-07
Attn: DCPC-QCM Calibration
Baltimore, MD 21244

30.2.14 - CMS Monitoring
(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

For monitoring purposes, contractors' telephone systems shall allow calls from CMS or CMS representatives to CSRs. These CMS callers will not have a provider number. CSRs shall respond to these calls as if they were calls from the provider community. *CMS will provide contractors with feedback about results of monitoring and provide information about the evaluation process used through the PCUG listserv and monthly meetings.*

30.3 – *Provider* Written Inquiries
(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

Contractors typically handle the following three types of written inquiries:

1. *General--General written inquiries are those that are not forwarded to a specialized unit with its own CMS mandated timeliness standards, such as MSP and Appeals. General inquiries are subject to the performance standards in this section. Timeliness standards for General inquiries are defined in §60.3.2.1.*

2. *PRRS--PRRS inquiries are provider inquiries that require extra research and cannot be handled by the general inquiries staff. PRRS inquiries also include all beneficiary inquiries that are referred to the MAC from the Beneficiary Contact Center (BCC). All PRRS inquiries are subject to the performance standards in this section. Timeliness standards for PRRS inquiries are defined in §60.3.2.2 and §60.3.2.3.*

3. *Congressional--Congressional inquiries are those that the contractor receives either directly from a Congressional office or are transferred to the contractor from either CMS CO or a CMS Regional Office. Congressional inquiries are subject to the performance standards in this section. Timeliness standards for Congressional inquiries are defined in §60.3.2.4.*

All written inquiries, including letters, faxes, and e-mails, shall be handled consistently for accuracy, *professionalism* and timeliness. *Every inquiry shall receive a final response that accurately and completely addresses the issues contained in the incoming inquiry.* For written inquiries received that could be handled by the IVR, such as claim

status and eligibility (see §50.1), it is strongly suggested that contractors include language in the responses to those inquiries that the information being requested is available on the IVR. *Additionally, responses should include information about relevant training seminars or computer based training on the contractor's provider education Web site if that is appropriate to the topic of the inquiry.*

In cases where a duplicate inquiry is received, contractors shall verify, by telephone or letter, that the provider has received a response.

30.3.1 - Controlling Written Inquiries

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

Contractors shall control all general written inquiries until they are closed by the written inquiries unit. If an inquiry is transferred to another unit that has its own reporting system and timeliness standards, such as MSP and Appeals, the inquiry shall be closed by the general written inquiries unit and responsibility for the inquiry shall be transferred to *the* unit to which the inquiry was referred. Documentation shall be kept in the provider inquiry tracking system to identify that the inquiry was referred and/or forwarded to another unit (see §30.6).

The contractor shall stamp the cover page of all written inquiries including letters, e-mails and faxes, and the top page of all attachments with the date of receipt in the corporate mailroom and control them until a final answer is sent. E-mails and faxes that contain system generated *date-stamps* are not required to receive an additional corporate date stamp*; however, e-mails* and faxes received after the close of the contractor's normal business day *shall* be date-stamped the next business day. *For provider inquiry timeliness purposes, the date of receipt shall be counted as day one.*

Contractors shall not be required to keep the incoming envelope. However, if it is a contractor's normal operating procedure to keep envelopes with the incoming correspondence, the envelope, incoming letter and the top page of all attachments shall be date-stamped in the corporate mailroom.

30.3.2 – Written Inquiry Storage

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

Contractors *shall* allow CMS access to all written inquiries stored off site within 24 hours of notification to the contractor. All written inquiries, whether maintained on site or off-site, shall be clearly identified and filed in a manner that will allow for easy selection for review.

By the end of the first month of the contract year contractors shall enter the physical address of where they store their provider written inquiries into PCID. This requirement only applies to those contractors who only maintain hard copy files. This requirement

does not apply to contractors who maintain electronic versions of written inquiries. Any changes to this information shall be entered in PCID within 2 weeks of the change.

30.3.3 – Telephone Responses

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

Contractors may respond to *general and PRRS* written inquiries by phone within 45 business days. *Contractors shall use their* discretion when identifying which written inquiries (e.g., provider correspondence that represents simple questions) can be responded to by phone.

For tracking and evaluation purposes, the contractor shall develop a report of contact for each telephone response. The report of contact shall be retained in the same manner and time frame as written responses. All reports of contact shall contain the following information:

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

If the inquirer requests a copy of the report of contact, a response letter *containing all the information in the "Summary of Discussion" shall* be sent. *Contractors may send the information via e-mail or facsimile, if requested by the provider and the response does not contain any protected health information.* It is not acceptable to send the report of contact itself. All *timeliness and quality* guidelines for a written response apply *to the response sent*.

If the contractor cannot reach the provider by phone, the contractor shall develop a written response within 45 business days from the incoming inquiry. It is not acceptable to leave a message/response on the provider's voicemail.

30.3.4 - E-mail and Fax Responses

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

In some cases, inquiries can be responded to by e-mail or fax. Since both represent official correspondence with the public, it is paramount that contractors use sound e-mail and fax practices and proper etiquette when communicating electronically. Contractors shall ensure that e-mail and fax responses *follow* the same *timeliness and quality* guidelines that pertain to all written inquiries. Responses that contain financial *or*

protected health information shall not be sent by e-mail or fax. If the response *contains* this information, it shall be mailed in hardcopy to the provider or a telephone response shall be *used*.

30.3.5 - Check Off Letters

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

Check-off letters are appropriate for routine inquiries like claim status or eligibility. Check-off letters shall not be used to address more complex inquiries. Each check-off letter shall be personalized and *follow the same timeliness and quality guidelines that pertain to all written inquiries.*

30.3.6 – *Quality* Guidelines for Written Responses

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

Contractors shall ensure that the responses sent to written inquiries are accurate, complete, responsive, clearly written and presented in a professional manner. As such, contractors shall use the CMS Writing Guide to assist in the preparation of written responses. The Writing Guide can be found on the QWCM Web site at https://www.qwcmscores.com/ under Documentation. Because the CMS Writing Guide cannot possibly address every issue encountered in responding to written inquiries, contractors may also use other resources (e.g. grammar guides) to supplement their writing process.

30.3.7 – Stock Language/Form Letters

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

Periodically CMS may request that contractor's submit their most frequently used stock language and/or form letters. CMS will review this language and provide suggestions on how the language can be improved. If CMS determines that the form letters and/or stock language contain accuracy errors or other errors that affect the readability and/or meaning of the response, contractors shall have 60 days from receipt of the information to make any necessary changes.

30.3.8 – Written Inquiries Quality Monitoring Program

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

Contractors shall have a monitoring program in place to ensure the quality of written inquiries responses. The *monitoring program applies* to contractors' general provider written inquiry responses, *Congressional responses* and PRRS responses. The standards shall not apply to those written inquiries handled by other units within the contractor (e.g., appeals, fraud, MSP).

As contractors are ultimately responsible for their responses to provider inquiries, contractors shall use the results of their *quality* program to identify, and act upon, areas of

needed improvement, both for the PCC as a whole and for individual PCC staff. Contractors shall document their monitoring efforts and corrective action plans as applicable, and provide such information to CMS upon request.

30.3.8.1 - Quality Written Monitoring Program Minimum Requirements
(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

The contractor's monitoring program shall, at a minimum, follow the requirements and performance standards as set forth in the Quality Written Correspondence Monitoring (QWCM) program. Copies of the *official* QWCM *scorecards*, s*coring charts, Handbook, and User G*uide can be obtained through the QWCM database web site at https://www.qwcmscores.com/. *A detailed description of each evaluation criteria can be found on the official QWCM scoring charts and Handbook. In addition, the contractor's written inquiries monitoring program shall ensure that:*

1. *All Correspondents responding to general, PRRS or Congressional provider written inquiries are monitored throughout the month. This includes letters written by temporary employees and part-time employees.*

2. Responses monitored are from providers and of the type that the correspondent typically handles (general, PRRS, Congressional.)

3. Responses monitored are sampled randomly so as to be representative of varying days of the week, weeks of the month, and monitors/auditors.

4. Monitoring *is done* using the official QWCM scorecards and *scoring* charts and *recorded in the* QWCM database -- separate scorecards and scoring criteria are used to evaluate written and telephone responses.

5. *All responses are evaluated* and scores are entered into the QWCM database by the *tenth day* of the following month. For example, responses scored in December shall be entered into the QWCM database by January 10th.

6. Correspondent trainees and new correspondents are adequately monitored. However, scores for correspondent trainees will be excluded from QWCM performance for one 30-day period following the end of their formal classroom training.

7. Monitoring is done in a way that is conducive to the success of the monitoring program.

8. *Timely* feedback is provided to correspondents.

9. PCC staff *is* properly educated about the program and its use; *and all* c*orrespondents, reviewers, and supervisors have copies of the official QWCM scorecards, scoring charts*, *Handbook, and Writing Guide.*

10. The QWCM Handbook is *followed*.

30.3.8.2 – QWCM Calibration

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

Calibration is a process to help maintain fairness, objectivity and consistency in scoring calls by staff within one or more contact centers.

Contractors shall participate in all national QWCM calibration sessions organized by CMS. National sessions are held once per quarter. Appointments will be sent to all provider contact centers via the PCUG listserv (see §10).

Contractors with more than one contact center shall conduct monthly calibration sessions among multiple centers. Contact centers with more than one reviewer shall conduct monthly calibration sessions within the contact center. Contact centers shall keep written records of their internal calibration meetings, including attendance lists. These records shall be provided to CMS upon request.

On a quarterly basis, contractors shall submit to CMS ten written inquiry cases for each line of business in their contract—Part A, Part B, HH+H and DME. Cases shall be submitted by the following dates:

- *March 1st*
- *June 1st*
- *September 1st*
- *December 1st*

The cases shall be actual provider written inquiries responded to within the prior contract quarter. In addition, all cases must have been scored using the QWCM tool and entered into the QWCM database. Each case shall contain the incoming inquiry, response, screenshots showing any associated research done in order to supply the response, as well as a copy of the QWCM scorecard. All submissions shall be mailed to the following address:

Centers for Medicare & Medicaid Services
7500 Security Boulevard
Mail Stop: C4-13-07
Attn: DCPC – QWCM Calibration
Baltimore, MD 21244

30.3.9 - Replying to Correspondence from Members of Congress

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

In addition to the guidelines outlined above, contractors shall follow the following instructions when preparing replies to correspondence from Members of Congress:

A –Sending the Response
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 releases the replies to each Member of Congress at the same time.

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. 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).

C - 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.

D - Replying Directly to a Constituent at the Request of a Member of Congress
When addressing a reply to a constituent, the contractor sends a courtesy letterhead copy to the Member of Congress, along with a copy of the constituent's letter.

E - Replying to an Inquiry from Former Members of Congress
Unless the former Member of Congress requests otherwise, the contractor addresses the reply to the constituent. The contractor shall send a courtesy copy to the former Member of Congress.

F – Addressing the response

The Honorable (full name)
United States Senate
Washington, D.C. 20510
Dear Senator (surname):

or

The Honorable (full name)
House of Representatives
Washington, D.C. 205l5
Dear Mr./Mrs./Miss/Ms./Dr. (surname):

When replying to a home office, address the letter:

The Honorable (full name)
United States Senator
(local address)
Dear Senator (surname):

The Honorable (full name)
Member, United States House of Representatives
(local address)
Dear Mr./Mrs./Miss/Ms./Dr. (surname):

See CMS' Writing Guide for additional forms of address and salutations.

G - Courtesy Copies

The contractor prepares a courtesy copy for each congressional response, if the congressional office has indicated by phone or letter that they want one. Document the file if the Member of Congress indicates that he/she does not need a copy.

H - 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

30.4 - Walk-In Inquiries

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

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

- Name of inquirer
- Time of arrival
- Time service was provided
- Name of the person handling the inquiry
- *A statement indicating whether the inquiry was closed or is still pending*

30.4.1 – Guidelines for Walk-In Service

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

The *contractor shall use the following guidelines when providing high quality walk-in service:*

- The *inquirer shall be given the opportunity to* meet with a service representative
- Waiting room accommodations shall provide seating
- Inquiries shall be *handled completely* during the initial interview to the extent possible
- Current Medicare publications shall be available to the provider (upon request)
- *Contractors shall maintain a log or record of walk-in inquiries during the year*

30.5 - Provider Relations Research Specialists (PRRS)

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

Contractors shall maintain PRRS as a joint effort between the PCC and POE units in order to provide consistent, accurate, and timely information to Medicare providers regarding complex inquiries that cannot be answered by the contractor's telephone or written inquiries staff and/or require significant research. Therefore, contractors shall design and staff the PRRS component so that questions beyond the expertise of the CSRs or general written inquiry staff which require more time to adequately research can be answered in a timely and efficient manner. *The PRRS staff shall also identify provider education topics based on the complex inquiries received if the contractor determines that general provider education on these specific topics would be practical and useful to the provider community and reduce inquiries.* In addition, the PRRS shall also handle complex beneficiary inquiries that cannot be resolved by the BCC in the MAC environment.

For *workload reporting purposes*, upon referral of a telephone inquiry to the PRRS, the telephone inquiry shall be closed and a written inquiry shall be opened. *A written inquiry that is transferred to the PRRS shall remain open and only be counted once.*

30.5.1 - Complex Provider Inquiries

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

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

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

30.5.2 - Complex Beneficiary Inquiries

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

In the MAC environment, complex beneficiary inquiries will be identified and referred to the PRRS by the *BCC or the CMS RO* via the Next Generation Desktop (NGD) and may include telephone, written, and email inquiries. Once an inquiry is referred, the PRRS shall take ownership of the inquiry and be accountable for its resolution. While the PRRS is held accountable for the response, the contractor may use other resources to develop the response, as appropriate. The contractor shall respond directly to the beneficiary *via telephone, written mail or e-mail* and document the response in NGD (See IOM Pub 100-9, Chapter 2, §20.1.10 for NGD technical specifications). Complex inquiries from beneficiaries shall receive the same priority and attention as complex inquiries from providers. *For Benefit Integrity Unit escalations, the contractor should consider the action complete and close the Complex Inquiry in NGD when the Benefit Integrity Unit referral is placed into the 2nd level screening work flow, and not when the 2nd level screening is complete.*

The contractor shall have adequate language capabilities (English, Spanish, and TTY/TDD) to handle telephone communications with beneficiaries. Contractors shall not be required to install a separate TTY/TTD for complex beneficiary inquiries. The contractor shall obtain foreign language support service by contract for languages *other than Spanish*. Additionally, the contractor shall fog written responses for reading level (8th grade or less), in accordance with IOM Pub 100-9, Chapter 2, 20.2.1.

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

30.6 - Inquiry Tracking

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

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

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

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

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

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

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

Contractors shall follow these additional requirements when tracking or logging their inquiry types:

1. Contractors shall not create a subcategory “Other” under any of the existing categories of the CMS Standardized Provider Inquiry Chart.

2. Contractors shall not report under “General Information” – “*Other*” inquiries that belong to other categories if those inquiries do not belong to “General Information.”

3. Multi-Carrier System Desktop Tool (MCSDT) users shall list the name of the category in the subcategory listing *as well* when finalizing the logging of an issue, as explained in the example below.

   Example: If the CSR or correspondent received a call or a letter related to a claim denied, they shall select the "Claim Denials" category and if the reason for the *inquiry* fell outside of the 18 existing/predefined subcategories for "Claim Denials", the CSR or correspondent shall select "Claim Denials" again as a subcategory.

4. *For general inquiries that belong exclusively to the* "General Information" category, contractors shall select the "Other Issues" subcategory to log an inquiry that inquiry *falls* outside of the existing/predefined subcategories of the "General Information" category.

Contractors shall report the number of telephone and written inquiries logged for each category and subcategory monthly. This data shall be entered in PCID within 15 calendar days after the end of each month (see §70.2.3).

30.6.1 - Updates to *the CMS Standardized Provider Inquiry* Chart

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

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

- A definition of the inquiry type to be added,
- Examples of questions where the inquiry type could be used, and
- Information about the number of inquiries associated with it.

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

A. Contractor-Specific Subcategories

Contractors shall *adhere to* the following requirements when adding contractor-specific subcategories to the *Monthly* Contractor Inquiry Tracking Report:

1. Contractors shall avoid the reporting of contractor-specific subcategories when the CMS Standardized Provider Inquiry Chart provides existing subcategories that can be used to log and report those inquiries.

   Example: A contractor-specific subcategory called "HCPCS" under "Coding" when the existing listing already provides "Procedure Codes" as one of the standard subcategories under "Coding."

2. Contractors shall assign a specific descriptive name to contractor-specific subcategories reported to CMS. The use of Sub-category 1, Sub-category 2 as names is unacceptable.

3. Contractors shall create contractor-specific subcategories for issues that are significant to the contractor operation and represent a significant amount of inquiries related to a topic.

4. Contractors shall not create contractor-specific subcategories under the "Temporary Issues" category that could be added as a contractor-specific subcategory under a more related category.

   Example: The addition of "HMO Refunds" as a contractor-specific subcategory that could be reported under "Financial Information" instead of "Temporary Issues."

30.7 - *Fraud and Abuse*

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

Contractors shall ensure that when a provider inquiry or complaint of potential fraud and abuse is received, it is immediately sent, along with a referral package, to the Program Safeguard Contractor (PSC) or *Zone Program Integrity Contractor (ZPIC).* The referral package shall consist of the following information:

1. Provider name and address;
2. Type of provider involved in the allegation and the perpetrator, if an employee of a provider;
3. Type of service involved in the allegation;
4. Relationship to the provider (e.g., employee or another provider);
5. Place of service;
6. Nature of the allegation(s);
7. Timeframe of the allegation(s);
8. Date of service, procedure code(s);
9. Name and telephone number of the contractor employee who received the complaint;
10. Beneficiary name who received the service, if known;

11. HIC number of the beneficiary receiving the service, if known; and
12. Date the referral is forwarded to the PSC or *ZPIC*.

The Medicare contractor shall keep a record of the cost and workload associated for all provider inquiries of potential fraud and abuse that are referred to the *PSC or ZPIC* using Activity Code *13201/01* in the Beneficiary Inquiries function.

30.8 – *Surveys*

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

The CMS requires contractors to perform periodic surveys of their customer service operations. The time frame for performing surveys is dependent upon the activity or service to be measured. Examples of areas to be surveyed and/or measured are indicated on the specific notice. Examples include annual contact center technology surveys, staffing profiles, training needs, etc.

30.8.1 - *Medicare Contractor Provider Satisfaction Survey (MCPSS)*

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

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

A. Contractor Activities Related to the *MCPSS*

Contractors shall:

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

    a. *Determine* if a provider is actively participating in the Medicare program,

    b. *Contact* active providers for the MCPSS (e.g., names, Identification Numbers (IDs), business and *physical* mailing addresses, business telephone numbers, *business e-mail address, if available,* provider types, key contact information *(most knowledgeable person)*for the appropriate respondent in each provider organization), and

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

2. Perform marketing and outreach for the MCPSS--Contractors shall support CMS in disseminating information about the MCPSS to providers by:

    a. *Placing* information about the survey on listservs, newsletters, bulletins, and other provider communications channels,

b. *Posting* information about MCPSS on their Web sites and *including* a link to the *CMS MCPSS web site* at www.cms.hhs.gov/MCPSS and *a link to the MCPSS Home Study web page available to each contractor at a secure site designated by CMS*.

c. *Including* information about the survey on their IVR systems, or automatic call distributor (ACD) systems, and any other communications channel with providers (survey information can be included as part of general Medicare information referenced in § 50.1). A media kit with sample documents*, to include, but not be limited to, a project timeline and key tasks will be available to contractors on the MCPSS Home Study web site available to each contractor at a secure site designated by CMS.*

3. Create a letter, using contractor letterhead, signed by a senior official, to be included in *the MCPSS notification packet sent to the selected providers*. CMS will provide a template so that *consistent* information *is* shared with the provider community. The template and instructions will also be available at *the MCPSS Home Study web site available to each contractor at a secure site designated by CMS*. *Contractors* shall customize the letter to reference the particular services (see #4) that the *c*ontractor provides. The survey contractor*, who is responsible for administration of the MCPSS,* will make copies of the *contractor* letter to include in the *survey* notification packet *and will mail the packets to select providers*.

4. Review and confirm the services that *the contractor offers*. The survey is customized to include ONLY those services that pertain to the *contractor's* providers. A matrix of *contractor's services will be available for review on the MCPSS Home Study web site available to each contractor at a secure site designated by CMS.*

5. Appoint a MCPSS contact person. Contractors shall submit the contact name, business address, business telephone number and e-mail to CMS *by October 15th of each year via an e-mail address provided in the MCPSS media kit and/or notification from CMS*. CMS will provide the contact person a username and secured-password to access information relevant to the Contractor's individual survey results and/or response rates.

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

B. Contractor Use of MCPSS Results

Contractors shall use the MCPSS survey results and provider feedback to identify and implement process improvement initiatives*, including activities for the PCC and POE*.

C. Information for Contractors

A main objective of MCPSS is to support and assist *c*ontractors in using provider feedback to implement process improvement initiatives. To this effect, CMS will provide detailed results of the survey on *the MCPSS Home Study Web site available to each contractor at a secure site designated by CMS*. This page will include:

1. Data Collection Reports: The reports will include counts and percentages overall and by provider type for completed responses and each category of the survey sample disposition (e.g., postal non-deliverables, non-locatables, refusals and ineligibles)

2. Survey Results: The results of the survey will be available via an interactive online reporting system *located at a secure web site designated by CMS*. *The contractor's MCPSS contact will have access to the survey results via a username and password (see #5 above).*

3. *Study Updates, Fact Sheets, FAQs and Media Messages:* As the project progresses, *CMS will* continue to update the MCPSS *Home* Study *web site* with new materials (e.g., fact sheets, FAQs, media messages). Contractors may access *the* secure *web site* at any time to download relevant project information.

4. CSR Script: The script is part of the media kit material that *c*ontractors can access through the MCPSS *Home Study web site available to each contractor at a secure site designated by CMS*.

The dates when this information will be available to Contractors *are* listed in the MCPSS Project Timeline. This timeline can be found under Reference Documents tab at the MCPSS *Home Study web site at the address designated by CMS*.

30.8.2 – Telephone Satisfaction Survey

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

CMS has established call center telephone satisfaction surveys at several Medicare provider contact centers. These surveys evaluate caller satisfaction with customer service representatives and/or IVR units. The American Customer Satisfaction Index methodology is being used to measure nationally benchmarked indicators for satisfaction, future behavior and customer impact.

The CFI Group is responsible for maintaining the telephone satisfaction surveys, collecting, analyzing, and updating the results. CMS will use the survey results to identify opportunities to improve customer service.

At the request of CMS, contractors shall:

- *Work with CMS and CFI Group to implement the telephone satisfaction surveys*
- *Develop contractor specific custom questions*
- *Participate in conference calls to discuss trends and enhancements*

30.8.3 – Web Site Satisfaction Survey
(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

Medicare providers and their staffs are increasingly using contractors' web sites to obtain information for their business and professional needs. As such, it is important to gauge the effectiveness of contractor provider education web sites. The Medicare web site satisfaction survey provides a tool to determine this because it is based on actual usage and produces measures that are understandable, consistent, reliable and nationally standardized.

ForeSee Results, a corporate web-satisfaction management company, is responsible for administering the Web site surveys, collecting, analyzing and housing the data, and reporting results in understandable and useful terms and metrics. The initial Web site satisfaction score is calculated after approximately 300 responses are collected. After that, satisfaction scores and their impacts are generated on a continuous basis but always encompass 300 responses.

At the request of CMS, contractors shall participate in the Web site Satisfaction Surveys. Participation includes, but is not limited to:

- *Meeting with CMS and Foresee Results to implement the web survey*
- *Developing contractor specific questions for the web survey*
- *Adding code supplied by Foresee results to the contractor's web site*
- *Reviewing survey results on a regular basis*
- *Improving the contractor's web site based on survey results*

40 - PCSP Staff Development and Education
(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

Contractors shall be fully responsible for the education, development, evaluation, and management of PCSP staff. This shall be accomplished by contractors providing initial and ongoing education and training of all PCSP staff. In addition, contractors shall have an education and development plan in place and documented for each staff member that addresses the education of new staff and the continued education and development of existing staff. Education and reference materials and tools, as well as policy manuals, shall be made readily available and accessible for all staff. Contractors shall ensure that educational opportunities are afforded *to all PCSP* staff, and that staff are afforded promotion pathways through the design and implementation of the PCC *and POE functions*.

40.1 - POE Staff Training

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

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

40.2 - PCC Staff Development and Training

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

Contractors shall provide training for all new PCC hires and refresher training updates for existing personnel. This training shall enable the CSRs and correspondents to answer the full range of customer service inquiries and equip them with the knowledge and tools to meet CMS' performance requirements. Contractors shall have a training evaluation process in place for new hire and ongoing training to certify that the CSR or correspondent is ready to independently handle inquiries on the topics covered.

Ongoing data analysis shall be used to determine training topics for PCC staff. Contractors shall consider data sources such as inquiry analysis, quality scores, direct and remote monitoring results, and error rate data analysis when developing training topics. The PRRS shall be involved in the development of training materials for the general inquiries staff. Training shall be tailored to the level/degree of specialization of the CSR. In addition to formal classroom training, regular feedback to CSRs and PRRS regarding their performance shall be a part of the staff development of the PCC.

Contractors shall ensure that CSRs and written correspondents are equipped with the tools they need to handle providers' inquiries while meeting the CMS' performance requirements for telephone and written provider inquiries. These tools, at a minimum, shall include the use of the CMS' Web sites, the contractor's Provider Web site, CMS-produced CSR education and reference materials, and CMS-produced provider education materials.

CMS will also continue to increase and improve the consistent national training information available to CSRs *and correspondents*. Upon receipt of CMS developed standardized training materials, contractors shall implement these materials for all CSRs *and correspondents* on duty and those hired in the future. Since the development of these materials will be done by CMS, *there will not* be any costs to the contractors to use these training materials. Standardized training materials and other training information will be posted at http://www.cms.hhs.gov/FFSProvCustSvcGen/30_Contractor_Training_and_Resources.asp#TopOfPage Contractors may supplement the standard materials with their own materials as long as there is no contradiction of policy or procedures.

40.2.1 – *Required Training*

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

In addition to the training topics determined by contractors, all contractors shall train their CSRs and correspondents on the following topics at least once during the contract year. If a CSR or correspondent is hired after the training has occurred for the year, contractors shall include the training as part of their new hire training.

1. Contractors shall train their CSRs *and correspondents* about how to find, navigate and use their *provider outreach and education Web site. This includes the contractor FAQs, the schedule of upcoming outreach and education events and all available online education.*

2. Contractors shall train their CSRs *and correspondents* about how to find, navigate and use *the CMS Web site. This includes the CMS FAQs and all online education resources provided through the Medicare Learning Network at http://www.cms.hhs.gov/MLNGeninfo/.*

3. *Contractors shall train their CSRs and correspondents on how to access and use MLN Matters Articles and Job Aids.*

4. Contractors shall train CSRs and correspondents *on* the CMS Standardized Inquiry Chart *categories, subcategories and definitions* and *they shall* be trained to *accurately* log their inquiry types according to the CMS Standardized Inquiry Chart in the tracking system used by the contractor.

5. *Contractors shall train CSRs and correspondents about the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act. Training about protecting beneficiary and provider identifiable information is provided for by CMS and can be found on the CMS Web site at http://www.cms.hhs.gov/FFSProvCustSvcGen/30_Contractor_Training_and_Resources.asp#TopOfPage*

40.2.2 - Provider Contact Centers Training Program

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

To help contractors provide ongoing training for their CSRs and correspondents, on Federal holidays, in lieu of answering telephone inquiries, PCCs may choose to close their contact center to provide CSR training. In addition, PCCs may close on for up to 8 hours per month for CSR training and/or staff development. The goal is to help CSRs improve the consistency and accuracy of their answers to provider questions, to increase their understanding of issues, and to facilitate retention of the facts of their training by increasing its frequency.

PCCs shall adhere to the following guidelines when closing for training on days other than Federal holidays:

- *The 8 hours per month shall be used for training only*
- *The 8 hours per month* shall not be used for corporate meetings
- Contractors shall request permission to close according to *§§*40.2.5 and 40.2.6 of this chapter
- Training time not used within a specific month shall not be carried over to the next month

40.2.2.1 - Closure Determination
(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

Contractors shall perform an analysis to evaluate the appropriate time for closure to anticipate the impact on their ability to meet all CMS performance requirements. Contractors shall consult their POE Advisory Group about the best hours for training closures and training topics. *Training time closures shall not be the justification for poor performance.*

40.2.2.2 - Provider Complaints
(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

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

40.2.2.3 - Training Schedule
(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

Contractors shall submit to CMS a training schedule, including dates, times, topics, sub-topics and contact information by the 15th of the month prior to when the training will be performed *to the provider services mailbox at providerservices@cms.hhs.gov using the subject line "Training Schedule."* CMS will post training schedules and contact information submitted by all provider Medicare contractors at http://www.cms.hhs.gov/FFSProvCustSvcGen/30_Contractor_Training_and_Resources.asp#TopOfPage Upon receipt of the training schedule, CMS will send an acknowledgement e-mail. Contractors shall assume approval of closures of 4 hours or less unless they receive notification to the contrary.

40.2.2.4 - Training Closures of More Than Four Hours
(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

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

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

40.2.2.5 - Provider Notifications
(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

Contractors shall notify providers about their closure time for training. At a minimum, contractors shall post a closure notification for providers on their IVRs and *Web sites*. Contractors with separate lines for IVR and CSRs shall post a closure notification for providers on both lines. *Additional instructions regarding IVR posting are in §50.1 of this chapter.* Contractors shall use their listserv to notify their provider community of their closure times the first time they *close their site for training*. *Contractors shall also* use their listserv to notify providers of *a* CMS authorized one time only training closure or a training closure out of the contractor's regular training schedule.

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

40.2.2.6 - CSR and Correspondent Feedback
(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

To assure that CSRs *and correspondents* are receiving the maximum benefit of the training program, contractors shall implement a process to evaluate the *staff's* progress on a monthly basis. Also, contractors shall implement a process to evaluate the *staff's* retention of training information on a periodic basis. Contractors shall use pre-and post-training *evaluation* results *and staff* feedback to *improve* their training program.

40.2.2.7 – Training Information Reporting
(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

Contractors shall report the following *about their training closures*:

- The number of hours per month that the contractor closed for training during normal business hours
- The number of hours *per month* used for training on Federal holidays

Contractors who did not close for training during the month should enter a zero in these fields. For legacy contractors, this information shall be reported using the Customer Service Assessment and Management System (CSAMS). For MACs, this information shall be reported using the Provider Inquiries Evaluation System (PIES). For more details about these systems, please refer to §70 of this chapter.

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

40.3 - PRRS Staff Training
(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

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

50 - Provider Self-Service Technology
(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

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

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

1. *IVRs* for telephone inquiries;
2. A provider Web site;
3. Internet-based provider educational offerings;
4. Use of electronic mailing lists (Listservs)*; and*
5. *Internet technology for the transmission of and/or receipt of healthcare transactions, if approved by CMS (See IOM Pub 100-17, section 5).*

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

50.1 - Interactive Voice Response System (IVR)

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

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

1. Contractor hours of operation for CSR service

2. After-hours message indicating normal business hours. (It is not necessary to duplicate this message if the caller is informed of the normal business hours via the telephone system prior to being delivered to the IVR.)

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

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

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

6. Routine eligibility information. Eligibility inquiries handled in the IVR shall adhere to the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule by authenticating callers as required in section 30 of this chapter.

Providers shall be required to use IVRs to access claim status and beneficiary eligibility information. *CSRs shall refer providers back to the IVR if they have questions about claims status or eligibility that can be handled by the IVR. CSRs may provide claims status and/or eligibility information if it is clear that the provider cannot access the information through the IVR because the IVR is not functioning.* IVRs shall be updated to address provider needs as determined *through the* contractors' *PCSP* inquiry analysis at least once every six months.

The IVR shall be available to providers 24 hours a day, 7 days a week with allowances for normal claims processing and system mainframe availability, as well as normal IVR and system maintenance. When information is not available, contractors shall post a message alerting providers on the IVR.

Contractors shall print and distribute a clear IVR operating guide to providers upon request. The guide shall also be posted on the contractor's Web site. *As IVR functionality changes, the operating guide shall be updated timely and the revisions posted to the Web site.*

50.2 - Provider Web Site

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

Contractors shall offer a provider Web site as a provider self-service technology to serve as a self-help tool for Medicare providers in gaining information and assistance regarding the Medicare program. This Web site shall be dedicated to furnishing providers with timely, accessible, and understandable Medicare program information.

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

50.2.1 – *General Requirements*

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

The information contained on *the contractor's* Web site shall be structured in such a way that information is easily found and searchable, so as to reduce the number of pages a user has to go through in order to gain access to the information they are seeking.

To reduce costs, the contractor shall use existing resources and technologies whenever possible. Contractors are ultimately responsible for the structure of their provider Web

site, but are encouraged to design it so that it is clear to providers that they are accessing a provider Web site for their particular interest (specifically, A/B MAC, Part A, Part B, DME MAC, etc.). To maintain the quality of the site, contractors shall periodically ensure that information posted is current and does not duplicate information posted at http://www.cms.hhs.gov/ and http://www.medicare.gov/.

50.2.2 – Webmaster and Attestation Requirements

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

Contractors shall assign a Webmaster responsible for maintaining and updating relevant portions of the contractor's Web site in a timely manner. The Webmaster shall ensure that the Web site complies with CMS' Contractor Web site guidelines and standards located at http://www.cms.hhs.gov/AboutWebsite/01_Overview.asp#TopOfPage *Webmasters shall pay close attention to the requirements for compliance with the requirements outlined in Section 508 of the Rehabilitation Act of 1973.*

Contractors shall periodically review the CMS Contractor Guidelines to determine their continued compliance. By the end of the sixth month of their contract year, contractors shall send two statements from their Webmaster attesting that their Web site complies with:

- CMS Contractor Guidelines
- Requirements stated in IOM Pub 100-4, Chapter 23 §20.7 regarding the use of Current Procedural Terminology (CPT)[1] codes and descriptions

If a Webmaster determines that the contractor's site is not in compliance with any of the CMS requirements, including the requirements outlined in Section 508, the contractor shall outline the steps it is taking to become compliant. This information shall be submitted with the attestation statement.

Contractors may submit these statements via e-mail to the Provider Services mailbox at providerservices@cms.hhs.gov *or through postal mail. MACs shall submit their statements using the appropriate MAC deliverables mailbox.* Contractors may submit these attestations separately or together.

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

50.2.3 – Feedback Mechanism

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

Contractors shall develop and implement a feedback mechanism for users of their Web sites. Users shall be able to easily reach the feedback instrument from the Provider Web site. This mechanism shall ask site users for their appraisals of the helpfulness and ease of use of the site and the information contained on it, as well as their thoughts and

suggestions for improvement or additions to the site. Any contractor response provided that is directly related to feedback received related to the format of the Web site shall not be counted and reported as part of the contractor's provider inquiry workload.

Within their feedback mechanism contractors shall provide information about how providers can offer comments to CMS about contractors' performance in dealings with providers. Contractors shall provide the post office mailing address *or e-mail address* of their CMS *Technical Monitor or PO* as the referral point for these reactions.

50.2.4 – Contents

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

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

1. Provider bulletins or newsletters for the past 2 years;

2. Information on how to join contractor provider listservs;

3. Frequently Asked Questions updated at least quarterly (See § 50.2.4.2);

4. A schedule of upcoming provider education events (e.g., seminars, workshops, fairs);

5. Ability to register for contractor sponsored education events;

6. Search engine functionality;

7. A "What's New" or similarly titled section that contains important information that is of an immediate or time sensitive nature;

8. A site map that shows in simple text headings the major components of the provider Web site and allows users direct access to these components through selecting and clicking on the titles. This feature shall be accessible from the home page of the Web site using the words "Site Map";

9. A tutorial explanation of how to use the Web site that is accessible from the home page. The tutorial shall describe how to navigate through the site, how to find information, and explain features. The tutorial information can be on a "help" page as long as the" help" feature is accessible from the home page;

10. Information for providers on electronic claims submission;

11. Information about the contractor, at a minimum including the telephone number(s) for provider inquiries, a fax number(s) for provider inquiries, and a mailing address for provider written inquiries;

12. An IVR operating guide;

13. CMS products, articles and messages posted, as directed; and,

14. A feedback mechanism as described in 50.2.3.

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

1. The CMS Web site at http://www.cms.hhs.gov/

2. The MLN at http://www.cms.hhs.gov/MLNGenInfo/

3. The site for downloading CMS manuals and transmittals at http://www.cms.hhs.gov/Manuals/ and http://www.cms.hhs.gov/Transmittals/

4. CMS' Quarterly Provider Update (QPU) Web site page at http://www.cms.hhs.gov/QuarterlyProviderUpdates/

5. The site that contains descriptions for Remittance Advice reason codes and remark codes at http://www.wpc-edi.com/servicesreview.asp

6. CMS' HIPAA Web site at http://www.cms.hhs.gov/HIPAAGenInfo/

7. CMS' central provider page at http://www.cms.hhs.gov/center/provider.asp

8. CMS' *Physician Quality Reporting Initiative* page at *http://www.cms.hhs.gov/pqri/*

9. *CMS' ICD-10 page at http://www.cms.hhs.gov/ICD10/*

10. Other CMS Medicare contractors, partners, QIOs, and other sites that may be useful to providers.

11. CMS' MREP Software information at http://www.cms.hhs.gov/AccesstoDataApplication/

12. Medicare Contractor Provider Satisfaction Survey (MCPSS) page at http://www.cms.hhs.gov/MCPSS/

50.2.4.1 - Information from CMS

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

Contractors shall receive instructions from CMS to print a provider education article or other information in their provider bulletin or newsletter and also place it on their Web

site. Unless specifically directed otherwise, the article or information or the pertinent link shall be put on the Web site and sent on their listserv within 1 calendar week after *the date the information is sent to the contractor. The information or link* shall remain on the Web site for 2 months, or until the bulletin or newsletter in which it is appearing is put on the Web site, whichever is later. *Contractors are only required to post the articles, information or links that are relevant to their line of business (e.g. Part A, Part B HH+H or DME).*

If the article, information or link has been revised, contractors shall ensure that the information posted on their Web site represents the most current instruction from CMS. Revised information shall be posted within seven calendar days after the listserv notification is sent. Contractors shall remove the outdated article, information or link after receiving revised information from CMS. If the accompanying change request has been cancelled, contractors shall remove the information from their Web site immediately.

50.2.4.2 – FAQs

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

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

50.2.5 - Web Site Promotion

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

Contractors shall actively promote, market and explain their Medicare provider communications Web site and the information and features contained on it. Information about the contractor's Web site shall be part of, or made available at, all contractor provider education and training workshops and seminars, training sessions with individual providers, and all other provider education events a contractor has or participates in. *Contractors shall determine if the PCC may also be an effective way to promote the contractor's provider education Web site.*

50.3 - Electronic Mailing List/Listserv

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

Contractors shall offer electronic mailing lists/listservs to assist Medicare providers in gaining information about the Medicare program. These listservs shall notify registrants via e-mail of important, time-sensitive Medicare program information, upcoming

provider communications events, and other announcements necessitating immediate attention. Providers/suppliers shall be able to join electronic mailing lists via Provider Web sites. Subscribers to the electronic mailing lists shall also be able to unsubscribe via the Web site. Notices shall be published on the Web sites and in bulletins/newsletters that encourage subscription to the electronic mailing lists. *Subscriptions to the listserv shall also be promoted by the PCC.* Contractors' electronic mailing lists shall be capable of accommodating all of the providers/suppliers it serves. It is recommended that electronic mailing list(s) be constructed for only one-way communication, i.e., from contractors to subscribers.

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

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

50.3.2 - Listserv Promotion

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

The contractors shall actively market and promote the benefits of being a member of the listserv(s) through the use of all regular provider communications tools and channels (e.g., bulletins, workshops, education events, advisory group meetings, ACT calls, *PCC* and written materials.) *Contractors shall consider having CSRs register providers for their listserv during a call if the provider is not currently registered and the CSR believes the provider would benefit from the information provided through the listserv. Contractors shall also coordinate with other areas of the contractor to encourage listserv registration.*

60 - PCSP Performance Management

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

MACs shall be held accountable for the standards in their Statements of Work where MAC requirements may be different than those listed here.

60.1 - POE - Listserv Membership

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

For fiscal intermediaries, the total number of unique, individual members of its listserv(s) shall be at 60 *percent* or higher of its active provider count. For carriers, the total number

of unique, individual members of its listserv(s) shall be at 25 *percent* or higher of its active provider count. *MACs* shall have their listserv population at *30 percent* or higher of their active provider count one year after *award*. *MACs who are awarded the same contract after a contract re-compete shall maintain the percentage of listserv registrants achieved in the last year of the previous contracting period during the first year of the new contract.*

For the purpose of calculating this percentage, no one individual member of a contractor's listserv(s) can be counted more than once, and active providers are all individual providers who have had billing activity during the previous 12 months.

It is a goal of CMS that listserv(s) populations continually increase. *As such, MACs shall increase the percentage of active providers registered for their listserv by 5 percent per year.*

60.2.2 - Call Completion

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

- Each CSR and IVR combined line shall have a completion rate of no less than 70 *percent*. This standard will be measured quarterly and will be cumulative for the quarter.

- Each CSR-only line shall have a completion rate of no less than 70 *percent*. This standard will be measured quarterly and will be cumulative for the quarter.

- Each IVR-only line shall have a completion rate of no less than 90 *percent*. This standard will be measured quarterly and will be cumulative for the quarter.

60.2.5 – Callbacks

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

Contractors shall make 3 attempts to reach a provider for a callback. The contractor may leave a message requesting a return call, including the patient's name if appropriate, but no PHI should be left on the message. If the provider does not respond after 3 callbacks, the contractor has the discretion to prepare a written response, completed within 10 business days of the original inquiry. The contractor shall not close out the inquiry without any type of response to the caller. Contractors shall not leave the responses on provider voicemails. All callbacks shall be completed and closed out within 10 business days of the original inquiry and documented in the inquiry tracking system, discussed in § 30.6 and 90.

60.2.6 – QCM Performance Standards

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

Contractors shall monitor a minimum of three calls per CSR per month. *Any deviation from this requirement shall be documented by the contact center. Documentation shall be maintained in the event the number of calls monitored is questioned.*

- For all calls monitored for the quarter, the percent scoring as "Pass" shall be no less than 90 percent for Adherence to the Privacy Act. This standard will be measured quarterly and will be cumulative for the quarter.

- For all calls monitored for the quarter, the percent scoring as "Achieves Expectations" or higher shall be no less than 90 percent for Customer Skills Assessment. This standard will be measured quarterly and will be cumulative for the quarter.

- For all calls monitored for the quarter, the percent scoring as "Yes" shall be no less than 90 percent for Knowledge Skills Assessment. This standard will be measured quarterly and will be cumulative for the quarter.

60.3.1 – QWCM Performance Standards

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

Contractors shall evaluate and enter into the QWCM application a minimum of three provider responses per correspondent per month or the entire universe available for monitoring, whichever is less, regardless of how many locations for which the correspondent is responding. *Any deviation from this requirement shall be documented by the contact center. Documentation shall be maintained in the event the number of calls monitored is questioned.* Contractors shall meet the following standards:

- For all provider responses monitored for the quarter, the percent scoring as "Pass" shall be no less than 90 percent for Adherence to the Privacy Act. This standard will be measured quarterly and will be cumulative for the quarter.

- For all provider responses monitored for the quarter, the percent scoring as "Achieves Expectations" or higher shall be no less than 90 percent for Customer Skills Assessment. This standard will be measured quarterly and will be cumulative for the quarter.

- For all provider responses monitored for the quarter, the percent scoring as "Yes" shall be no less than 90 percent for Knowledge Skills Assessment. This standard will be measured quarterly and will be cumulative for the quarter.

60.3.2 – *Written* Inquiries Timeliness

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

Standards for responding timely to provider written inquiries (general, PRRS and Congressional) are calculated using business days. See the chart below for assistance with converting calendar days to business days. This chart is provided as a guide only and is not definitive. The chart assumes the contractor was open for business every day during the reporting period. Days where the contractor is closed for business, shall not count as business days.

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

60.3.2.1 – General Inquiries Timeliness

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

All *general* written inquiries *(including those received by fax or e-mail)* shall be responded to in writing or by telephone within 45 business days.

This timeframe begins the day the inquiry is originally received and date-stamped by the contractor and ends the day the contractor sends the *final* response. *For those general inquiries that cannot be answered in final within 45 business days, contractors shall issue an interim response acknowledging receipt of the inquiry and explaining the reason for the delay. Acceptable reasons for an interim response include referral to CMS, a shared systems maintainer, or other non-contractor entity.* When possible, inform the provider about how long it will be until a final response will be sent. *Sending an interim response does not resolve the issue and the* inquiry is not considered closed until the final response is sent. *The final response shall be sent within 5 business days after receipt of the needed information. Any interim responses sent to general inquiries will count toward the contractor's overall allowance of no more than 5 percent of interim responses for the universe of written inquiries.*

There may be instances when an inquiry is mistakenly sent to another address used by the contractor. *The* 45 business day timeframe will begin once the inquiry is received in the contractor mailroom where written inquiries are routinely sent. This does not apply to contractors who choose to have all of their mail sent to a separate location and then

forwarded to the proper written inquiry unit. For these contractors, the 45 business day timeframe starts the day that the mail is received at the initial location.

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

60.3.2.2 – PRRS Timeliness - Provider Inquiries
(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

The PRRS staff shall provide clear and accurate answers within 25 business days for at least 75 percent of cases referred by telephone CSRs. The remaining 25 percent of cases referred by telephone CSRs and all cases referred by the general written inquiries area shall receive clear and accurate written responses within 45 business days.
This timeframe begins the day the inquiry is originally received and date-stamped by the contractor and ends the day the contractor sends the *final* response. *For those PRRS inquiries that cannot be answered in final within 45 business days, contractors shall issue an interim response acknowledging receipt of the inquiry and explaining the reason for the delay. Acceptable reasons for an interim response include referral to CMS, a shared systems maintainer, or other non-contractor entity.* When possible, inform the provider about how long it will be until a final response will be sent. *Sending an interim response does not resolve the issue and the* inquiry is not considered closed until the final response is sent. *The final response shall be sent within 5 business days after receipt of the needed information. Any interim responses sent to PRRS inquiries will count toward the contractor's overall allowance of no more than 5 percent of interim responses for the universe of written inquiries.*

60.3.2.3 – PRRS Timeliness - Complex Beneficiary Inquiries (MAC Only)
(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

PRRS staff shall provide clear and accurate responses within 25 business days for at least 75 percent of cases referred by the BCC or the CMS ROs; and 45 business days for 100 percent of all cases.

This timeframe begins the day the inquiry is originally received in the NGD and ends the day the contractor sends the final response. For Benefit Integrity Unit escalations, the contractor should consider the action complete and close the Complex Inquiry in NGD when the Benefit Integrity Unit referral is placed into the 2nd level screening work flow, and not when the 2nd level screening is complete.

For those complex beneficiary inquiries that cannot be answered in final within 45 business days, contractors shall issue an interim response acknowledging receipt of the inquiry and explaining the reason for the delay. Acceptable reasons for an interim response include referral to CMS, a shared systems maintainer, or other non-contractor entity. When possible, inform the beneficiary about how long it will be until a final response will be sent. Sending an interim response does not resolve the issue and the inquiry is not considered closed until the final response is sent.

The final response shall be sent within 5 business days after receipt of the needed information. Any interim responses for complex beneficiary inquiries will count toward the contractor's overall allowance of no more than 5 percent of interim responses for the universe of written inquiries. Responses to complex beneficiary inquiries shall be documented in the NGD.

60.3.2.4 – Congressional Inquiries Timeliness
(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

All Congressional written inquiries shall be responded to in writing within 10 business days.

This timeframe begins the day the inquiry is originally received and date-stamped by the contractor and ends the day the contractor sends the final response. For those Congressional inquiries that cannot be answered in final within 10 business days, contractors shall issue an interim response within 10 business days explaining the reason for the delay. Acceptable reasons for an interim response include referral to CMS, a shared systems maintainer, or other non-contractor entity. When possible, inform the Congressional office about how long it will be until a final response will be sent. Sending an interim response does not resolve the issue and the inquiry is not considered closed until the final response is sent. The final response shall be sent within 5 business days after receipt of the needed information. Any interim responses sent to Congressional inquiries will count toward the contractor's overall allowance of no more than 5 percent of interim responses for the universe of written inquiries.

70 – *PCSP Data* Reporting
(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

70.1 – *Provider Inquiries Evaluation System (PIES) and Customer Service Assessment and Management System (CSAMS)*
(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

CMS collects and displays contact center performance data on a monthly basis. For MACs, this data is collected through PIES at https://www.pie-system.com. For legacy contractors this data is collected through CSAMS. Definitions, calculations and additional information for each of the required data elements as well as associated

standards are posted on each site. Contact centers shall regularly review and use their contact center performance data to improve their overall performance.

70.1.1- Access to PIES

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

The PIES is an interactive web-based tool that is password protected, and accessible only to authorized users. To help ensure the integrity of the data, CMS limits the number of user accounts per contract (e.g. FI, Carrier, DME MAC, and A/B MAC). Contractors may assign the same person to more than one contract type. To request access to PIES send the following information to the PIES mailbox at pie-system@cms.hhs.gov:

- *Name*
- *Phone number*
- *E-mail address*
- *Contract (e.g. DME MAC or A/B MAC)*

Incoming MACs shall request access for at least one staff member within 30 days after contract award.

70.1.2 – Due Date for Data Submission

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

Each contact center shall enter required contact center data elements into PIES or CSAMS between the 1st and 10th of each month for the prior month. CMS understands that data on the number of callbacks closed within 10 days may not be available by the 10th of the month. Not having this data shall not prevent the contact center from entering all other available data into PIES or CSAMS in a timely manner. The contact center shall supply the missing data to CMS within two business days after it becomes available to the contractor.

To change data after the 10th of the month, users shall inform CO of the requested change via the appropriate resource mailbox. Changes to PIES data shall be submitted to pie-system@cms.hhs.gov. Changes to CSAMS data shall be submitted to csams@cms.hhs.gov.

70.1.3- Data to Be Reported Monthly

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

Telephone inquiries data: Contractors shall capture and report the data elements appropriate for their contractor profile (i.e. CSR and IVR only lines or combined CSR and IVR line).

Written inquiries data (MACs only): Contractors shall capture and report the data elements specified in the PIES database related to their general, PRRS and Congressional written inquiries.

The list of data elements and their corresponding definitions are available on the PIES and CSAMS Web sites.

70.2 – *Provider Customer Service Program Contractor Information Database (PCID)*

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

The PCID is a secure web-based system developed to serve as a central place to capture and store information about Medicare contractors' PCSP activities as well as provide an online reporting mechanism for the contractors' quarterly inquiry tracking reports. The database and its accompanying user guide are located at https://www.p-cid.com.

70.2.1- Access to PCID

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

The PCID is an interactive web-based tool that is password protected, and accessible only to authorized users. To help ensure the integrity of the data, CMS limits the number of user accounts per contractor to no more than two people per contract (e.g. FI, Carrier, DME MAC, and A/B MAC). Contractors may assign the same person to more than one contract type. To request access to PCID all send the following information to the PCID mailbox at p-cid@cms.hhs.gov:

- *Name*
- *Phone number*
- *E-mail address*
- *Contract (e.g. FI, Carrier, DME MAC, A/B MAC)*

Incoming MACs shall request access for at least one staff member within 30 days after contract award.

70.2.2- Contract Data to Be Reported in PCID

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

Contractors shall be responsible for entering and maintaining the following data elements in PCID:

- *Number of Active Providers Served*
- *Remote Monitoring Procedures*
- *IVR Information*
- *Contractor Mailing Address*

- *Contractor Web site Address*
- *Number of Listserv Subscribers at the end of each month*
- *Location of Written Inquiries*
- *Emergency Contact Information*
- *Contractor Closures*
- *Contractor Points of Contact*
  - *PCSP Program Manager (MAC only)*
  - *POE Contact (Primary)*
  - *Contact Center Contacts*

Contractors shall populate the required data elements within 60 days after award. If the data is not available at that time, it shall be entered within 7 calendar days after it becomes available. Changes/updates to any of the data points maintained by contractors shall be made within 14 calendar days of the change. In addition, contractors shall review the data in the system at least monthly to determine if updates are necessary. Updates shall be entered by the 10th of the month for the prior month.

70.2.3- Inquiry Tracking Data to Be Reported in PCID

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

Contractors shall report their monthly telephone and written inquiry tracking information in PCID within 15 calendar days after the end of the month. After that date, the data entry capability will no longer be available to the contractors, the data will be considered late, and the information will need to be entered by CMS. Contractor shall send a note to the provider services mailbox at providerservices@cms.hhs.gov at the same time the monthly telephone and written inquiry reports are submitted in PCID.

PCID does not allow contractors to choose the main inquiry category if the reason for the inquiry does not relate to the existing subcategories. For this reason, there is a subcategory for every category (except General Information) called "Not Classified" where contractors shall report any inquiries related to a particular category that do not relate to any of the existing subcategories.

Contractors may also create "Contractor-Specific" subcategories for every category (except General Information). Contractors who have at least one contractor-specific subcategory shall enter the total number of inquiries for all the contractor-specific subcategories into "Contractor-Specific" field for the category. Currently there is no place in the system for contractors to provide the definitions for these "Contractor-Specific" categories. For this reason, contractors who enter data in these fields shall, on a monthly basis, complete the Excel spreadsheet on the PCID site, under the Documentation link and submit it to the provider services mailbox at providerservices@cms.hhs.gov with the subject line "Contractor-Specific Subcategories Report.

Because the inquiry tracking reports are considered a formal deliverable for MACs, all MACs shall send a note to their respective deliverables mailboxes after they submit their

inquiry tracking information to PCID. This is to inform the PO that the required information has been submitted to CMS.

Any changes that need to be made to the inquiry tracking reports after the reporting period has closed shall be sent to the PCID mailbox at p-cid@cms.hhs.gov.

80.3.4 – Requests for Information Available on the Remittance Advice

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

If a CSR or written inquiry correspondent receives an inquiry about information that can be found on a remittance advice (RA), the CSR/correspondent *should* take the opportunity to educate the inquirer on how to read the RA, in an effort to encourage the use of self-service. The CSR/correspondent *should* advise the inquirer that the RA is needed in order to answer any questions for which answers are available on the RA. Providers *should* also be advised that any billing staff or representatives that make inquiries on his/her behalf will need a copy of the RA.

The contractor should take this opportunity to suggest the use of the Medicare Remit Easy Print (MREP) software. Information about MREP is available at http://www.cms.hhs.gov/AccesstoDataApplication/02_MedicareRemitEasyPrint.asp.

Contractors should also take advantage of national training materials available to educate providers and their representatives about reading an RA. The national training materials include the MLN product, "Understanding the Remittance Advice: A Guide for Medicare Providers, Physicians, Suppliers, and Billers," which is available at http://www.cms.hhs.gov/MLNProducts/Downloads/MLNCatalog.pdf to assist in educating providers about how to read a RA.

Also available is a web site that serves as a resource allowing providers to check the definitions of the Claim Adjustment Reason Codes and Remittance Advice Remark Codes. Contractors should refer providers to http://www.wpc-edi.com/products/codelists/alertservice.

There are two web-based training courses, Understanding the Remittance Advice for Professional Providers, and Understanding the Remittance Advice for Institutional Providers. Both are available at http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5. The courses provide continuing education credits and contain general information about RAs, instructions to help interpret the RAs received from Medicare and reconcile them against submitted claims, instructions for reading Electronic Remittance Advices (ERAs) and Standard Paper Remittance Advices, and an overview of the MREP software that Medicare provides free to providers for viewing ERAs.

80.5.4 – Authentication of Beneficiary Elements

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

IF THE PROVIDER CONTACT INQUIRES ABOUT:	AND INQUIRES VIA:	AFTER THE PROVIDER ELEMENTS HAVE BEEN AUTHENTICATED, THE FOLLOWING BENEFICIARY ELEMENTS SHALL BE AUTHENTICATED (all elements must match unless otherwise specified):	THEN THE FOLLOWING ELEMENTS SHOULD BE RELEASED:
1. Routine Eligibility Elements[2]	Call to CSR or written inquiry	• Beneficiary full last name (including hyphenated names, suffixes (i.e., Jr., Sr.) and abbreviation of titles (i.e., Fr. for Father, Sr. for Sister) NOTE: Because systems limitations sometimes prevent full last names and suffixes from showing on contractor records, an exact name match is not required; however, the CSR shall be certain that the beneficiary surname given by the provider is a match to the name on the beneficiary record being displayed. • Beneficiary first name or first initial • Current or previously assigned HICN, including both alpha and numerical	Contractors have the discretion to routinely release all elements or only release when requested. Contractors shall use inquiry and rejected/denied claims analysis results to decide what elements to routinely release. • Part A current and previous entitlement and termination dates • Part B current and previous entitlement and termination dates • Deductible Met – Yes / No • Managed Care – Yes / No • MSP – Yes / No • Crossover established – Yes / No • Home Health – Yes / No

[2] **Note about Medicare Advantage Plans, Medicare Advantage Prescription Drug Plans and Medicare Prescription Drug Plans:** These Plans have access to eligibility information to enroll Medicare beneficiaries in Part C or Part D. Once enrolled, Plans have access to Medicare information about their enrollees. Provider contact centers should not be receiving inquiries from these Plans. Contractors receiving inquiries from these Plans shall tell the Plans that they do not handle these inquiries and to check their guidance from CMS about how to access beneficiary information.

		characters (if a new HICN displays when the provider supplies the HICN, then the CSR may disclose the new number) • Date of birth NOTE: If there is an error, the CSR should tell the inquirer which overall element (for example, date of birth instead of day, month and year) does not match and to check the beneficiary's record, which should include a copy of the Medicare card, and/or follow up with the beneficiary, for the correct information.	• Hospice – Yes / No • SNF – Yes / No • Pneumoccocal Vaccine – Yes / No --- When prompted by the inquirer: • Deductible amount remaining (Part A) or applied (Part B) • Managed Care – plan #, name, address, type, enrollment and termination dates • MSP – insurer name, policy #, effective and termination dates, type of primary insurance, and insurer address. * Contractors shall release this information with a caveat that this information may not be correct and that the beneficiary is the best source for insurance information. For inquiries about the accuracy of the MSP information on the beneficiary's auxiliary record, CSRs shall refer the caller to the Coordination of Benefits Contractor at 1-800-999-1118. The COBC is responsible for the accuracy of the MSP information in Medicare's file. • Claims Crossover Status – insurer or supplemental payer names(s), Coordination of Benefits Agreement (COBA) ID(s), effective and termination dates, deletion dates. * For inquiries concerning why the supplemental payer insurer did or did not include the beneficiary on its eligibility files so that claims can be crossed over, the CSRs shall direct the provider to the beneficiary's supplemental insurer.

			• Home Health – applicable earliest and latest dates • Hospice - applicable earliest and latest dates • SNF – applicable earliest and latest dates • Pneumoccocal Vaccine – administration date • Influenza Vaccine – administration date • Hepatitis B Vaccine – administration date • Blood Deductible • Date of Death
2. Routine Eligibility Elements[3]	IVR (involves touchtone or speech recognition technology)	• Beneficiary last name – first 6 letters (no special characters); if using speech recognition technology, may use first 6 letters or entire last name, including hyphenated last names, suffixes (i.e., Jr., Sr.) and abbreviation of titles (i.e., Fr. for Father, Sr. for Sister) NOTE: Because systems limitations sometimes prevent full last names and suffixes from showing on contractor records, an exact name match is not required; however, the contractor shall program the IVR to ensure that the beneficiary surname given by the provider is a good match to the name on the beneficiary record being accessed. For	Contractors shall frequently analyze IVR usage and inquiry and rejected/denied claims analysis results to determine which elements should be routinely offered. Elements in other categories below may be offered routinely, if providers are frequently requesting this information and to include it here would improve provider service and satisfaction and decrease CSR-handled calls. • Part A current and previous entitlement and termination dates • Part B current and previous entitlement and termination dates • Deductible Met – Yes / No • Managed Care – Yes / No • MSP – Yes / No

[3] **Note about Medicare Advantage Plans, Medicare Advantage Prescription Drug Plans and Medicare Prescription Drug Plans:** These Plans have access to eligibility information to enroll Medicare beneficiaries in Part C or Part D. Once enrolled, Plans have access to Medicare information about their enrollees. Provider contact centers should not be receiving inquiries from these Plans. Contractors receiving inquiries from these Plans shall tell the Plans that they do not handle these inquiries and to check their guidance from CMS about how to access beneficiary information.

		surnames of less than 6 letters, contractors should program their IVRs to match names of less than 6 letters or should include instructions for callers in the IVR operating guide on how to input spaces or blanks so that 6 digits are input. • Beneficiary first name or first initial • Currently or previously assigned HICN, including both alpha and numerical characters (the IVR may disclose the current HICN when a previously assigned HICN is input) • Date of birth NOTE: The IVR response, if feasible, should relay which overall element (for example, date of birth instead of day, month and year) does not match and to check the beneficiary's record, which should include a copy of the Medicare card, and/or follow up with the beneficiary, for the correct information.	• Crossover established – Yes / No • Home Health – Yes / No • Hospice – Yes / No • SNF – Yes / No • Pneumoccocal Vaccine – Yes / No --- NOTE: For the elements below, contractors have discretion on whether to offer these elements and if so, how to program the IVR to offer these additional elements. When prompted by the inquirer: • Deductible amount remaining (Part A) or applied (Part B) • Managed Care – plan #, name, address, type, enrollment and termination dates • MSP – insurer name, policy #, effective and termination dates, type of primary insurance, and insurer address. * Contractors shall release this information with a caveat that this information may not be correct and that the beneficiary is the best source for insurance information. For inquiries about the accuracy of the MSP information on the beneficiary's auxiliary record, the IVR shall refer the caller to the Coordination of Benefits Contractor at 1-800-999-1118. The COBC is responsible for the accuracy of the MSP information in Medicare's file. • Claims Crossover Status – insurer or supplemental payer names(s), Coordination of Benefits Agreement (COBA) ID(s), effective and

			termination dates, deletion dates. * For inquiries concerning why the supplemental payer insurer did or did not include the beneficiary on its eligibility files so that claims can be crossed over, the IVR shall direct the provider to the beneficiary's supplemental insurer. • Home Health – applicable earliest and latest dates • Hospice - applicable earliest and latest dates • SNF – applicable earliest and latest dates • Pneumoccocal Vaccine – administration date • Influenza Vaccine –administration date • Hepatitis B Vaccine –administration date • Blood Deductible • Date of Death
3. Optional Eligibility Elements Based on Type of Provider and Type of Service Provided (Contractors shall use discretion in determining the type of information to be released to an inquirer; the contractor shall only release this information to assist the provider in	Call to CSR or written inquiry	• Beneficiary full last name (including hyphenated names, suffixes (i.e., Jr., Sr.) and abbreviation of titles (i.e., Fr. for Father, Sr. for Sister) NOTE: Because systems limitations sometimes prevent full last names and suffixes from showing on contractor records, an exact name match is not required; however, the CSR shall be certain that the beneficiary surname given by the provider is a match to the name on the beneficiary record being displayed. • Beneficiary first name or first initial • Current or previously assigned HICN, including both alpha and numerical	NOTE – Contractors should not routinely make this information available to all providers/suppliers. Contractors should make this information available on a need to know basis and should disclose it only to enable a provider to bill Medicare properly. For example, a SNF may need information about hospital stays in order to bill properly. ● **ESRD:** ● Renal Supplies: • ESRD effective dates • Transplant discharge date ● Alternate Method Dialysis: • Method 1 • Method 2

billing Medicare properly. Contractors are not required to respond to inquiries if the contractor does not have access to the information necessary to answer the inquiry. If possible, the contractor should refer the inquirer to the entity (i.e., another Medicare contractor) that may be able to address the inquiry. In instances where the provider is part of a multiple physician practice, but the specialty is not identified, contractors have discretion as to whether data should be released.)		characters (if a new HICN displays when the provider supplies the HICN, then the CSR may disclose the new number) • Date of birth NOTE: If there is an error, the CSR should tell the inquirer which overall element (for example, date of birth instead of day, month and year) does not match and to check the beneficiary's record, which should include a copy of the Medicare card, and/or follow up with the beneficiary, for the correct information.	• ESRD effective date • Transplant discharge date ● **Home Health:** ● Provider name ● Servicing contractor ● Applicable dates ● **Hospice:** ● Provider name ● Servicing contractor ● Applicable dates ● **Hospital:** ● Days remaining ● Deductible amount ● Co-insurance days remaining ● Lifetime reserve days ● Benefits Exhaust Date ● Date of earliest billing action/date of last billing action ● **Long Term Care:** ● Hospital days remaining ● Deductible amount ● Co-insurance days remaining ● Lifetime reserve days ● **Rehabilitation Room & Board:** ● Hospital days remaining ● Co-insurance hospital days remaining ● Lifetime reserve days ● **Psychiatric Limitation:**

			● Days remaining (full benefit, lifetime) ● Co-insurance days remaining (regular coinsurance, lifetime reserve coinsurance) ● Benefits Exhaust Date ● **SNF:** ● Days remaining ● Co-insurance days remaining ● Date of earliest billing action/date of last billing action ● **Therapy Cap information, including remaining limitation dollar amount and/or amount applied:** ● Speech therapy ● Occupational therapy ● Physical therapy
4. Optional Eligibility Elements Based on Type of Provider and Type of Service Provided (Contractors shall use discretion in determining whether to release this information and, if so, the type of information to be released to an inquirer; the contractor shall only	IVR (involves touchtone or speech recognition technology)	• Beneficiary last name – first 6 letters (no special characters); if using speech recognition technology, may use first 6 letters or entire last name, including hyphenated last names, suffixes (i.e., Jr., Sr.) and abbreviation of titles (i.e., Fr. for Father, Sr. for Sister) NOTE: Because systems limitations sometimes prevent full last names and suffixes from showing on contractor records, an exact name match is not required; however, the contractor shall program the IVR to ensure that the beneficiary surname given by the provider is a good match to the name on the	NOTE – Contractors should not routinely make this information available to all providers/suppliers. Contractors should make this information available on a need to know basis and should disclose it only to enable a provider to bill Medicare properly. For example, a SNF may need information about hospital stays in order to bill properly. ● **ESRD:** ● Renal Supplies: • ESRD effective dates • Transplant discharge date ● Alternate Method Dialysis: • Method 1

release this information to assist the provider in billing Medicare properly. Contractors are not required to respond to inquiries if the contractor does not have access to the information necessary to answer the inquiry. In instances where the provider is part of a multiple physician practice, but the specialty is not identified, contractors have discretion as to whether data should be released.)		beneficiary record being accessed. For surnames of less than 6 letters, contractors should program their IVRs to match names of less than 6 letters or should include instructions for callers in the IVR operating guide on how to input spaces or blanks so that 6 digits are input. • Beneficiary first name or first initial • HICN, including both alpha and numerical characters (the IVR may disclose the current HICN when a previously assigned HICN is input) • Date of birth NOTE: The IVR response, if feasible, should relay which overall element (for example, date of birth instead of day, month and year) does not match and to check the beneficiary's record, which should include a copy of the Medicare card, and/or follow up with the beneficiary, for the correct information.	• Method 2 • ESRD effective date • Transplant discharge date ● **Home Health:** ● Provider name ● Servicing contractor ● Applicable dates ● **Hospice:** ● Provider name ● Servicing contractor ● Applicable dates ● **Hospital:** ● Days remaining ● Deductible amount ● Co-insurance days remaining ● Lifetime reserve days ● Benefits Exhaust Date ● Date of earliest billing action/date of last billing action ● **Long Term Care:** ● Hospital days remaining ● Deductible amount ● Co-insurance days remaining ● Lifetime reserve days ● **Rehabilitation Room & Board:** ● Hospital days remaining ● Co-insurance hospital days remaining ● Lifetime reserve days

			● **Psychiatric Limitation:** ● Days remaining (full benefit, lifetime) ● Co-insurance days remaining (regular coinsurance, lifetime reserve coinsurance) ● Benefits Exhaust Date ● **SNF:** ● Days remaining ● Co-insurance days remaining ● Date of earliest billing action/date of last billing action ● **Therapy Cap information, including remaining limitation dollar amount and/or amount applied:** ● Speech therapy ● Occupational therapy ● Physical therapy
5. Preventive Services -Next Eligible Date - Contractors shall use discretion in determining the type of provider to whom to release this information; the contractor shall only release this information to assist the provider in	Call to CSR or written inquiry	• Beneficiary full last name (including hyphenated names, suffixes (i.e., Jr., Sr.) and abbreviation of titles (i.e., Fr. for Father, Sr. for Sister) NOTE: Because systems limitations sometimes prevent full last names and suffixes from showing on contractor records, an exact name match is not required; however, the CSR shall be certain that the beneficiary surname given by the provider is a match to the name on the beneficiary record being displayed. • Beneficiary first name or first initial	**Next eligible dates for professional / technical components for the following services:** • Abdominal Aortic Aneurysm Screening • Adult Immunizations • Bone Mass Measurements • Cancer Screenings • Cardiovascular Screening • Diabetes Screening • Diabetes Supplies • Diabetes Self-Management Training • Medical Nutrition Therapy (for Medicare beneficiaries with diabetes or renal disease)

determining a beneficiary's eligibility for these services or billing Medicare properly.		• Currently or previously assigned HICN, including both alpha and numerical characters (if a new HICH displays when the provider supplies the HICN, then the CSR may disclose the new number) • Date of birth NOTE: If there is an error, the CSR should tell the inquirer which overall element (for example, date of birth instead of day, month and year) does not match and to check the beneficiary's record, which should include a copy of the Medicare card, and/or follow up with the beneficiary, for the correct information.	• Glaucoma Screening • Initial Preventive Physical Exam ("Welcome to Medicare" Physical Exam) • Smoking and Tobacco-Use Cessation Counseling The inquirer should provide the HCPCS code or a description of the service. If a description is provided, instead of a HCPCS code, confirm the exact service being referenced to ensure that the information being disclosed is what is being requested. *NOTE: The list of preventive services is accurate as of the publication date of this document and is provided for informational and educational purposes only. If preventive services change before the Disclosure Desk Reference is updated, contractors shall use the most current list of preventive services. Be sure to pay close attention to relevant Change Requests for updates. In addition, more information can be found at the following Web sites:* http://www.cms.hhs.gov/PrevntionGenInfo/ http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf

6. Preventive Services -Next Eligible Date - Contractors shall use discretion in determining whether to release this information in the IVR and, if so, the type of provider to whom to release this information; the contractor shall only release this information to assist the provider in determining a beneficiary's eligibility for these services or billing Medicare properly.	IVR (involves touchtone or speech recognition technology)	• Beneficiary last name – first 6 letters (no special characters); if using speech recognition technology, may use entire last name, including hyphenated last names, suffixes (i.e., Jr., Sr.) and abbreviation of titles (i.e., Fr. for Father, Sr. for Sister) NOTE: Because systems limitations sometimes prevent full last names and suffixes from showing on contractor records, an exact name match is not required; however, the contractor shall program the IVR to ensure that the beneficiary surname given by the provider is a good match to the name on the beneficiary record being accessed. For surnames of less than 6 letters, contractors should program their IVRs to match names of less than 6 letters or should include instructions for callers in the IVR operating guide on how to input spaces or blanks so that 6 digits are input. • Beneficiary first name or first initial • Currently or previously assigned HICN, including both alpha and numerical characters (the IVR may disclose the current	**Next eligible dates for professional / technical components for the following services:** • Abdominal Aortic Aneurysm Screening • Adult Immunizations • Bone Mass Measurements • Cancer Screenings • Cardiovascular Screening • Diabetes Screening • Diabetes Supplies • Diabetes Self-Management Training • Medical Nutrition Therapy (for Medicare beneficiaries with diabetes or renal disease) • Glaucoma Screening • Initial Preventive Physical Exam ("Welcome to Medicare" Physical Exam) • Smoking and Tobacco-Use Cessation Counseling The inquirer should provide the HCPCS code or a description of the service. If a description is provided, instead of a HCPCS code, confirm the exact service being referenced to ensure that the information being disclosed is what is being requested.

		HICN when a previously assigned HICN is input) • Date of birth NOTE: The IVR response, if feasible, should relay which overall element (for example, date of birth instead of day, month and year) does not match and to check the beneficiary's record, which should include a copy of the Medicare card, and/or follow up with the beneficiary, for the correct information.	*NOTE: The list of preventive services is accurate as of the publication date of this document and is provided for informational and educational purposes only. If preventive services change before the Disclosure Desk Reference is updated, contractors shall use the most current list of preventive services. Be sure to pay close attention to relevant Change Requests for updates. In addition, more information can be found at the following Web sites:* http://www.cms.hhs.gov/PrevntionGenInfo/ http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf
7. Processed claims information NOTE – Contractors should release information prior to claim submission only with the	CSR (also applies to written inquiries)	• Beneficiary full last name (including hyphenated names, suffixes (i.e., Jr., Sr.) and abbreviation of titles (i.e., Fr. for Father, Sr. for Sister) NOTE: Because systems limitations sometimes prevent full last names and suffixes from showing on contractor records, an exact name match is not	Contractors shall use discretion in determining what information to release. **Assigned Claims** Participating and non-participating - any information on that provider/supplier's claim or any other related claim from that provider/supplier for that beneficiary, including

beneficiary's authorization or if, in the contractor's discretion, the provider needs information in order to bill Medicare properly and avoid an overlapping rejected claim.		required; however, the CSR shall be certain that the beneficiary surname given by the provider is a match to the name on the beneficiary record being displayed. • Beneficiary first name or first initial • Currently or previously assigned HICN, including both alpha and numerical characters (if a new HICH displays when the provider supplies the HICN, then the CSR may disclose the new number) ● Date of service NOTE: If there is an error, the CSR should tell the inquirer which overall element(for example, date of birth instead of day, month and year) does not match and to check the beneficiary's record, which should include a copy of the Medicare card, and/or follow up with the beneficiary, for the correct information.	whether the claim was crossed to whom it was crossed with, and the reason why it crossed, if applicable. **Non-assigned Claims** Information regarding only the claim in question; information is restricted to claim received (yes / no), date processed and why it was denied or reduced, including whether the claim was crossed over, to whom it was crossed with, and the reason why it crossed, if applicable. The following paragraphs apply to both assigned and unassigned claims. General Note – Contractors should speak with the provider/supplier about his/her own claims. Contractors should also disclose information about another provider/supplier as long as both providers/ suppliers have a relationship with the beneficiary and the purpose of the disclosure is to facilitate the payment of the provider/supplier that receives the information. ** If a provider inquires about a claim that was denied due to the beneficiary being incarcerated, the contractor shall tell the provider that Social Security *r*ecords indicate that this patient was a prisoner when the service was rendered and that Medicare does not cover items and services furnished to an individual while they are in *s*tate

			or local custody under a penal authority. **If a provider inquires about a claim that was denied due to the beneficiary being deported, the contractor shall tell the provider that Social Security records indicate that the individual has been deported and that Medicare does not cover items and services furnished to individuals who have been deported.
8. Processed claims information Contractors shall not release any processed claims information about incarcerated beneficiaries or deported beneficiaries via the IVR.	IVR (involves touchtone or speech recognition technology)	• Beneficiary last name – first 6 letters (no special characters); if using speech recognition technology, may use first 6 letters or entire last name, including hyphenated last names, suffixes (i.e., Jr., Sr.) and abbreviation of titles (i.e., Fr. for Father, Sr. for Sister) NOTE: Because systems limitations sometimes prevent full last names and suffixes from showing on contractor records, an exact name match is not required; however, the contractor shall program the IVR to ensure that the beneficiary surname given by the provider is a good match to the name on the beneficiary record being accessed. For surnames of less than 6 letters, contractors should program their IVRs to match names of less than 6 letters or should include instructions for callers in the IVR operating guide on how to input spaces or blanks so	Contractors shall use discretion in determining what information to release. **Assigned Claims** Participating and non-participating - any information on that provider / supplier's claim or any other related claim from that provider / supplier for that beneficiary, including whether the claim was crossed over to whom it was crossed with, and the reason why it crossed, if applicable. **Non-assigned Claims** Information regarding only the claim in question; information is restricted to claim received (yes / no), date processed and why it was denied or reduced, including whether the claim was crossed over to whom it was crossed with, and the reason why it crossed, if applicable.

		that 6 digits are input. • Beneficiary first name or first initial • Currently or previously assigned HICN, including both alpha and numerical characters (the IVR may disclose the current HICN when a previously assigned HICN is input) • Date of service NOTE: The IVR response, if feasible, should relay which overall element (for example, date of birth instead of day, month and year) does not match and to check the beneficiary's record, which should include a copy of the Medicare card, and/or follow up with the beneficiary, for the correct information.	
9. Certificate of Medical Necessity (CMN) and DME MAC Information Form (DIF)	Call to CSR or written inquiry	**Before a claim is submitted:** • Beneficiary full last name (including hyphenated names, suffixes (i.e., Jr., Sr.) and abbreviation of titles (i.e., Fr. for Father, Sr. for Sister) NOTE: Because systems limitations sometimes prevent full last names and suffixes from showing on contractor records, an exact name match is not required; however, the CSR shall be certain that the beneficiary surname given by the provider is a match to the name on the	Contractors shall use discretion in determining what information to release. Contractors should only release information from CMNs and/or DIFs that will facilitate providers / suppliers billing Medicare properly. Although not an authentication element, the caller will need to provide the HCPCS Code or item description in order for the CSR to provide the correct information about the CMN and/or DIF. • Initial date • Recertification date • Length of need

		beneficiary record being displayed. • Beneficiary first name or first initial • Current or previously assigned HICN, including both alpha and numerical characters (if a new HICN displays when the supplier gives the HICN, then the CSR may disclose the new number) ● Date of birth **After a claim is processed:** • Beneficiary full last name (including hyphenated names, suffixes (i.e., Jr., Sr.) and abbreviation of titles (i.e., Fr. for Father, Sr. for Sister) NOTE: Because systems limitations sometimes prevent full last names and suffixes from showing on contractor records, an exact name match is not required; however, the CSR shall be certain that the beneficiary surname given by the provider is a match to the name on the beneficiary record being displayed. • Beneficiary first name or first initial • Currently or previously assigned HICN, including both alpha and numerical characters (if a new HICN displays when the supplier gives the HICN, then the CSR may disclose the new number) ● Date of service	• Other elements necessary to properly bill Medicare Contractors shall confirm whether the answers to the question sets on the CMN and/or DIF on file match what the supplier has in his/her records.

		NOTE: If there is an error, the CSR should tell the inquirer which overall element (for example, date of birth instead of day, month and year) does not match and to check the beneficiary's record, which should include a copy of the Medicare card, and/or follow up with the beneficiary, for the correct information.	
10. Certificate of Medical Necessity (CMN) and DME MAC Information Form (DIF)	IVR (involves touchtone or speech recognition technology)	**Before a claim is submitted:** • Beneficiary last name – first 6 letters (no special characters); if using speech recognition technology, may use first 6 letters or entire last name, including hyphenated last names, suffixes (i.e., Jr., Sr.) and abbreviation of titles (i.e., Fr. for Father, Sr. for Sister); NOTE: Because systems limitations sometimes prevent full last names and suffixes from showing on contractor records, an exact name match is not required; however, the contractor shall program the IVR to ensure that the beneficiary surname given by the provider is a good match to the name on the beneficiary record being accessed. For surnames of less than 6 letters, contractors should program their IVRs to match names of less than 6 letters or should include instructions for callers in the IVR operating guide on how to input spaces or blanks so	Contractors shall use discretion in determining what information to release. Contractors should only release information from CMNs and/or DIFs that will facilitate providers / suppliers billing Medicare properly. Although not an authentication element, the caller will need to provide the HCPCS Code in order for the IVR to return the correct information about the CMN and/or DIF. • Initial date • Recertification date • Length of need • Other elements necessary to properly bill Medicare

		that 6 digits are input. • Beneficiary first name or first initial • Currently or previously assigned HICN, including both alpha and numerical characters (the IVR may disclose the current HICN when a previously assigned HICN is input) ● Date of birth **After a claim is processed:** • Beneficiary last name – first 6 letters (no special characters); if using speech recognition technology, may use entire last name, including hyphenated last names, suffixes (i.e., Jr., Sr.) and abbreviation of titles (i.e., Fr. for Father, Sr. for Sister) NOTE: Because systems limitations sometimes prevent full last names and suffixes from showing on contractor records, an exact name match is not required; however, the contractor shall program the IVR to ensure that the beneficiary surname given by the provider is a good match to the name on the beneficiary record being accessed. For surnames of less than 6 letters, contractors should program their IVRs to match names of less than 6 letters or should include instructions for callers in the IVR operating guide on how to input spaces or blanks so that 6 digits are input.	

		• Beneficiary first name or first initial • Currently or previously assigned HICN, including both alpha and numerical characters (the IVR may disclose the current HICN when a previously assigned HICN is input) ● Date of service NOTE: The IVR response, if feasible, should relay which overall element (for example, date of birth instead of day, month and year) does not match and to check the beneficiary's record, which should include a copy of the Medicare card, and/or follow up with the beneficiary, for the correct information.	
11. Call back to a Provider	*Referencing a specific claim.*	*Authenticate the provider using the most current authentication protocol.*	*If you call back a provider or provider representative about a specific claim you may release the name of the beneficiary and/or date of birth in order for the provider or provider representative to pull up or retrieve the necessary information and authenticate you.* *Authenticate the beneficiary using the following elements except for the elements that you released (name and/or date of birth).* ● *HICN* ● *Date of service or procedure*
12. Call back to a	*For reasons*	*Authenticate the provider using the most*	*If you call back a provider or provider*

provider	*other than a specific claim.*	*current authentication protocol.*	*representative for reasons other than a specific claim you may release the name of the beneficiary and/or date of birth in order for the provider or provider representative to pull up or retrieve the necessary information and authenticate you.* *Authenticate the beneficiary using the following elements except for the elements that you released (name and/or date of birth).* ● *HICN* ● *One of the following pieces of information: address, phone number, whether the beneficiary has Part A or Part B, entitlement date(s).*

90 - Provider Inquiry Standardized Categories

(Rev.26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)

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

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

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

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
Adjustments	Changing the information on a submitted claim to correct an error or the correction of a claim denied in error.	*Cancellation of Claim/Return Claim/Billed in Error*	Contact is asking to cancel a claim that was submitted in error. Includes "services not rendered."
		Claim Processing Error	Contact is asking for an adjustment of an incorrect payment due to a processing error by the local or shared systems, imaging errors, interest not paid or penalties applied in error.
		Claim Information Change	Contact is asking for change or correction of information on a submitted/processed claim; for example, contact asks to add or remove modifiers or procedure codes to correct the amount of units provided, etc.
		Medical Review	Contact is asking about corrections/changes in diagnosis/treatment on processed claim.
		MSP	Contact is asking about the adjustment process for changes in the beneficiary MSP or HMO record.
Administrative Billing Issues	The mechanism and processes of how to bill for Medicare Services, which includes the explanation of CMS instructions, procedures and decision-making criteria for claim review and payment decisions. This does not include an explanation of why a particular claim was denied.	*1500/UB-04 Form*	Contact is asking how to complete the claim form and/or where to find it, including an electronic equivalent of both 1500 and *UB04* Forms.
		Advance Beneficiary Notice (ABN)	Contact is asking for general information on ABN, for example, When is it appropriate to use an ABN?, What do I have to do with an ABN?
		Claims Related Reports	Contact is asking for information about accessing and/or receiving reports produced by Medicare regarding to billing trends, history of Medicare payments, comparative billing reports, medical review reports, etc.
		Claim Documentation	Contact is asking what information is necessary to submit with a claim to allow processing and/or adjudication of the claim, for example, medical record, progress notes, physicians orders, x-rays, etc.

CMS Standardized Provider Inquiry Chart

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

CMS Standardized Provider Inquiry Chart

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

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		Psychiatric Hospital PPS	Contact is asking for the Psychiatric Hospital PPS payment amount for a particular item or service provided to a Medicare beneficiary.
		Rehabilitation Hospital PPS	Contact is asking for the Rehabilitation Hospital PPS payment amount for a particular item or service provided to a Medicare beneficiary.
		Skilled Nursing Facility PPS	Contact is asking for the Skilled Nursing Facility PPS payment amount for a particular item or service provided to a Medicare beneficiary.
Appeals	Action initiated by the provider due to disagreement on a Medicare's claim determination.	*Process/Rights*	Contact is asking for general appeal information, appeal process instructions and/or appeal rights.
		Status/Explanation/Resolution	Contact is asking the status of the appeal. This involves whether an appeal has been received and/or whether the time to file an appeal has expired, an explanation of Medicare's determination with respect to the submitted appeal and requests for duplicates of Medicare Redetermination Notices (MRN).
		Qualified Independent Contractor (QIC) Contractor	Contact is asking about an appeal status or information related to appeals reviewed by the QIC.
Beneficiary Inquiries	*Contact initiated by a Medicare beneficiary or designated representative to a Medicare Provider Contact Center (PCC) to inquire or complain about a variety of aspects of the Medicare operation. These types of inquiries are considered misrouted and belong to 1-800 Medicare or related partners, who are designated to provide customer service to Medicare beneficiaries. Each Medicare beneficiary inquiry received by a Medicare PCC must be logged using this category or any of the subcategories below, as appropriate.*	*Claim Issues*	*Contact is asking questions related to status of claims, including appeals, and questions related to information contained in the MSN. Also, include requests for a copy of an MSN, requests for reopening of claims due to processing errors, scanning errors and system errors, and/or requests to cancel or reissue a Medicare claim related check.*

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		Complaints	*Contact (Medicare Beneficiary or designated representative) is presenting issue involving a Medicare beneficiary that reflects dissatisfaction with any aspect of the Medicare Program operation, its staff and its providers (i.e., about appointments with the MD, clearinghouse dismissals). Also, include complaints related to difficulty accessing 1-800 Medicare.*
		Coverage/Benefits	*Contact is asking questions related to services covered or excluded by the Medicare Program. Also, include inquiries related to diagnosis codes or procedure codes eligible for payment, prescription drug issues (i.e., requesting pre-authorization on a drug) and/or requests for Medicare publications (i.e., MEDPAR directory).*
		Eligibility/Entitlement	*Contact is asking questions related to Medicare beneficiary demographic information (i.e., date of birth, date of death, address), entitlement dates, benefit days, deductible or coinsurance. Also, include inquiries to confirm MSP information and/or a beneficiary enrollment to a Medicare Advantage plan and/or HIPAA/Privacy – third-party authorizations.*
		Fraud and Abuse	*Contact is reporting issues with providers related to possible abusive and/or fraudulent practices(i.e. , payment assignments and violations to them)*
		MSP	*Contact is asking questions related to Medicare as primary or secondary insurance, and other coordination of benefits issues (i.e. coordination between Part A and Part B, files updates). It includes beneficiary inquiries attempting to update the MSP record due to issues with a Medicare Advantage Plan, co-insurance coordination with primary or secondary insurance, and/or issues due to a crossover claim.*
Claim Denials	Claim that has been fully adjudicated and a non-payment determination has been made based on Medicare rules and regulations.	*ABN*	Contact is asking for clarification on a particular claim denial where the use of ABN applies and the patient is not required to pay the provider for a service.
		Certification Requirements	Contact is asking about claim(s) denied due to certification requirements not being met. This includes Hospice certifications and/or Certificates of Medical Necessity

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
			(CMNs).
		Claim Overlap	Contact is asking about claim(s) denied due to an overlap in service dates with a previously processed claim. This may include the denial of a Part B claim for physical therapy services that conflicted with a previously processed inpatient claim with overlapping dates of service.
		Coding Errors/Modifiers	Contact is asking about a claim(s) denied due to an invalid or incorrect code. Includes the absence or incorrect use of a modifiers*, global surgery denials and denials due to CCI edits.*
		Contractor Processing Errors	Contact is asking about a claim(s) denied due to a contractor error (incorrect edit, shared systems issue, etc.), when processing the claim.
		Contractual Obligation Not Met	Contact is asking about a claim(s) denied because the provider did not comply with their Medicare contractual obligation (for example, the claim was submitted with missing information, the claim was not filed timely, etc).
		CWF Rejects	Contact is asking about a claim(s) denied because information on the claim does not match the CWF beneficiary information (for example, Managed Care/HMOs status, discharge status, name mismatch, female patient with a male procedure claimed). Log under this sub-category CWF issues that need to be corrected through SSA because the provider submitted correct information on the claim and CWF file needs to be updated. Please note that “frequency limit” issues identified by CWF should be categorized under "frequency limitation" (See below).
		Denial Letter Request	Contact is asking for a copy of the Medicare denial letter, establishing the reason for non payment of services in order to bill another insurer.
		DME POS Issues	Contact is asking about a claim(s) denied due to equipment, item or service not received by a beneficiary or returned to a supplier and other maintenance/services issues. Also, includes break-in service denials.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		Duplicate	Contact is asking about a claim(s) denied due to same date of service, claim previously processed or paid for the same date and same provider.
		EMC Filing Requirements	Contact is asking about a claim(s) where payment was denied as not being covered unless they are submitted electronically.
		Eligibility	Contact is asking about a claim(s) denied due to incorrect patient information submitted by the provider that does not agree with CWF (for example, incorrect suffix, transposed numbers) and affects the patient's eligibility for Medicare Benefits. Log under this sub-category, issues were there is no need to update information on CWF files.
		Evaluation & Management Services	Contact is asking about a claim(s) where payment was denied or reduced due to a changed E&M code. E&M codes explain how the physician gathered and analyzed patient information determined a condition and advised the best treatment. Includes services such as: office visits, hospital visits, consultation visits, and care plan oversight.
		Frequency / Dollar Amount Limitation	Contact is asking about a claim(s) that was denied because the allowable number of incidences or dollar amount limit for that service in a given time period has been exhausted or exceeded due to a service that was previously billed. Also, includes inquiries related the outpatient therapy cap and to billing frequency limits for durable medical equipment and supplies (same or similar equipment denials) such as Capped Rental.
		LCD	Contact is asking about a claim(s) that was denied or reduced based on a local coverage determination (LCD) by the contractor. Coverage determinations reflect the local contractor decision as to whether a product, service, or device is reasonable and necessary.
		Life Time Days Met	Contact is asking about claim(s) denied because a particular benefit is disallowed for a Medicare beneficiary due to the lifetime days limit exhausted.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		Medical Necessity	Contact is asking about a claim(s) denied because the information presented did not indicate services or supplies are reasonable and necessary for the diagnosis and treatment of the illness or injury. *Includes denials related to medically unbelievable edits.*
		MSP	Contact is asking about a claim(s) denied due to other insurance existing on the beneficiary file that is primary to Medicare.
		NCD	Contact is asking about a claim(s) that was denied or reduced based on a national coverage determination (NCD) by CMS. Coverage determinations reflect national Medicare coverage policies governing specific medical service, procedure or device.
		Provider Number	*Contact is asking about a claim(s) denied due to issues between the shared systems and the provider identification number (i.e. UPIN, NPI, Group Number).*
		Statutory Exclusion	Contact is asking about a claim(s) that items or services were denied by law.
Claim Status	Information about where the claim is in the process and whether it has been paid. Routine claim status questions are to be referred to the IVR.	*Additional Development Request (ADR) Letters*	Contact is asking about a Medicare letter received from the contractor that requests more information or documentation to process pending claim(s). Contact may also be providing a response to a written request.
		Applied to Deductible	Contact is asking about a processed claim where payment was not generated because the payment amount was applied to the beneficiary's annual deductible amount.
		ATP Amount/Check Information	Contact is asking for current Approved to Pay (ATP) amount, current pending claims totals and/or payment information on a claim (i.e., status of check, check number, check amount and issued date).
		Crossover	Contact is asking for information on a claim that is covered by a supplemental insurer, such as Medigap or other private insurance.
		Not on File	Contact is asking for a claim that Medicare does not have on file or that has not been received by the contractor.

CMS Standardized Provider Inquiry Chart

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

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		Evaluation & Management Codes (E&M)	Contact is asking about codes that explain how the physician gathered and analyzed patient information, determined a condition, and advised the best treatment. Examples are: care plan oversight, office visits, hospital visits and consultations. E&M codes are a part of the AMA's CPT-4 coding system.
		Modifiers	Contact is asking about two digit codes used in conjunction with a procedure code that provides additional information about the service. The modifier may affect the reimbursement rate of a service.
		MSP Payer/Value Codes	Contact is asking about codes used to designate that another insurer is responsible for full or partial payment where Medicare has no payment or secondary payment responsibility.
		Revenue Codes	Contact is asking about codes that identify specific accommodations or ancillary charges that are provided in a hospital, (e.g., blood, cardiology, radiology, laboratory services, etc.
		Patient Status Codes	Contact is asking about codes that indicate the patient's status as of the "Through" date of the billing period. These codes reflect the destination of the patient not the service received at the ending date. Includes also inquiries related to source of admission codes and discharge status codes.
		Place of Service Codes	Contact is asking about codes on professional claims to identify where the service was rendered.
		Specialty Codes	Contact is asking about codes used on a claim form to indicate a provider's type or medical specialty.
Complaints	An expression of dissatisfaction with service from providers in regards to different aspects of the Medicare operation.	*Contact Center Closure*	Contact is expressing dissatisfaction due to hours of operation or call center closures for CSR training.
		Medicare Contractor Operation	Contact is expressing dissatisfaction due to contractor operational errors, procedures, policies, processes, and staff issues not addressed by other subcategories included in this section.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		Medicare Program	Contact is expressing dissatisfaction due to issues with the Medicare program. Includes provider expressions of intentions of leaving the Medicare program.
		Provider Education and Outreach	Contact is expressing dissatisfaction with educational activities, education staff performance or availability of educational resources or activities for Medicare providers.
		Self Service Technology	Contact is expressing dissatisfaction due to content, functionality, instability, formatting and processes related to Provider Self Service tools such as CMS or contractor website, online tools for eligibility inquiries or claim submissions, IVR, etc.
		Staff	Contact is expressing dissatisfaction due to CSR or Staff attitude, incorrect information given or non response to an inquiry.
Direct Data Entry (DDE)	The Direct Data Entry system is an on-line application that allows direct on-line access to Medicare claims, such as: claim entry, error correction, eligibility inquiry, claims status, claim adjustment and roster billing.	*Connectivity/Installment/Processing Issues*	Contact is requesting assistance with the connection, installment, password resets, claim processing and adjustments through DDE.
		Orientation Package	Contact is requesting information or an orientation package related to DDE.
DMEPOS Competitive Bidding Program	*Inquiries related to the DMEPOS Competitive Bidding Program designed to improve the effectiveness of Medicare's DMEPOS payments, reduce beneficiary out-of-pocket costs, and save the Medicare program money while ensuring beneficiary access to quality DMEPOS items and services. It requires the suppliers to be accredited by a Medicare-recognized accreditation organization.*	*Bidding Cycle*	*Contact is asking questions regarding the DMEPOS bidding cycle i.e. application requirements, evaluation criteria and deadlines. Also, Includes question about the accreditation process.*

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		Claim Denials	*Contact is asking about claim(s) denied due to issues related to DMEPOS items i.e. non-contract supplier billing, repair/service/replacement, misuse or missing modifiers.*
		Complaints	*Contact is expressing dissatisfaction with different aspects and/or processes of the DMEPOS Competitive Bidding Program.*
		Filing/Billing Instructions	*Contact is asking for instructions on i.e. how to file a claim for a DMEPOS item, modifiers to use, documentation required including an ABN.*
		Policy/Coverage Rules	*Contact is asking for clarification of Medicare contract and CBAs policy, to cover and pay DMEPOS items. Also, includes CBAs rules about repair and replacement of beneficiary-owned items, questions about product categories covered by the program, traveling beneficiary rules, grandfathering provisions, non-contract supplier issues and special rules for certain provider specialties and medical facilities.*
		Provider Outreach& Education	*Contact is asking questions or requesting information about outreach opportunities and reference educational materials related to the DMEPOS Competitive Bidding Program including the directory of contract suppliers and the list of contract items.*
		Single Payment Amount	*Contact is asking for the allowed payment amount established by the DMEPOS Competitive Bidding Program.*
Electronic Data Interchange (EDI)	The system for submitting claims electronically and retrieving Electronic Remittance Advices.	*Connectivity/Installment Issues*	Contact is requesting assistance with the connection, installment and password resets through EDI.
		Front End or Vendor Editing	Contact is requesting information or assistance with errors in the transmission or status of claims submitted electronically.
		Information package/HIPAA Compliant Billing Software	Contact is requesting information or an orientation package related to EDI.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
Eligibility/Entitlement	The qualification of an individual to receive Medicare, including various qualifying aspects of Medicare coverage (as described in the associated subcategories). If multiple sub-categories are discussed in the same inquiry, log main category for tracking purposes.	*Beneficiary Demographic*	Contact is asking to verify or update (within the contractor's ability) beneficiary personal information, such as HIC number, address, date of birth, date of death, etc.
		Benefit Days Available	Contact is asking for the number of days in a hospital or SNF that remain available for the beneficiary.
		Deductible	Contact is asking if the beneficiary's annual deductible amount has been met so that Medicare payment for providers' services or supplies can begin.
		DME Same or Similar Equipment	Contact is asking if beneficiary has a DME Certificate of Medical Necessity (CMN) or DMERC Information Form (DIF) active, or if a beneficiary has same or similar equipment previously covered by Medicare on file.
		HMO Record	Contact is asking whether the beneficiary is enrolled in an HMO, when HMO enrollment began, or for HMO contacts information.
		Hospice	Contact is asking if beneficiary has a hospice record open.
		MSP Record	Contact is asking for information related to other insurance coverage that the beneficiary might have that is primary to Medicare.
		Next Eligible Date	Contact is asking when is the next eligible date for the beneficiary to receive one or more preventive services.
		Outpatient Therapy Cap	Contact is asking if the beneficiary's outpatient therapy cap amount has been reached.
		Part A Entitlement	Contact is asking when the beneficiary became eligible for Part A benefits.
		Part B Entitlement	Contact is asking when the beneficiary became eligible for Part B benefits or whether the beneficiary is eligible for Part B benefits.

CMS Standardized Provider Inquiry Chart

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

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		Overpayment	Contact is asking about the notice that they have received due to Medicare funds in excess of amounts that are due and payable to them under the Medicare statute and regulation. The amount of the overpayment is a debt owed to the U.S. Government.
		Refunds	Contact is asking about a refund, such as, its status, notifying Medicare that a refund is needed, or asking about the process to request it.
		Stop Payment / Check to Be Reissued	Contact is requesting a stop payment, reissuance a check, asking how to request it or verifying the status of a previous request. Also, includes check reissue inquiries due to stale dated checks and checks sent to wrong provider.
General Information	Information that cannot be included in other categories.	*Address /Phone/Fax/Web Address*	Contact is asking for contractor's addresses including website, fax and phone numbers.
		Issue Not Identified/Incomplete Information Provided	Contact failed to explain the reason for the inquiry, or omitted a HIC number or provider number. This sub-category may apply to written correspondence only.
		Misrouted Telephone Call/Written Correspondence	Contact is asking a question that should be handled in another contractor area, by another contractor and or by another agency/program.
		Reference Resources Referral/Request	Contact is asking where to find or access information about specific topics or requesting information about resources available for provider education or self service options, such as, MEDPARD directory, online claim status availability, electronic remittance advice, IVR, etc.
		Other Issues	Contact is discussing subjects that are not classifiable into the defined categories or subcategories.
HIPAA Privacy/ Privacy Act	The statutory authorities that govern the protections for personally identifiable patient health information and the conditions of its release.	*Authorizations*	Contact is asking for a consent/authorization form or a copy of their patient's authorization, which is necessary to release the information requested.
		Release of Information Request	Contact is requesting a copy of patient history or record.
		Requirements	Contact is asking about the HIPAA Privacy or Privacy Act requirements. Also, includes inquiries related to HIPAA contingency plans and the compliance with HIPPA

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
			transaction rules.
MSP	The term used when Medicare is not responsible for paying primary on a claim that is otherwise the primary responsibility of another payer.	*COB/MSP Rules*	Contact is asking about Coordination of Benefits Rules and/or Medicare Secondary Payer Rules.
		Coordination of Benefits (COB) Contractor	Contact is asking about the COB contractor responsibilities and contact information. Includes situations that require a referral to the COB contractor.
		File Updates	Contact is asking for beneficiary MSP/COB files information or providing information for MSP/COB file update.
		Liens and Liabilities/Settlements	Contact is asking about requesting or accepting a Medicare conditional payment, for services that would otherwise be covered under Workers Compensation, No Fault Insurance, Liability and Group Health Plans (GHP). Also, includes questions about settlement information and the status of a conditional payment.
Policy/ Coverage Rules	Includes inquiries related to policy questions, coverage rules and benefits information.	*Benefits/Exclusions/ Coverage Criteria/Rules*	Contact is asking for clarification of rules and criteria used by Medicare to cover and pay for services furnished to Medicare beneficiaries by Medicare providers.
		Certifications Requirements	Contact is asking about requirements, electronic submissions and/or status, when applicable, of certifications for Medicare Benefits. This may include Hospice certifications and/or Certificate of Medical Necessity.
		Local Coverage Determination (LCD)	Contact is asking about a local coverage policy developed by the Medicare contractor to describe the circumstances for Medicare coverage for a specific medical service, procedure or device within their jurisdiction.
		National Coverage Determination (NCD)	Contact is asking about a national coverage policy developed by the Centers for Medicare & Medicaid Services to describe the circumstances for Medicare coverage for a specific medical service, procedure or device.
		Non-published Items	Contact is asking about the coverage of items with no criteria published by contractor or CMS.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		Pre-authorization	Contact is asking about or requesting a pre-authorization for providing Medicare benefits.
		Statutes and Regulations	Contact is asking about the Federal law and regulations that govern the Medicare Program and its operation.
Provider Enrollment	The forms and process by which an individual, institution or organization becomes a provider in the Medicare program, eligible to bill for their services.	*National Provider Identifier*	Contact is asking about the National Provider Identifier (NPI).
		Provider Demographic Information Changes	Contact is asking for verification of their provider demographic information or asking how to request a change/correction of its existing information.
		Provider Eligibility	Contact is asking about his or her status as a Medicare Program participant or not participant provider, and how to change it. Also, includes inquiries related to a provider alert/sanction status period.
		Provider Enrollment Requirements	Contact is asking about the requirements to become a participating provider of the Medicare Program. Also, includes inquiries from a provider not certified by Medicare, overview/orientation of the Provider Enrollment Forms (CMS 855 Form), where to find it and/or instructions on how to complete it.
Provider Outreach	The contractor's educational effort and activities with the provider community.	*Education Referrals*	Contact is requesting contact/visit from Professional Relations Staff to provide supplemental education, discuss an issue in-depth, or to request clarification of a confusing situation.
		Workshop Information	Contact is asking for information about provider outreach activities or educational opportunities for providers and their staff.
Remittance Advice (Remit)	The paper or electronic summary statement for providers, including payment information for one or more beneficiaries.	*Duplicate Remittance Notice*	Contact is asking for a duplicate remittance notice. Includes inquiries where provider did not received his/her remittance notice, needs to send it to the patient's second insurance, needs a single line or a no pay remittance notice.
		ERA Election	Contact is asking for information about how to access and/or receive remittance notices electronically. *Include inquiries related to the Medicare Easy Print (MREP) software.*

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		How to read RA	Contact is asking for assistance in reviewing and/or understanding their remittance notice. Includes explanation of the Claim Adjustment Reason Codes and Remittance Advice Remark Codes on the Remittance Notice.
RTP/Unprocessable Claim	A claim(s) with incomplete, invalid, or missing information will be returned to the provider as unprocessable. This action cannot be appealed and the corrected claim(s) needs to be submitted as a new claim. Includes "W Status of Claim" and status of claims to be returned to provider.	*1500 / UB-04 Form Item*	Contact is asking about a claim(s) that was returned because the CMS claim form was not completed with the required information, such as, missing or invalid HICN, name, date of birth or sex. Includes the explanation of narrative of reason codes in the contractor's claims correction file, claims processing system and reports.
		Clinical Laboratory Improvement Act (CLIA)	Contact is asking about a claim(s) that was returned because the claim had a missing or incorrect CLIA number.
		Contractor Error	Contact is asking about a claim(s) that was returned to provider as unprocessable due to a contractor error.
		Contractual Obligation Not Met	Contact is asking about a claim(s) rejected because the provider did not comply with his or her Medicare contractual obligation. For example, the claim was presented with missing information (other than codes or modifiers), the billing was not timely, etc.
		Shared Systems	Contact is asking about a claim(s) that was returned because the patient information on the claim does not match information on CMS's shared systems (FISS, MCS, VMS and CWF).
		Missing/Invalid Codes	Contact is asking about a claim(s) that was returned because of a missing or invalid or changed code. Includes "Invalid CPT" inquiries.
		Place of Service	Contact is asking about a claim(s) that was returned due to invalid place of service or the place of service was not related to the procedure.
		Provider Information	Contact is asking about a claim(s) that was returned due to an incorrect or missing UPIN/NPI.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		Submitted to Incorrect Program	Contact is asking about a claim(s) that was returned because it was submitted to the incorrect program (FI, Carrier or DMERC).
		Truncated Diagnosis	Contact is asking about a claim(s) that was returned due to incorrect, invalid or missing diagnosis information.
Systems Issues	Medicare electronic systems, including the Medicare Claims Processing Systems and/or customer self-service applications (I.e. CMS website, contractor website, IVR, etc).	*Medicare Claims Processing System Issues*	Contact is presenting situation related to issues with the Medicare Processing Systems; for example, issues due to an aged claim, recycling claim and release of claims, etc.
		Website Issues	Contact is reporting problems with the functionality, stability or use of the CMS and contractor website.
		IVR Issues	Contact is reporting problems with the functionality or use of the contractor's IVR.
Temporary Issues	Includes inquiries that CMS would like to track temporarily due to special circumstances. CMS will provide specific timeframes for the monitoring of temporary issues. For contractor specific temporary issues, please follow instructions on IOM 100-9, Chapter 3, Section 20.5 or Chapter 6, Sections 30.1.1 – 30.1.1.2.	*CD-ROM Initiative*	Contact is requesting a hard-copy of the Annual Disclosure Statement, the "Dear Provider" letter and provider enrollment material in CD-ROM form, or asking for clarification of the CD-ROM content. Includes logging of CD-ROM related problems that providers encountered.
		CERT	Contact is asking information related to the Comprehensive Error Rate Testing (CERT) Program.
		Competitive Acquisition Program (CAP)	Contact is asking general questions about the CAP.
		E-Prescribing	*Contact is asking for general information about E-Prescribing and the E-Prescribing Incentive Program, with the exception of a request for an E-Prescribing Feedback Report.*
		E-Prescribing Feedback Report Request	*Contact is requesting an E-Prescribing Feedback Report by using the National Provider Identifier*

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		HIGLAS	Contact is presenting a situation due to the implementation of HIGLAS, the new financial accounting system. Includes inquiries about HIGLAS's training material, its impact on claim processing, recoup overpayments, demand letters, settlements and penalty withholdings, HIGLAS changes on remittance advices and checks (voided/reissued).
		Part D Drug Coverage	Contact is presenting situation related to issues with the implementation of the Part D Medicare Prescription Drug Coverage.
		PQRI	*Contact is asking for information about the Physician Quality Reporting Initiative, with the exception of a request for a PQRI Feedback Report.*
		PQRI Feedback Report Request	*Contact is requesting a Physician Quality Reporting Initiative Feedback Report by using the National Provider Identifier.*
		Recovery Audit Contractor (RACs)	Contact is asking information about a CMS initiative using RACs to identify underpayments and overpayments and to recoup overpayments. Includes inquiries related to demand letters and records requested by RACs.

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
R21COM	01/11/2008	Instructions Related to the CMS Standardized Provider Inquiry Chart for FY2008	02/11/2008	5848
R20COM	07/13/2007	IOM Pub. 100-09, Chapters 3- Provider Inquiries and Chapter 6- Provider Customer Service Program Updates	07/30/2007	5597
R19COM	06/29/2007	IOM Pub. 100-09, Chapters 3- Provider Inquiries and Chapter 6- Provider Customer Service Program Updates - Replaced by Transmittal 20	07/30/2007	5597
R18COM	09/08/2006	Provider Customer Service Program	10/02/2006	5277
R16COM	07/21/2006	Disclosure Desk Reference for Provider Contact Centers	10/02/2006	5089
R15COM	11/18/2005	Initial Issuance of Chapter	12/19/2005	4137