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 20	**Date: JULY 13, 2007**
	Change Request 5597

NOTE: Transmittal 19, dated June 29, 2007is being rescinded and replaced by Transmittal 20, dated July 13, 2007. In chapter 3, sections 30.4.1 through 30.4.4 are deleted. The information has moved to new sections 30.5.1 through 30.5.4. In chapter 6, sections 80.4.1 through 80.4.4 are deleted. The information has moved to new sections 80.5.1 through 80.5.4. Additionally, in section 30.3.6.1 # 6 in chapter 6 the word "CSR" is replaced by "correspondent" and the word "QCM" is replaced by "QWCM." In section 60.3.1 in chapter 6, the word "calls" in all three bullets, are replaced by "provider responses."

SUBJECT: IOM Pub. 100-09, Chapters 3 – Provider Inquiries and Chapter 6 - Provider Customer Service Program Updates

I. SUMMARY OF CHANGES: This Change Request updates chapter 6, and reorganizes and updates chapter 3 in IOM Pub. 100-09. Clarification is provided regarding the authentication requirements needed to release beneficiary and claim-specific information to providers/suppliers. In addition, the requirements for telephone and written inquiries have been updated to reflect current guidelines.

New / Revised Material
Effective Date: May 23, 2007
Implementation Date: July 30, 2007

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

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

R/N/D	Chapter / Section / Subsection / Title
R	3/Table of Contents
R	3/20.1.1/Availability of Telephone Services
R	3/20.1.2/Automated Services - Interactive Voice Response (IVR)
R	3/20.1.3/Toll Free Network Services
R	3/20.1.4/Publication of Toll Free Numbers

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R	3/20.1.10/Provider Contact Center User Group (PCUG)
N	3/20.1.11/Performance Improvements
R	3/20.2/Contractor guidelines for High Quality Responses to Telephone Inquiries
R	3/20.2.1/Quality Call Monitoring (QCM) Program
N	3/20.2.1.1/QCM Calibration
N	3/20.2.1.2/QCM Performance Standards
D	3/20.2.2/Quality Written Correspondence Monitoring (QWCM)
D	3/20.2.2.1/QWCM Program
D	3/20.2.2.2/QWCM Calibration
D	3/20.2.2.3/QWCM Performance Standards
R	3/20.3/Written Inquiries
R	3/20.3.1/Contractor Guidelines for High Quality Responses to Written Inquiries
N	3/20.3.1.1/Quality Written Correspondence Monitoring (QWCM) Program
N	3/20.3.1.1.1/QWCM Calibration
N	3/20.3.1.1.2/QWCM Performance Standards
R	3/20.4/Walk-In Inquiries
R	3/20.4.1/Guidelines for High Quality Walk-In Service
D	3/20.4.2/Provider Satisfaction Surveys
D	3/20.4.2.1/Contractor Activities Related to the Medicare Contractor Provider Satisfaction Survey (MCPSS)
R	3/20.5/Surveys
N	3/20.5.1/Customer Service Operations Surveys
N	3/20.5.2/Provider Satisfaction Surveys
N	3/20.5.2.1/Contractor Activities Related to the Medicare Provider Satisfaction Survey (MCPSS)
N	3/20/6 - Provider Inquiry Reporting Standardization

R	3/30.1/Provider Transaction Access Number (PTAN)
D	3/30.1.1/Telephone Inquiries
D	3/30.1.1.1/Contractor Discretion Concerning IVR Information
D	3/30.1.2/Written Inquiries
R	3/30.2/Inquiry Types
R	3/30.2.1/Telephone Inquiries
N	3/30.2.1.1/Contractor Discretion Concerning IVR Information
R	3/30.2.2/Written Inquiries
R	3/30.3/Special Inquiry Topics
N	3/30.3.1/Overlapping Claims
N	3/30.3.2/Pending Claims
N	3/30.3.3/Requests for Information Available on the IVR
N	3/30.3.4/Requests for Information Available on the Remittance Advice Notice
R	3/30.4/Deceased Beneficiaries
D	3/30.4.1/Authentication of Provider Elements for CSR Inquiries
D	3/30.4.2 -Authentication of Provider Elements for IVR Inquiries
D	3/30.4.3 –Authentication of Provider Elements for Written Inquiries
D	3/30.4.4 –Authentication of Beneficiary Elements
R	3/30.5/Disclosure Desk Reference for Provider Contact Centers
N	3/30.5.1/Authentication of Provider Elements for CSR Inquiries
N	3/30.5.2/Authentication of Provider Elements for IVR Inquiries
N	3/30.5.3/Authentication of Provider Elements for Written Inquiries
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R	6/Table of Contents
R	6/20.1/POE Goals
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R	6/80.2.2/Written Inquiries
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III. FUNDING:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2007 operating budgets.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

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

Attachment - Business Requirements

Pub. 100-09	**Transmittal: 20**	**Date: July 13, 2007**	**Change Request: 5597**

NOTE: Transmittal 19, dated June 29, 2007is being rescinded and replaced by Transmittal 20, dated July 13, 2007. In chapter 3, sections 30.4.1 through 30.4.4 are deleted. The information has moved to new sections 30.5.1 through 30.5.4. In chapter 6, sections 80.4.1 through 80.4.4 are deleted. The information has moved to new sections 80.5.1 through 80.5.4. Additionally, in section 30.3.6.1 # 6 in chapter 6 the word "CSR" is replaced by "correspondent" and the word "QCM" is replaced by "QWCM." In section 60.3.1 in chapter 6, the word "calls" in all three bullets, are replaced by "provider responses."

SUBJECT: IOM Pub. 100-09, Chapters 3 – Provider Inquiries and Chapter 6 - Provider Customer Service Program Updates

Effective Date: May 23, 2007

Implementation Date: July 30, 2007

I. GENERAL INFORMATION

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

B. Policy: The administrative simplification provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 (P.L. 104-191) require the Secretary of Health and Human Services to adopt a national standard identifier for health care providers. HIPAA mandates that the NPI be used in standard transactions in lieu of Medicare legacy numbers. CMS published a Final Rule on January 23, 2004, that announced the (NPI) as the standard identifier.

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.

Contractors not funded for CR 3376 shall follow the chapter 3 referenced requirements. All other contractors, including Medicare Administrative Contractors (MACs) shall follow the chapter 6 referenced requirements.

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	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5597.1	Contractors shall have the discretion to end a provider telephone inquiry if placed on hold by the caller for two minutes or longer, in accordance with IOM 100-09, Chapter 6, section 30.2.3, and Chapter 3, section 20.1.1.	X	X	X	X		X					RRB
5597.2	Contractors shall evaluate and enter evaluation scores into the Quality Call Monitoring (QCM) and Quality Written Correspondence Monitoring (QWCM) databases by the 10th of the month following the month the call was taken and/or the response was sent, in accordance with Chapter 6, sections 30.2.7.1 and 30.3.6.1 and Chapter 3, sections 20.2.1 and 20.3.1.1.	X	X	X	X		X					RRB
5597.3	Contractors shall follow the guidance in the QCM and QWCM Handbooks, in accordance with Chapter 6, sections 30.2.7.1 and 30.3.6.1, and Chapter 3, sections 20.2.1 and 23.3.1.1.	X	X	X	X		X					RRB
5597.4	Contractors shall send a letter in response to a provider's request for a copy of a Report of Contact, in accordance with Chapter 6, section 30.3.3 and Chapter 3, section 20.3.1.	X	X	X	X		X					RRB
5597.5	Contractors shall authenticate providers inquiring about an overlapping claim only when the contractor is the initial contact, in accordance with Chapter 6, section 80.3.1, and Chapter 3, section 30.3.1.	X	X	X	X		X					RRB
5597.6	Contractors shall have the discretion to refer providers and their representatives inquiring via telephone or in writing, to the IVR when the requested information is available on the IVR, in accordance with Chapter 6, section 80.3.3, and Chapter 3, section 30.3.3.	X	X	X	X		X					RRB
5597.7	Contractors shall refer providers and their representatives inquiring via telephone or in writing, to the remittance advice when the requested information is available on the remittance advice, in accordance with Chapter 6, section 80.3.4, and Chapter 3, section 30.3.4.	X	X	X	X		X					RRB
5597.8	Contractors shall release Abdominal Aortic Aneurysm screening information to providers, in accordance with Chapter 6, section 80.5.4 and Chapter 3, section 30.5.4.	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	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5597.9	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X	X	X	X		X					RRB

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

B. For all other recommendations and supporting information, use this space:

V. CONTACTS

Pre-Implementation Contact(s): Emily Norment, 410-786-0495, emily.norment@cms.hhs.gov

Post-Implementation Contact(s): Emily Norment, 410-786-0495, emily.norment@cms.hhs.gov

VI. FUNDING

A. ***For Fiscal Intermediaries, Carriers, and the Durable Medical Equipment Regional Carrier (DMERC)*:**
No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.

B. ***For Medicare Administrative Contractors (MAC)*****:**

The contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the Statement of Work (SOW). 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 3 - Provider Inquiries

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(Rev.20, 07-13-07)

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20.1.1 - *Availability of Telephone Services*

(Rev.20, Issued: 07-13-07, Effective: 05-23-07, Implementation: 07-30-07)

1. Contractors shall make CSR telephone service available to callers continuously during normal business hours, including lunch and breaks.
2. Normal business hours for live telephone service are defined as 8:00 a.m. through 4:00 p.m. for all time zones of the geographical area serviced, Monday through Friday. Where provider call volume supports it, the normal business hours may be shifted to 8:30 a.m. – 4:30 p.m. for all time zones. Contractors adopting these hours shall notify CMS by sending an e-mail to Service Reports (servicereports@cms.hhs.gov) no later than the first day of the contract year (October 1) or one month in advance of an anticipated change within a contract year.
3. Planned closures during normal business hours must be approved by CMS CO. Contractors shall notify CMS via the service reports mailbox (servicereports@cms.hhs.gov) by October 31st of each year about any planned call center closures. This list shall also be sent to the appropriate RO. Call centers shall notify the provider community of the approved closure at least two weeks in advance of closure.
4. On Federal holidays, in lieu of answering telephone inquiries, contractors may choose to perform other appropriate call center work, e.g., provide CSR training. Contractors shall notify CMS via the service reports mailbox (servicereports@cms.hhs.gov) by October 31st of each year about any planned call center closures. This list shall also be sent to the appropriate RO. Call centers shall notify the provider community of the planned closure at least two weeks in advance of closure, including Federal holiday closures.
5. Contractors shall notify CMS via the service reports mailbox (servicereports@cms.hhs.gov) of any unplanned closures (those not submitted by October 31st) at least three weeks before the planned date of closure. If CMS CO grants approval of the closure the contractor shall notify the provider community of the approved closure at least two weeks in advance of the closure.
6. Call center staffing shall be based on the pattern of incoming calls per hour and day of the week, ensuring that adequate coverage of incoming calls throughout each workday is maintained. *In 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 call may disconnect if the CSR is placed on hold for two minutes.*
7. In accordance with Section 508 of the Rehabilitation Act of 1973 and the Workforce Investment Act of 1998, all call centers shall provide the ability for deaf, hard of hearing or speech-impaired providers to communicate via TeleTYpewriter (TTY) equipment. A TTY is a special device permitting, hard of hearing, or speech-impaired individuals to use the telephone, by allowing them to type messages back and forth to one another instead of talking and listening. (A TTY is required at both ends of the conversation in order to communicate.) Contractors shall publicize the TTY line on their websites.

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

20.1.2- *Automated Services – Interactive Voice Response (IVR)*
(Rev.20, Issued: 07-13-07, Effective: 05-23-07, Implementation: 07-30-07)

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

1. Contractor hours of operation for CSR service

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

3. Specific information about claims in process and claims completed. For claims status inquiries handled in the IVR, all call centers shall adhere to the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule by authenticating callers as required in section 30 of this chapter.

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

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

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

NOTE: IVRs shall be programmed to provide callers with an after-hours message

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

Contractors shall print and distribute a clear IVR operating guide to providers upon request. The guide shall also be posted on the contractor's Web site.
Contractors who are able to provide claims status information through their IVR shall require providers to use the IVR to obtain this information.

20.1.3 - *Toll Free Network Services*

(Rev.20, Issued: 07-13-07, Effective: 05-23-07, Implementation: 07-30-07)

A. Inbound Services

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

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

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

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

C. Troubleshooting

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

Step 1

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

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

Step 2

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

Step 3

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

Step 4

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

Step 5

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

D. Disaster Recovery

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

By December 31st of each year, call centers shall submit to CMS their current written contingency plan describing how the Medicare provider telecommunications operations will be maintained or continued in the event of manmade or natural disasters. The plan shall cover partial loss of telecommunications capabilities due to equipment or network failures through the total loss of a call center. The plan may include arrangements with one or more other contractors to assist in telephone workload management during the

time the call center is unable to receive provider phone calls. Contractors shall submit these plans to the service reports mailbox at servicereports@cms.hhs.gov or via postal mail, with a copy to the RO. Contractors may choose to submit the portion of their contingency plan that deals with telecommunications developed in relation to the Centers for Medicare & Medicaid Services (CMS) Business Partners Systems Security Manual.

E. Inbound Service Costs

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

20.1.4 - *Publication of Toll Free Numbers*

(Rev.20, Issued: 07-13-07, Effective: 05-23-07, Implementation: 07-30-07)

A. Directory Listings

Contractors shall not be responsible for the publication of their inbound 800 services in any telephone directory. However, at their discretion, contractors may choose to publish their general provider toll free number in the directory they feel is most appropriate.

B. Publicizing Toll Free Numbers on the Web

Any toll-free Medicare provider customer service number provided and paid for by CMS shall be prominently displayed on the contractor's Web site.

20.1.5 - *Call Handling Requirements*

(Rev.20, Issued: 07-13-07, Effective: 05-23-07, Implementation: 07-30-07)

A. Call Acknowledgement

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

B. Providing Busy Signals

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

C. Call Routing

When a call center routes calls to another site, CMS needs to make sure that the contractor handling the calls gets credit for the work. If a call is forwarded over a

contractor's system there is no way for CMS to determine the final termination point of the call. Therefore, prior to transferring calls to another center, contractors shall notify CMS through the Service Reports mailbox at servicereports@cms.hhs.gov. Contractors shall also notify the appropriate Regional Office.

D. Queue Message

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

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

E. General Inquiries Line

The provider toll free numbers installed for general provider inquiry traffic shall not be used for other applications (e.g., MSP, reviews, EDI, provider enrollment, and other non-claim related provider inquiries) beyond answering general questions for each application. At a minimum, these general lines shall be used to handle questions related to billing, claims, eligibility, and payment. Complex questions (ones that might currently require an internal transfer) shall be directed to the "other" units on a different toll free number than the general inquiry number. It is not necessary for each "other" function to have its own unique toll free number, although contractors can choose this option. Other acceptable options are having a single "other" toll free number to handle all the "other" (non general inquiry) functions or a few "other" toll free numbers handling more than one "other" function via each number. The CSRs on the general inquiry line shall not transfer callers to the "other" functional units but rather shall instruct the caller to hang up and dial the appropriate number. "Other" numbers shall not be subject to CSAMS reporting or the call performance standards that govern the general inquiries line. If contractors need toll free service for other Medicare applications currently being handled on the provider claims inquiry toll free numbers, please follow the established process for adding additional toll free numbers. We will consider all requests for additional toll free numbers.

F. CSR Identification to Callers

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

G. Sign-in Policy

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

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

H. *Average Speed of Answer (ASA)*

The contractor shall maintain an average speed of answer of 120 seconds. This standard shall be measured quarterly and will be cumulative for the quarter.

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

I. *Initial Call Resolution*

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

J. *Call Completion*

1. *Each CSR and IVR combined line shall have a completion rate of no less than 70%. This standard will be measured quarterly and will be cumulative for the quarter.*
2. *Each CSR-only line shall have a completion rate of no less than 70%. This standard will be measured quarterly and will be cumulative for the quarter.*
3. *Each IVR-only line shall have a completion rate of no less than 90%. This standard will be measured quarterly and will be cumulative for the quarter.*

K. *Callbacks*

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

L. *Equipment Requirements:*

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

1. Online access to a computer terminal for each CSR responsible for claims-related inquiries. Locate the computer terminal so that representatives can research data

without leaving their seats.
2. Access to the contractor's Web site and www.cms.hhs.gov.
3. An outgoing line for callbacks.
4. A supervisory console for monitoring CSRs.

M. ***Limiting the Number of Issues per Call***

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

N. ***Coding Inquiries***

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

1. Current Procedural Terminology (CPT-4) are codes proprietary to the American Medical Association (AMA). As such, CPT coding questions from providers (with exception noted in 4 below) shall be referred to the AMA. The AMA offers CPT Information Services (CPT-IS). This new internet based service is a benefit to AMA members and is available as a subscription fee-based service for non-members and non-physicians. The AMA also offers CPT Assistant. Information about these resources is found at www.ama-assn.org.
2. ICD-9-CM related questions are handled by the American Hospital Association's Coding Clinic. Details about this resource are available at www.ahacentraloffice.org.
3. Level II Healthcare Common Procedure Coding System (HCPCS) codes related to Durable Medical Equipment or prosthetics, orthotics, and supplies are answered by the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) or, in the future, the Data and Analysis Coding function contractor (DAC). This contractor has a website with lots of information and a toll-free help line.
4. The American Hospital Association's Coding Clinic for HCPCS responds to questions related to CPT-4 codes for hospital providers and Level II HCPCS codes, specifically A-codes for ambulance service and radiopharmaceuticals, C-codes, G-codes, J-codes, and Q-codes (except Q0136 through Q0181), for hospitals physicians and other health professionals who bill Medicare. Details about this resource are available at www.ahacentraloffice.org.

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

(Rev.20, Issued: 07-13-07, Effective: 05-23-07, Implementation: 07-30-07)

The CSAMS is an interactive Web-based software tool used by CMS to collect and display call center telephone performance data. Each call center site shall enter required telephone customer service data elements into CSAMS between the 1st and 10th of each month for the prior month. To change data after the 10th of the month, users shall inform

CO via CSAMS at csams@cms.hhs.gov. In those rare situations where one or more data elements are not available by the 10th of the month, the missing data shall not prevent the call center from entering all other available data into CSAMS timely. The call center shall supply the missing data to CMS within two workdays after it becomes available to the contractor. *Definitions, calculations and additional information for each of the required telephone customer service data elements as well as associated standards are posted on the CMS' telephone customer service Web site at https://cms.hhs.gov/csams.* Call centers shall use CSAMS call handling data to improve call center performance.

A. Definition of Call Center for CSAMS

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

B. Data to Be Reported Monthly

Contractors shall capture and report the following data each month:

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

6. Call Abandonment Rate - This is the percentage of provider calls that abandon from the ACD queue. This shall be reported as calls abandoned up to and including 60 seconds.
7. Average Speed of Answer - This is the amount of time that all calls waited in queue before being connected to a CSR. It includes ringing, delay recorder(s), and music. This time begins when the caller enters the CSR queue and includes both calls delayed and those answered immediately.
8. Total Sign-in Time (TSIT) - This is the amount of time the CSRs were available to answer telephone inquiries. This time includes the time that CSRs were plugged-in, logged-in, handling calls, making outgoing calls, in the after call work state or in an available state.
9. Number of Workdays - This is the number of calendar days for the month that the call center is open and answering telephone inquiries. For reporting purposes, a call center is considered open for the entire day even if the call center was closed for a portion of the day and/or not able to answer telephone inquiries for a portion of the day.
10. Total Talk Time - This is the total amount of time that all CSRs were connected to callers and includes any time the caller is placed on hold by the CSR during the conversation.
11. Available Time - Available time is the amount of time that CSRs were signed-in on the telephone system waiting for a call to be delivered (i.e., the CSR is not handling calls, making outgoing calls, or in the after call work (ACW) state).
12. After Call Work Time - This includes the time that CSRs need to complete any administrative work associated with a call after the customer disconnects.
13. Status of Calls Not Resolved at First Contact - Report as follows:

a. Number of callbacks required. This number is based on calls received for the calendar month and represents the number requiring a callback as of the last workday of the month.
b. Number of callbacks closed within 10 workdays. This number is based on calls received for the calendar month and represents the number closed within 10 workdays even if a callback is closed within the first 10 workdays of the following month.

14. IVR Handle Rate - Report data needed to calculate the IVR handle rate. For call centers with combined CSR and IVR lines this includes:

a. The number of calls offered to the IVR (defined as the total number of calls receiving a prompt offering the use of the IVR during or after business hours.)
b. The number of calls handled by the IVR.
c. For call centers with separate CSR and IVR lines this includes:
    1) The number of calls offered to the IVR (defined as the total number of IVR-only calls receiving a prompt offering the use of the IVR during or after business hours plus the total number of CSR completed calls.)
    2) The number of calls handled by the IVR (defined as the number of calls where the caller selected and played at least one informational message.)

15. Calls in CSR queue - This is the total number of calls delivered to the CSR queue.
16. Calls Answered by CSRs - This represents the total number of calls answered by all CSRs for the month from the CSR queue.

17. Calls Answered <= 60 Seconds - This represents the total number of calls answered by all CSRs within 60 seconds from the CSR queue.
18. Calls Answered <= 120 Seconds - This represents the total number of calls answered by all CSRs within 120 seconds from the CSR queue.
19. Calls Abandoned <= 120 Seconds - This represents the total number of calls abandoned before or at 120 seconds from the CSR queue.
20. Quality Call Monitoring (QCM)-Number of CSRs Available for Monitoring - This is the number of CSRs (not FTEs) that take calls on a regular basis, both full-time and part-time CSRs. This number is obtained from the QCM Database.
21. QCM-Number of Completed Scorecards – This is the number of scorecards that were completed and entered into the QCM database for the month. This number is obtained from the QCM Database.
22. QCM-Customer Skills Assessment - This is the percent of calls monitored that scored greater than or equal to Achieves Expectations. This number is obtained from the QCM Database.
23. QCM-Knowledge Skills Assessment - This is the percent of calls monitored that scored greater than or equal to Achieves Expectations. This number is obtained from the QCM Database.
24. QCM-Privacy Act - This is the percentage of calls that scored as pass. This number is obtained from the QCM Database.
25. Training Hours – Normal Business Days - Report the number of hours (rounded to the nearest half-hour) that the provider contact center closed for CSR training per month. This indicator is used to measure the time the provider contact center is closed during normal business hours for staff development. The number of hours used each month can not exceed 8 hours per month.
26. Training Hours – Federal Holidays - Report the number of hours (rounded to the nearest half-hour) that the provider contact center closed for CSR training on a Federal holiday(s) per month. This indicator is to measure the time the contact center closed on a Federal Holiday for staff development.

20.1.7 - *CSR Qualifications*

(Rev.20, Issued: 07-13-07, Effective: 05-23-07, Implementation: 07-30-07)

Contractors shall fully train CSRs to respond to provider questions, whether of a substantive nature, a procedural nature, or both. The CSRs who answer telephone calls shall be qualified to answer general questions about initial claims determinations, operation of the Medicare program, and appeal rights and procedures. To ensure that these services are provided, CSRs shall have the following qualifications:

- Knowledge of Medicare (prior customer service experience in positions where the above skills are utilized, e.g., claims representative or telephone operator, is desired but not necessary);
- Good telephone communications skills;
- Flexibility to handle different situations that may arise;
- Good keyboard computer skills.

20.1.8 – *Staff Development and Training*

(Rev.20, Issued: 07-13-07, Effective: 05-23-07, Implementation: 07-30-07)

A. General Requirements

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

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

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

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

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

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

***B.* Provider Contact Centers Training Program**

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

- The 8 hours approved by CMS for contact center closure shall be used for training time only.
- The training time shall not be used for corporate meetings. Contractors shall request permission to close in those circumstances according to Section *20.1.1* of this chapter.
- Training time not used within a specific month shall not be carried over to the next month.

Time used for training on Federal holidays is in addition to the 8 hours per month allowed by CMS for CSR training closure. This 8 hour allowance is separate from any training time occurring during Federal holidays in accordance with Section *20.1.2* of this chapter.

1. Closure Determination

Contractors shall perform an analysis to evaluate the appropriate time for closure to anticipate the impact on their ability to meet all CMS performance requirements as instructed in Sections *20.1.5* and *20.1.6* of this chapter. Contractors should consult their POE Advisory Group about the best hours for training closures and training topics. CMS will not view performance waivers favorably if the training time closures are the justification for poor performance.

2. Provider Complaints

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

3. Training Schedule

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

4. Training Closures of More than Four Hours

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

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

5. Provider Notifications

Contractors shall notify providers about their closure time for training. At a minimum, contractors shall post a closure notification for providers on their IVRs and websites. Contractors with separate lines for IVR and CSRs shall post a closure notification for providers on both lines. See additional instructions regarding IVR posting in Section *20.1.2* of this chapter. In addition to the IVR and website, contractors shall use their listserv to notify providers of CMS authorized one time only-training closure or a training closure out of the contractor’s regular training schedule. Contractors shall use their listserv to notify their provider community of their closure times the first time that they implement the Training Program in their site.

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

6. CSR Feedback

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

7. Reports

Contractors shall report in CSAMS the following:

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

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

8. CMS Monitoring

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

20.1.9 - *Fraud and Abuse*

(Rev.20, Issued: 07-13-07, Effective: 05-23-07, Implementation: 07-30-07)

When a provider inquiry or complaint of potential fraud and abuse is received, the second level screening staff shall not perform any screening, but prepare a referral package and send it immediately to the PSC or Medicare fee-for-service BIU. The referral package shall consist of the following information:

- Provider name and address;
- Type of provider involved in the allegation and the perpetrator, if an employee of a provider;
- Type of service involved in the allegation;
- Relationship to the provider (e.g., employee or another provider);
- Place of service;
- Nature of the allegation(s);
- Timeframe of the allegation(s);
- Date of service, procedure code(s); and
- Name and telephone number of the Medicare fee-for-service contractor employee who received the complaint.

The Medicare fee-for-service 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 Program Safeguard Contractor (PSC) or Medicare fee-for-service contractor Benefit Integrity Unit using Activity Code 13201 in the Beneficiary Inquiries function.

20.1.10 – *Provider Contact Center User Group (PCUG)*

(Rev.20, Issued: 07-13-07, Effective: 05-23-07, Implementation: 07-30-07)

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

20.1.11 - Performance Improvements

(Rev.20, Issued: 07-13-07, Effective: 05-23-07, Implementation: 07-30-07)

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

20.2 – *Contractor Guidelines for High Quality Responses to Telephone Inquiries*

(Rev.20, Issued: 07-13-07, Effective: 05-23-07, Implementation: 07-30-07)

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

Retention of Taped Calls

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

Remote Access

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

1. Specific workstation (CSR)
2. Next call from the network or next call from the CSR queue
3. Specific business line

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

Contractors shall submit the instructions to remotely monitor their provider inquiry toll free lines to the servicereports@cms.hhs.gov mailbox. If the contractor monitoring system requires changes in its access codes or other parts of the instructions from what was previously submitted, the contractor shall submit the revised instructions or access codes to the servicereports@cms.hhs.gov mailbox at least 3 business days before the beginning of the affected month. CMS will take reasonable measures to ensure the security of this access (e.g., passwords will be controlled by one person.)

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

20.2.1 - *Quality Call Monitoring (QCM) Program*

(Rev.20, Issued: 07-13-07, Effective: 05-23-07, Implementation: 07-30-07)

Contractors shall be responsible for:

1. Monitoring, measuring and reporting the quality of service continuously by utilizing the CMS-developed QCM process. Contractors shall monitor all CSRs throughout the

quarter, using a sampling routine. The sampling routine shall ensure that all CSRs are monitored at the beginning, middle and end of each month (ensuring that assessments are distributed throughout the week), and during morning and afternoon hours. Contractors shall monitor a minimum of three calls per CSR per month. In centers where CSRs answer both beneficiary and provider calls, monitor a minimum of three calls, including at least one of each type, during the month. Any deviation from this requirement shall be requested and justified to the RO in order to determine if a waiver is warranted.

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

2. Recording all monitored calls on the standard scorecard, using the QCM chart as a guideline. Copies of the scorecard and chart can be obtained at QCM database Web site at https://www.qcmscores.com. Contractors shall use only the most current official versions of the scorecard and chart that are posted on the Web site. The QCM database, also available on the Web site, shall be used to collect monitoring results that will be reported monthly in CSAMS.
3. *Evaluating and entering* all *scores for the month before by the 10th of each following month. For example, calls answered in the month of November shall be evaluated and entered into the QCM database by December 10th.*
4. *Providing feedback to CSRs.*
5. Training every CSR and auditor on the scorecard, chart and database and ensuring that each person has a copy of the most current chart for reference. Contractors shall analyze individual CSR data frequently to identify areas needing improvement, and shall document and implement corrective action plans. Such information shall be available to CMS upon request.
6. Analyzing QCM data to develop a plan for continuous improvement and to determine where training is indicated, whether at the individual, team, or call center level and provide such training. Such information shall be available to CMS upon request.
7. Adhering to *the QCM Handbook.*

20.2.1.1 - QCM Calibration

(Rev.20, Issued: 07-13-07, Effective: 05-23-07, Implementation: 07-30-07)

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

20.2.1.2 - QCM Performance Standards

(Rev.20, Issued: 07-13-07, Effective: 05-23-07, Implementation: 07-30-07)

1. *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.*

2. *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.*

3. *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.*

20.3 - *Written Inquiries*

(Rev.20, Issued: 07-13-07, Effective: 05-23-07, Implementation: 07-30-07)

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

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

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

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

procedure to keep envelopes with the incoming correspondence, the envelope, incoming letter and the top page of all attachments shall be date-stamped in the corporate mailroom.

20.3.1 - *Contractor Guidelines for High Quality Responses to Written Inquiries*

(Rev.20, Issued: 07-13-07, Effective: 05-23-07, Implementation: 07-30-07)

A. **Written Inquiry Storage**

The majority of contractors currently retain all written inquiries on site. Some contractors house files at a remote location during the year due to cost and space constraints. Those contractors housing written inquiries off-site shall notify CMS within 6 weeks of the final BPR date of the exact address/location of their off site written inquiries. This information shall be sent electronically to the RO and to the provider services mailbox at providerservices@cms.hhs.gov. This notification is necessary in the event an onsite evaluation review is conducted. Contractors are required to allow CMS access to all written inquiries stored off site within 24 hours of notification to the contractor. All written inquiries, whether maintained on site or off-site, shall be clearly identified and filed in a manner that will allow for easy selection for review. Identification data shall be kept that will allow electronic production of a sequential listing of the universe of written inquiries. In addition, responses shall be kept in a format that allows for easy reproduction. Only necessary and related information shall be kept for each corresponding inquiry. Examples of necessary and related information include reports of contact, screenshots, copies of the incoming inquiry, copies of response, and any research required for response. Contractors shall be able to electronically reproduce, when requested, any documents the contractor deems relevant to the resolution of the written inquiry.

B. **Forwarding Misdirected Inquiries**

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

C. **Timeliness**

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

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

acknowledging receipt of the inquiry and the reason for any delay. When possible, inform the provider about how long it will be until a final response will be sent. *The inquiry is not considered closed until the final response is sent.*

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

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

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

***D.* Responding to Written Inquiries by Telephone**

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

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

If the inquirer requests the information in writing, a response letter must be sent. It is not acceptable to send the Report of Contact itself. All information contained within the Summary of Discussion must be included in the requested response. All guidelines for a written response apply.

It is also acceptable to send the information via e-mail or facsimile, if it is suggested by the provider and the response does not contain any beneficiary or claim specific information. All guidelines for a written response apply.

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

E. **E-mail and Fax Responses**

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

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

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

F. **Check Off Letters**

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

20.3.1.1 – Quality Written Correspondence Monitoring (QWCM) *Program*

(Rev.20, Issued: 07-13-07, Effective: 05-23-07, Implementation: 07-30-07)

Contractors shall have a monitoring program in place to ensure the quality of written inquiries responses. The guidelines established apply to contractors' general provider written inquiry responses. The standards shall not apply to those written inquiries handled by other units within the contractor (e.g., appeals, fraud, MSP). As contractors are ultimately responsible for the quality of their responses to provider inquiries, contractors shall use the results of their QWCM program to identify, and act upon, areas of needed improvement, both for the written inquiries unit as a whole and for individual

written inquiries staff. Contractors shall document their monitoring efforts and corrective action plans as applicable, and provide such information to CMS upon request.
Copies of the QWCM scorecard, guide, and chart can be obtained through the QWCM database Web site at https://www.qwcmscores.com.
At a minimum, the contractor's written inquiries monitoring program shall ensure that:

1. Responses monitored are from providers and of the type that the correspondent typically handles.
2. Responses monitored are sampled randomly so as to be representative of varying days *of the week, weeks of the month,* and monitors/auditors.
3. *Responses are evaluated using the official QWCM scorecards and charts (separate scorecards and scoring criteria are used to evaluate written and telephone responses.)*
4. *All responses are scored no more than one month from when the response was sent.*
5. *All scores are entered into the QWCM database by the 10th 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. *Contractors are encouraged to heavily monitor CSR trainees that have just completed classroom instruction before they begin to handle written inquiries independently. Scores for these trainees will be excluded from for a period up to 30 days following the end of formal classroom training;*
7. Monitoring is done in a way that is conducive to the success of the monitoring program.
8. Feedback is provided to correspondents.
9. Written inquiry staff are properly educated about the program and its use and each reviewer and correspondent has an up-to-date copy of the scorecard and chart for reference.
10. *The QWCM Handbook shall be followed.*

20.3.1.1.1 - QWCM Calibration

(Rev.20, Issued: 07-13-07, Effective: 05-23-07, Implementation: 07-30-07)

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

20.3.1.1.2 - QWCM Performance Standards

(Rev.20, Issued: 07-13-07, Effective: 05-23-07, Implementation: 07-30-07)

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

1. *For* all provider responses monitored for the quarter, the percent scoring as "Pass" for Adherence to the Privacy Act shall be no less than 90 percent. This standard will be measured quarterly and will be cumulative for the quarter.
2. *For* all provider responses monitored for the quarter, the percent scoring as "Achieves Expectations" or higher for Customer Skills shall be no less than 90 percent. This standard will be measured quarterly and will be cumulative for the quarter.
3. *For* all provider responses monitored for the quarter, the percent scoring as "Achieves Expectations" or higher for Knowledge Skills shall be no less than 90 percent. This standard will be measured quarterly and will be cumulative for the quarter.

20.4 - *Walk-In Inquiries*

(Rev.20, Issued: 07-13-07, Effective: 05-23-07, Implementation: 07-30-07)

Contractors shall not actively publicize the walk-in function. However, they shall give individuals making personal visits the same high level of service they would give through phone contact. The interviewer shall have the same records available as a telephone service representative to answer any questions regarding general program policy or specific claims-related issues.

If a provider inquires about a denied or reduced claim, the contractor gives the provider the opportunity to understand the decision made and an explanation of any additional information that may be submitted if an appeal is sought.

The contractor makes the same careful recording of the facts as for a telephone response. 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
- Statement indicating whether the inquiry is closed or still pending

20.4.1 - *Guidelines for High Quality Walk-In Service*

(Rev.20, Issued: 07-13-07, Effective: 05-23-07, Implementation: 07-30-07)

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

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

20.5 - Surveys

(Rev.20, Issued: 07-13-07, Effective: 05-23-07, Implementation: 07-30-07)

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

20.5.1 - Customer Service Operations Surveys

(Rev.20, Issued: 07-13-07, Effective: 05-23-07, Implementation: 07-30-07)

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

20.5.2 - Provider Satisfaction Surveys

(Rev.20, Issued: 07-13-07, Effective: 05-23-07, Implementation: 07-30-07)

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

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

(Rev.20, Issued: 07-13-07, Effective: 05-23-07, Implementation: 07-30-07)

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

Contractors shall:

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

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

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

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

2. Perform marketing and outreach for the MCPSS--Contractors shall support CMS in disseminating information about the MCPSS to providers. Contractors shall place information about the survey on listservs, newsletters, bulletins, and other provider communications channels. Contractors shall also post information about MCPSS on their Web sites and create a link to the MCPSS Study Website at www.mcpsstudy.org and CMS' MCPSS Web page at www.cms.hhs.gov/MCPSS. Contractors shall include

information about the survey on their Interactive Voice Response (IVR) systems, or automatic call distributor (ACD) systems, and any other communications channel with providers. This may be part of the general program information posted to the IVR as described in 20.1.B. A media kit with sample documents to use about the survey, a project timeline and key tasks will be available at www.mcpsstudy.org.

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

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

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

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

B. Contractor Use of MCPSS Results

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

C. Information for Contractors

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

1. Data Collection Reports: The reports will include counts and percentages overall and by provider type for completed responses and each category of the survey sample disposition (e.g., postal non-deliverables, non-locatables, refusals and ineligibles)
2. Survey Results: The results of the survey will be available via an interactive online reporting system. A model of the online reporting system is currently

available to provide an example of the functions and analysis capabilities of the system. Please note that the site does not include real data; the information is for illustrative purpose s only.

3. Study updates, fact sheets, FAQs and media messages. As the project progresses, we will continue to update the MCPSS Study Web site with new materials (e.g., fact sheets, frequently asked questions (FAQs), media messages). Contractors may access their secure Web page at any time to download relevant project information.
4. CSR Script: The script is part of the media kit material that Contractors can access through the MCPSS study Website page at www.mcpsstudy.org.

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

20.6 - Provider Inquiry Reporting Standardization

(Rev.20, Issued: 07-13-07, Effective: 05-23-07, Implementation: 07-30-07)

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

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

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

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

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

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

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

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

1. A definition of the inquiry type to be added.
2. Examples of questions where the inquiry type could be used.
3. Information about the number of inquiries associated with it.

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

CMS Standardized Provider Inquiry Chart

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

CMS Standardized Provider Inquiry Chart

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

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		Anesthesia Fee Schedule	Contact is asking for the Anesthesia Fee Schedule payment amount for a particular item or service provided to a Medicare beneficiary.
		Critical Access Hospitals	Contact is asking for the Critical Access Hospitals payment amount for a particular item or service provided to a Medicare beneficiary.
		Clinical Lab Fee Schedule	Contact is asking for the Clinical Laboratory Fee Schedule payment amount for a particular item or service provided to a Medicare beneficiary.
		Drug Average Sales Price (ASP) Resource	Contact is asking about the Medicare Part B Drug Average Sales Price Resource payment amounts. This extensive listing of drugs is a guide. It may not include all drugs that could be considered for payment by Medicare.
		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.

CMS Standardized Provider Inquiry Chart

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

CMS Standardized Provider Inquiry Chart

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

CMS Standardized Provider Inquiry Chart

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

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		LCD	Contact is asking about a claim(s) that was denied or reduced based on a local coverage determination (LCD) by the contractor. Coverage determinations reflect the local contractor decision as to whether a product, service, or device is reasonable and necessary.
		Life Time Days Met	Contact is asking about claim(s) denied because a particular benefit is disallowed for a Medicare beneficiary due to the lifetime days limit exhausted.
		Medical Necessity	Contact is asking about a claim(s) denied because the information presented did not indicate services or supplies are reasonable and necessary for the diagnosis and treatment of the illness or injury.
		MSP	Contact is asking about a claim(s) denied due to other insurance existing on the beneficiary file that is primary to Medicare.
		NCD	Contact is asking about a claim(s) that was denied or reduced based on a national coverage determination (NCD) by CMS. Coverage determinations reflect national Medicare coverage policies governing specific medical service, procedure or device.
		Statutory Exclusion	Contact is asking about a claim(s) that items or services were denied by law.
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.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		ATP Amount/Check Information	Contact is asking for current Approved to Pay (ATP) amount, current pending claims totals and/or payment information on a claim (i.e., status of check, check number, check amount and issued date).
		Crossover	Contact is asking for information on a claim that is covered by a supplemental insurer, such as Medigap or other private insurance.
		Not on File	Contact is asking for a claim that Medicare does not have on file or that has not been received by the contractor.
		Paid in Error	Contact is asking about a claim that they believe was paid in error.
		Payment Explanation/Calculation	Contact is asking for explanation on how the claim was paid or how the payment amount was calculated. Includes "reimbursement" questions.
		Suspended	Contact is asking about the status of a claim that is pending while waiting for information needed to complete processing.
Coding	Any set of codes used to encode data elements, such as tables of terms, medical concepts, medical diagnostic codes or medical procedure codes. Includes the codes, their descriptions, and how to use them.	*CCI Edits*	Contact is asking about Correct Coding Initiative edits that identify types of inappropriate coding combinations, such as comprehensive and component code combinations and code combinations of services or procedures that could not be performed together.
		Condition Codes	Contact is asking about billing codes that indicate whether the claimant meets a condition of the service.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		Procedure Codes	Contact is asking about the numeric representation of a procedure code used to determine reimbursement for services rendered on a claim or for other medical documentation. Includes CPT-4 codes, which belong to the American Medical Association and indicate physician services, physical and occupational therapy services, radiology procedures, clinical laboratory tests, medical diagnostic services, and hearing and vision services. Also, includes HCPCS Codes Level II that determines reimbursement for equipment and medical supplies.
		Diagnosis codes	Contact is asking about the numeric representation of a disease, injury, impairment, or other health problem that providers must use to report the diagnosis for each service and /or item they provide.
		Evaluation & Management Codes (E&M)	Contact is asking about codes that explain how the physician gathered and analyzed patient information, determined a condition, and advised the best treatment. Examples are: care plan oversight, office visits, hospital visits and consultations. E&M codes are a part of the AMA's CPT-4 coding system.
		Modifiers	Contact is asking about two digit codes used in conjunction with a procedure code that provides additional information about the service. The modifier may affect the reimbursement rate of a service.
		MSP Payer/Value Codes	Contact is asking about codes used to designate that another insurer is responsible for full or partial payment where Medicare has no payment or secondary payment responsibility.
		Revenue Codes	Contact is asking about codes that identify specific accommodations or ancillary charges that are provided in a hospital, (e.g., blood, cardiology, radiology, laboratory services, etc.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		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.
		Medicare Program	Contact is expressing dissatisfaction due to issues with the Medicare program. Includes provider expressions of intentions of leaving the Medicare program.
		Provider Education and Outreach	Contact is expressing dissatisfaction with educational activities, education staff performance or availability of educational resources or activities for Medicare providers.
		Self Service Technology	Contact is expressing dissatisfaction due to content, functionality, instability, formatting and processes related to Provider Self Service tools such as CMS or contractor website, online tools for eligibility inquiries or claim submissions, IVR, etc.
		Staff	Contact is expressing dissatisfaction due to CSR or Staff attitude, incorrect information given or non response to an inquiry.

CMS Standardized Provider Inquiry Chart

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

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		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.
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.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		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.
		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.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		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 transaction rules.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
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.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		ERA Election	Contact is asking for information about how to access and/or receive remittance notices electronically.
		How to read RA	Contact is asking for assistance in reviewing and/or understanding their remittance notice. Includes explanation of the Claim Adjustment Reason Codes and Remittance Advice Remark Codes on the Remittance Notice.
RTP/Unprocessable Claim	A claim(s) with incomplete, invalid, or missing information will be returned to the provider as unprocessable. This action cannot be appealed and the corrected claim(s) needs to be submitted as a new claim. Includes "W Status of Claim" and status of claims to be returned to provider.	*1500 / UB-92 Form Item*	Contact is asking about a claim(s) that was returned because the CMS claim form was not completed with the required information, such as, missing or invalid HICN, name, date of birth or sex. Includes the explanation of narrative of reason codes in the contractor's claims correction file, claims processing system and reports.
		Clinical Laboratory Improvement Act (CLIA)	Contact is asking about a claim(s) that was returned because the claim had a missing or incorrect CLIA number.
		Contractor Error	Contact is asking about a claim(s) that was returned to provider as unprocessable due to a contractor error.
		Contractual Obligation Not Met	Contact is asking about a claim(s) rejected because the provider did not comply with his or her Medicare contractual obligation. For example, the claim was presented with missing information (other than codes or modifiers), the 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.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		Place of Service	Contact is asking about a claim(s) that was returned due to invalid place of service or the place of service was not related to the procedure.
		Provider Information	Contact is asking about a claim(s) that was returned due to an incorrect or missing UPIN/NPI.
		Submitted to Incorrect Program	Contact is asking about a claim(s) that was returned because it was submitted to the incorrect program (FI, Carrier or DMERC).
		Truncated Diagnosis	Contact is asking about a claim(s) that was returned due to incorrect, invalid or missing diagnosis information.
Systems Issues	Medicare electronic systems, including the Medicare Claims Processing Systems and/or customer self-service applications (I.e. CMS website, contractor website, IVR, etc).	*Medicare Claims Processing System Issues*	Contact is presenting situation related to issues with the Medicare Processing Systems; for example, issues due to an aged claim, recycling claim and release of claims, etc.
		Website Issues	Contact is reporting problems with the functionality, stability or use of the CMS and contractor website.
		IVR Issues	Contact is reporting problems with the functionality or use of the contractor's IVR.
Temporary Issues	Includes inquiries that CMS would like to track temporarily due to special circumstances. CMS will provide specific timeframes for the monitoring of temporary issues. For contractor specific temporary issues, please follow instructions on IOM 100-9, Chapter 3, Section 20.5 or Chapter 6, Sections 30.1.1 – 30.1.1.2.	Part D Drug Coverage	Contact is presenting situation related to issues with the implementation of the Part D Medicare Prescription Drug Coverage.
		CD-ROM Initiative	Contact is requesting a hard-copy of the Annual Disclosure Statement, the "Dear Provider" letter and provider enrollment material in CD-ROM form, or asking for clarification of the CD-ROM content. Includes logging of

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
			CD-ROM related problems that providers encountered.
		CERT	Contact is asking information related to the Comprehensive Error Rate Testing (CERT) Program.
		Competitive Acquisition Program (CAP)	Contact is asking general questions about the CAP.
		HIGLAS	Contact is presenting a situation due to the implementation of HIGLAS, the new financial accounting system. Includes inquiries about HIGLAS's training material, its impact on claim processing, recoup overpayments, demand letters, settlements and penalty withholdings, HIGLAS changes on remittance advices and checks (voided/reissued).
		PQRI	*Contact is asking for information about the Physician Quality Reporting Initiative.*
		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.

30.1 – *Provider Transaction Access Number (PTAN)*

(Rev.20, Issued: 07-13-07, Effective: 05-23-07, Implementation: 07-30-07)

The provider transaction access number (PTAN) shall be a required authentication element for all telephone and written inquiries beginning May 23, 2007. Initially, the PTAN shall be the legacy number for currently enrolled providers. Newly enrolled and re-enrolled providers will be assigned a PTAN. The PTAN will be included in the provider enrollment letters.

30.2 – *Inquiry Types*

(Rev.20, Issued: 07-13-07, Effective: 05-23-07, Implementation: 07-30-07)

30.2.1 - *Telephone Inquiries*

(Rev.20, Issued: 07-13-07, Effective: 05-23-07, Implementation: 07-30-07)

The Disclosure Desk Reference chart contains the information contractors shall use to authenticate the identity of a caller, so that the information can then be released by CSRs or inquiries answered via IVR. Contractors are reminded that the guidance contained in this section does not supersede requirements in section 20.1.3 concerning operation of the Provider Contact Center and handling of telephone inquiries.

1. **CSR Telephone Inquiries** - CSRs shall authenticate providers with two data elements. For CSR inquiries through May 22, 2007, CSRs shall authenticate providers using provider name number and provider number. Beginning 23, 2007, CSRs shall authenticate providers using the *PTAN* and National Provider Identifier (NPI). *Contractors shall have the discretion to use the provider name as an additional authentication element in order to ascertain the specific claim and/or beneficiary information being requested.*

2. **IVR Telephone Inquiries** - For inquiries handled by the IVR, the authentication requirements are broken down by time frames related to the implementation of the NPI. For IVR inquiries through May 22, 2007, contractors' IVRs shall authenticate providers with one data element, provider number. Beginning May 23, 2007, contractors' IVRs shall authenticate providers with two data elements, NPI and Provider Transaction Access Number (PTAN.)

3. **Authentication of Providers with No NPI –** In limited circumstances, there will be situations where providers will never be assigned an NPI. These situations may include retired/terminated providers. *There also may be situations where an inquiry is made regarding a claim submitted by a provider who has since deceased.* After NPI implementation, telephone inquiries *about claims* from these providers shall be handled by CSRs. *Contractors have the discretion as to which data elements to use, but suggestions include name, PTAN, provider master address, and remittance address.*

For those providers never assigned an NPI, CSRs shall authenticate these providers with two data elements. Contractors have discretion as to the data elements chosen, but suggestions include name, *PTAN*, provider master address, and remittance address.

4. Beneficiary Authentication - Contractors shall authenticate four beneficiary data elements before disclosure of beneficiary information no matter the type of telephone inquiry (CSR or IVR) or the date of the call (pre- or post-NPI implementation.) The data elements are (1) last name, (2) first name or initial, (3) Health Insurance Claim Number (HICN) and (4) either date of birth (eligibility, next eligible date, Durable Medical Equipment Medicare Administrative Contractor Information Form (DIF) (pre-claim) **or** date of service (claim status, CMN/DIF (post-claim.)) Specific guidance related to these data elements, along with any exceptions, is contained in the disclosure chart.
If the CSR or IVR determines that the authentication elements provided are insufficient or inaccurate, the inquirer will be required to provide accurate information before the information being sought is released. The CSR and, if feasible, the IVR, should relay to the inquirer which element does not match (i.e., date of birth rather than day or month or year) and instruct them 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.
As mentioned above, for situations not specifically addressed here, the CSR should use his/her discretion, taking care to protect the beneficiary's privacy and confidentiality. CSRs shall refer situations in which he/she is unsure of whether or not to release information to his/her supervisor or to the contractor's privacy official. Contractors shall forward further questions to CMS at the email address provided above.
In situations where a caller is transferred from the IVR to a CSR, if the provider data elements were authenticated in the IVR and that information is passed to the CSR, the CSR should not re-authenticate the provider before information is released. If a contractor's desktop system displays caller authentication elements when the CSR picks up the call, then only the beneficiary elements need to be authenticated. The main point is that the CSR shall have all information relating to authentication and need only request from the caller those data elements not being populated on the CSR's screen by the desktop system.

30.2.1.1 - Contractor Discretion Concerning IVR Information

(Rev.20, Issued: 07-13-07, Effective: 05-23-07, Implementation: 07-30-07)

Contractors shall have discretion about whether to offer some types of information through their IVR. If contractors decide to offer this information, the Disclosure Desk Reference offers guidelines on how to authenticate providers prior to releasing information. Contractors should review the chart in 30.4.4 for more information.

Contractors shall use, among other data, analysis and provider feedback to determine what to offer via the IVR. Additionally, contractors shall determine the information relevant to their providers that can be automated and that which, if automated, would direct the most calls to the IVR and away from the CSRs. However, contractors shall note that the information contained in the disclosure chart does not supersede any requirements for IVR operation elsewhere in this chapter (20.1.B.)

30.2.2 *- Written Inquiries*

(Rev.20, Issued: 07-13-07, Effective: 05-23-07, Implementation: 07-30-07)

Authentication elements for providers are determined by the date of the written inquiry as well as how the inquiry is received, although CMS allows exceptions for inquiries

received on provider letterhead. Contractors shall use the guidelines in the chart to authenticate providers for written inquiries as well as the information below. Contractors are reminded that the guidance contained in this section does not supersede requirements in section 20.*3.1* concerning handling of written inquiries.

A. **Date of Written Inquiry - Provider Authentication** - Contractors shall authenticate providers on written inquiries with two data elements. The elements differ depending upon the date of the inquiry.

   For written inquiries dated May 22, 2007, or before, contractors shall authenticate providers using provider number and provider name.

   For written inquiries dated May 23, 2007, or after, contractors shall authenticate providers using provider name and one of the following two: (1) NPI or (2) PTAN.

   Contractors shall authenticate providers for all written inquiries using the elements mentioned above, with the exceptions noted in B.

B. **Exception: Method of Receipt – Hardcopy on Letterhead or Email with Attachment on Letterhead -** For written inquiries received on the provider's official letterhead, including emails with an attachment on letterhead, authentication of the provider will be met if the provider's name and address are included in the letterhead and clearly establish the identity of the provider. No provider identification number as detailed in A. above (i.e., current provider number, NPI or PTAN) is required. If all authentication elements are met, contractors shall respond with the information requested in writing via regular mail. (Contractors shall see the information about responding to inquiries received via email and fax below.)

   In the case of multiple addresses on the letterhead, as long as one of the addresses match, authentication is considered met. Providers should be educated to send in written inquiries on letterhead that contain all practice locations or to use letterhead that has the address that Medicare has on record for that provider.

   Contractors shall treat requests submitted via fax on provider letterhead as written inquiries and subject to the same authentication requirements as those received in regular mail. Contractors shall not fax responses containing protected health information, but shall instead send the information via regular mail.

C. **Method of Receipt – Hardcopy/No Letterhead, Email/No Attachment on Letterhead or Pre-formatted Inquiry Forms** – For inquiries received without letterhead, including hardcopy, fax, email, pre-formatted inquiry forms or inquiries written on Remittance Advice (RAs) or Medicare Summary Notices (MSNs), contractors shall authenticate providers as detailed in A. above using provider name and the appropriate provider identification number depending upon the date of the inquiry (current provider number or NPI or PTAN.)

D. **Special Note about Inquiries Received Via Email and Fax** - For requests received via email and fax, assuming all authentication elements are present as detailed in A. or B. above, whichever is applicable, contractors shall respond as directed in section 20.*3*.1.E in writing via regular mail with the requested

information if there is protected health information in the response. In the written response on contractor letterhead, contractors shall inform the provider that beneficiary-specific information cannot be disclosed electronically via email or fax and that, in the future, the provider must send a written inquiry through regular mail or use the IVR for beneficiary-specific information. Additionally, contractors shall have discretion to respond to these requests by telephone as specified in 20.*3*.1.

For email requests only, contractors shall not notify the provider by email that they will be responding via paper or telephone. However, contractors have discretion to send an automated email reply to an email request as long as no protected health information is in the automated reply. Contractors shall ensure that the automated reply conveys the message that no beneficiary-specific information may be disclosed via email and that, in the future, the provider must send a written inquiry through regular mail or use the IVR for beneficiary-specific information.

Contractors are reminded that they may respond via email to email requests not involving protected health information or beneficiary-specific information (i.e., policy questions.)

E. **Beneficiary Authentication** - Assuming provider authentication requirements are met as detailed in A. or B. above, whichever is applicable, contractors shall always authenticate beneficiary data elements before disclosure of information without regard to the date of the written inquiry or method of receipt. See the chart in 30.*5*.4 for more information about authentication of beneficiary elements.

F. **Requests Received Without Authentication Elements** - For any written requests received without one or more authentication elements, without regard to date of inquiry or method of receipt, contractors shall return the request in its entirety to the provider stating that the requested information will be supplied upon submission of all authentication elements. Contractors shall indicate which overall elements are missing or do not match for authentication (i.e., date of birth rather than day or month or year.) Contractors shall return the inquiry to the provider via regular mail, although if sent via email without any protected health information, the inquiry may be returned via email.

Contractors have discretion to follow up with a telephone call to obtain the rest of the authentication elements instead of returning the inquiry or to close out the written inquiry with a telephone call (see 20.*3*.1 in this chapter.) Contractors shall not leave a message containing protected health information on an answering machine. Contractors shall remind the provider to check its copy of the beneficiary's Medicare card and/or follow up with the beneficiary for the correct information.

For situations not specifically addressed here, the contractor should use discretion, taking care to protect the beneficiary's privacy and confidentiality. Contractors shall refer situations in which they are unsure of whether or not to release information to a supervisor or to the contractor's privacy official. Contractors shall forward further questions to CMS at CMS ProviderServices@cms.hhs.gov.

30.3 – *Special Inquiry Topics*

(Rev.20, Issued: 07-13-07, Effective: 05-23-07, Implementation: 07-30-07)

30.3.1 - Overlapping Claims

(Rev.20, Issued: 07-13-07, Effective: 05-23-07, Implementation: 07-30-07)

Contractors sometimes receive multiple claims with the same or similar dates of service or billing periods. Overlap occurs when a date of service or billing period conflicts with another, indicating that one or the other may be incorrect.

In cases where a contractor receives an inquiry from a provider or another Medicare contractor requesting provider information to resolve an overlapping claim, contractors shall work with each other. Resolution can occur through various ways. One way is for one contractor to call the other contractor with or without the provider on the line. This will allow the contractor calling to assure the other contractor that the provider has given all necessary authentication elements. The contractor shall then release the needed information.

Only the contractor who is initially contacted by the provider shall authenticate the provider. Contractors shall authenticate the provider by verifying the provider's name, provider's legacy number, or NPI, beneficiary name, HICN, and date of service for post-claim information, or date of birth for pre-claim information. Authentication does not need to be repeated when contacting the second contractor.

Contractors shall authenticate other contractors by one of three ways.

1) Both parties on the call look at the MBR record (or other beneficiary record to which they both have access.) The CSR can name a field on the MBR and ask that the other contractor to identify what is in that particular field.

2) The CSR may ask for the employee's phone number and call him/her back, making sure that the area code and exchanges matches a listed phone number for that contractor. Caller ID or a similar service may be used to verify the area code and exchange in lieu of a callback.

3) The CSR may take the name and telephone number of the contractor CSR, the name and telephone number of his/her supervisor, the date, and reason for the inquiry and post this information in the "Notes" screen, or similar screen.

Contractors shall have discretion to develop other avenues to work out overlapping claims with one another. Contractors are encouraged to share ideas with one another. However, if a contractor resolves an overlapping claim in a way other than directly calling the other contractor, the CSR shall make it clear to the inquiring provider that the information is not disseminated by CMS and CMS is not responsible for the accuracy of the information. All contractors shall work together to facilitate correct payment of all parties. In general, the servicing contractor of the inquirer should take the lead in resolving an overlapping situation.

Contractors shall release overlapping claim information whether a provider is inquiring about a claim that was rejected for overlapping information, or if the provider found overlapping information when checking eligibility for a new admittance. In situations

where the provider is seeking to avoid a claim being rejected, the contractor should, at their discretion, release information prior to claim submission. An example of this is a situation where some End State Renal Disease (ESRD) facilities prefer to obtain the inpatient hospital benefit days for the month, prior to the ESRD monthly bill being generated. This allows the ESRD facility to code the claim appropriately and bill around the inpatient hospital stay/stays. This situation falls into the category of disclosing information needed to bill Medicare properly and release is appropriate as long as all authentication elements are met. Other situations may arise that fall into this category as well, for example, skilled nursing facility and inpatient hospital stays. Contractors shall, in these situations, ensure that the request is legitimate and necessary for proper billing.

For specific information regarding the resolution of claim rejected by CWF, refer to IOM Pub. 100-04, Chapter 27, §50.

30.3.2 - Pending Claims

(Rev.20, Issued: 07-13-07, Effective: 05-23-07, Implementation: 07-30-07)

Contractors shall disclose information about pending claims to providers, preferably via the IVR, if feasible. A pending claim is one that is being processed or has been processed and is on the payment floor. As long as all authentication requirements are met, the IVR or the CSR shall provide information about pending claims, including receipt (yes/no) and the fact that the claim is still pending. Contractors shall have discretion to provide more information about pending claims, including Internal Control Number (ICN), pay date/amount or denial. If contractors choose to provide this additional information, the IVR or the CSR shall state that until payment is made or the RA issued, any information given on the call or in the written response may change. If a contractor chooses to provide this information via the IVR, providers should be educated to request this information via the IVR rather than calling the CSR.

30.3.3 – Requests for Information Available on the IVR

(Rev.20, Issued: 07-13-07, Effective: 05-23-07, Implementation: 07-30-07)

If a request for claim status or eligibility is received by a CSR or written inquiry correspondent and the requested information can be found on the IVR, the inquirer shall be directed to the IVR. If at any time during a telephone inquiry the inquirer requests information that can be found on the IVR, the CSR shall refer the inquirer back to the IVR. CSRs should not transfer callers back into the CSR queue.

30.3.4 – Requests for Information Available on the Remittance Advice

(Rev.20, Issued: 07-13-07, Effective: 05-23-07, Implementation: 07-30-07)

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/manuals/downloads/clm104c22.pdf.
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/MLNCatalog0506.pdf to assist in *educating providers about how to read a RA.*

Also available is a website 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 is also a Web-based training course, Understanding the Remittance Advice for Professional Providers, which is available at http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5. The course provides continuing education credits and contains general information about RAs, instructions to help interpret the RA received from Medicare and reconcile it 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.

30.4 – *Deceased Beneficiaries*

(Rev.20, Issued: 07-13-07, Effective: 05-23-07, Implementation: 07-30-07)

Although the Privacy Act of 1974 does not apply to deceased individuals, the HIPAA Privacy Rule concerning protected health information applies to individuals, both living and deceased. Therefore, contractors shall comply with authentication requirements when responding to requests for information related to deceased beneficiaries.

30.5 – *Disclosure Desk Reference for Provider Contact Centers*

(Rev.20, Issued: 07-13-07, Effective: 05-23-07, Implementation: 07-30-07)

NOTE – Contractors shall apply the guidance in 30.*5*.1, 30.*5*.2, 30.*5*.3 and 30.*5*.4 to providers/suppliers, billing services and clearinghouses unless otherwise specified. The use of provider/supplier in these charts refers to all institutional and non-institutional entities and individuals that bill the Medicare program. The guidance below is broken down into several components: (1) authentication of provider elements for CSR inquiries, (2) authentication of provider elements for IVR inquiries, (3) authentication of provider elements for written inquiries and (4) authentication of beneficiary elements.

30.5.1 – *Authentication of Provider Elements for CSR Inquiries*

(Rev.20, Issued: 07-13-07, Effective: 05-23-07, Implementation: 07-30-07)

EFFECTIVE DATES:	INQUIRY TYPE:	THE FOLLOWING PROVIDER ELEMENTS SHALL BE AUTHENTICATED (all elements must match unless otherwise specified):	THEN THE FOLLOWING ELEMENTS SHOULD BE RELEASED AFTER BENEFICIARY ELEMENTS HAVE BEEN AUTHENTICATED:
Present – May 22, 2007	**CSR**	• **Provider number** **and** • **Provider name**	**Contractors shall refer to chart below.**
On or after May 23, 2007	**CSR**	• Provider NPI **and** • Provider name	**Contractors shall refer to chart below.**

30.5.2 – *Authentication of Provider Elements for IVR Inquiries*

(Rev.20, Issued: 07-13-07, Effective: 05-23-07, Implementation: 07-30-07)

EFFECTIVE DATES:	INQUIRY TYPE:	THE FOLLOWING PROVIDER ELEMENTS SHALL BE AUTHENTICATED (all elements must	THEN THE FOLLOWING ELEMENTS SHOULD BE RELEASED AFTER BENEFICIARY ELEMENTS HAVE BEEN

		match unless otherwise specified):	**AUTHENTICATED:**
Present – May 22, 2007	**IVR**	• **Provider number**	**Contractors shall refer to chart below.**
On or after May 23, 2007	**IVR**	• Provider NPI **and** • Provider Transaction Access Number	**Contractors shall refer to chart below.**

30.5.3 – *Authentication of Provider Elements for Written Inquiries*

(Rev.20, Issued: 07-13-07, Effective: 05-23-07, Implementation: 07-30-07)

Present – May 22, 2007	**Written inquiries, including fax and email**	• Provider number **and** • Provider name NOTE: If the inquiry is sent on provider	**Contractors shall refer to chart below.**

		letterhead with the provider's name and address, clearly establishing the identity of the provider, provider number is not required for provider authentication (see 30.1.2.B.). See 30.1.2.C for information about requests on pre-formatted inquiry forms.	
On or after May 23, 2007	**Written inquiries, including fax and email**	• Provider name **and one of the following two:** Provider NPI **OR** Provider Transaction Access Number NOTE: If the inquiry is sent on provider letterhead with the provider's name and address, clearly establishing the identity of the provider, NPI is not required for provider authentication (see 30.1.2.B.)	**Contractors shall refer to chart below.**

		See 30.1.2.C for information about requests on pre-formatted inquiry forms.	

30.5.4 – *Authentication of Beneficiary Elements*

(Rev.20, Issued: 07-13-07, Effective: 05-23-07, Implementation: 07-30-07)

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[1]	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	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

[1] **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.

		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 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.	• 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 • 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, *telephone number,* 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, and 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. (NOTE: Customer service contact information may be referenced at http://www.cms.hhs.gov/medicare/COBAgreement.) • 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 – Yes / No, administration date • Hepatitis B Vaccine – Yes / No, administration date • Blood Deductible • Date of Death
2. Routine Eligibility Elements[2]	IVR (involves	• Beneficiary last name – first 6 letters (no	Contractors shall frequently analyze IVR usage and inquiry and rejected/denied claims analysis

[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.

	touchtone or speech recognition technology)	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 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	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 • 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,

		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.	*telephone number*, 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, and 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 or next eligible date • Influenza Vaccine – Yes / No, administration

			date or next eligible date • Hepatitis B Vaccine – Yes / No, administration date or next eligible 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 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	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 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	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 • ESRD effective date • Transplant discharge date • **Home Health:** • Provider name • *Provider address* • *Provider telephone number* • Servicing contractor • Applicable dates • **Hospice:**

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.)		copy of the Medicare card, and/or follow up with the beneficiary, for the correct information.	• Provider name • *Provider address* • *Provider telephone number* • 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 release this information to assist the provider in 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 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	NOTE: For the elements below, contractors have discretion about whether to release this information and, if so, how to program the IVR to offer these elements. ● **ESRD:** • Renal Supplies: • ESRD effective dates • Transplant discharge date • Alternate Method Dialysis: • Method 1 • Method 2 • ESRD effective date • Transplant discharge date ● **Home Health**: • Provider name • *Provider address* • *Provider telephone number* • Servicing contractor • Applicable dates

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.)		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.	• **Hospice:** • Provider name • *Provider address* • *Provider telephone number* • 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 determining a beneficiary's eligibility for these services or billing Medicare properly.	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 ● 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)	**Next eligible dates for professional / technical components based on HCPCS or service description provided by the inquirer:** ● Cardiovascular (80061, 82465, 83718, 84478) ● Colorectal (G0104, G0105, G0106, G0120, G0121, G0107, G0328) ● Diabetes (82947, 82950, 82951) ● Glaucoma (G0117, G0118) ● Initial preventive physical exam (G0344, G0366, G0367, G0368) ● Mammography (76092, G0202) ● Pap test (Q0091, P3000, G0123, G0143, G0144, G0145, G0147, G0148) ● Pelvic and clinical breast exam (G0101) ● Prostate (G0102, G0103) ● Bone density (G0130) ● Smoking and tobacco-use cessation counseling (G0375, G0376)—remaining sessions for coverage period

		• 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.	• *Abdominal Aortic Aneurysm (G0389)* NOTE: HCPCS codes are accurate as of the publication date of this document and provided for informational purposes only. If codes change before the desk reference is updated, contractors shall use the most updated codes. See http://www.cms.hhs.gov/MedHCPCSGenInfo/ for HCPCS information. **NOTE: If a description of the service is used instead of a HCPCS code, the CSR shall confirm the exact service being referenced to ensure that the information being disclosed is what is being requested. For example, there are several codes for colorectal screening. Depending upon the services the beneficiary has already received, the next eligible date will be specific to a particular service.**
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	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	**Next eligible dates for professional / technical components based on HCPCS provided by the inquirer:** • Cardiovascular (80061, 82465, 83718, 84478) • Colorectal (G0104, G0105, G0106, G0120, G0121, G0107, G0328) • Diabetes (82947, 82950, 82951) • Glaucoma (G0117, G0118) • Initial preventive physical exam (G0344, G0366, G0367, G0368) • Mammography (76092, G0202) • Pap test (Q0091, P3000, G0123, G0143, G0144, G0145, G0147, G0148)

release this information to assist the provider in determining a beneficiary's eligibility for these services or billing Medicare properly.		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 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.	• Pelvic and clinical breast exam (G0101) • Prostate (G0102, G0103) • Bone density (G0130) • Smoking and tobacco-use cessation counseling (G0375, G0376)—remaining sessions for coverage period • *Abdominal Aortic Aneurysm (G0389)* **NOTE: HCPCS codes are accurate as of the publication date of this document and provided for informational purposes only. If codes change before the desk reference is updated, contractors shall use the most updated codes. See http://www.cms.hhs.gov/MedHCPCSGenInfo/ for HCPCS information.**
7. Processed claims information NOTE – Contractors should release information prior to claim submission	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	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

only with the 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.		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 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.	provider/supplier for that beneficiary, including whether the claim was crossed over and the reason the claim was not crossed over, as 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 and the reason the claim was not crossed over, as applicable. However, see note below. 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 Records 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 State or local custody under a penal authority. The contractor shall direct the inquirer to follow up with the State Department of Corrections. **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	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 and the reason the claim was not crossed over, as 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 and the reason the claim was not crossed over, as applicable.

		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.	
9. DME MAC Information Form (DIF) – DME MAC ONLY	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	Contractors shall use discretion in determining what information to release. Contractors should release information about 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 DIF. • Initial date

		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 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	• Recertification date • Length of need • Other elements necessary to properly bill Medicare Contractors shall confirm whether or not the answers to the question sets on the DIF on file match what the supplier has in his/her records.

		the supplier gives 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.	
10. DME MAC Information Form (DIF) – DME MAC ONLY	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	Contractors shall use discretion in determining what information to release. Contractors should release information about 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 DIF. • Initial date • Recertification date • Length of need • Other elements necessary to properly bill Medicare

		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 **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.	

Medicare Contractor Beneficiary and Provider Communications Manual

Chapter 6 - Provider Customer Service Program

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(Rev.20, 07-13-07)

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20.1 - POE Goals

(Rev.20, Issued: 07-13-07, Effective: 05-23-07, Implementation: 07-30-07)

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

20.2.1 – *Error Rate Reduction Data*

(Rev.20, Issued: 07-13-07, Effective: 05-23-07, Implementation: 07-30-07)

Medicare contractors shall use error rate information to design appropriate provider education. Contractors shall focus on data from the CERT, HPMP, and RAC programs, as appropriate. Additionally, contractors shall use other data sources such as provider inquiry tracking data and claims submission error data, for error rate reduction.

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

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

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

20.5.3 – Error Rate Reduction Plan (ERRP)

(Rev.20, Issued: 07-13-07, Effective: 05-23-07, Implementation: 07-30-07)

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/DME program safeguard contractor plans to take in order to lower the paid claims error rate and provider compliance 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.

20.6.5 - Refunds/Credits for Cancellation of Events

(Rev.20, Issued: 07-13-07, Effective: 05-23-07, Implementation: 07-30-07)

In order to secure sites needed for future provider training events, the contractor may have to make commitments under which it will incur contractual expenses for training accommodations and services. The contractor shall make full or partial refunds/credits to providers who register for an event, and cancel before the event, or do not attend the event, *and notify the contractor before the event.* If training is scheduled and the contractor cancels the event, the contractor shall make a full refund to registrants.

Within the framework of the stipulations, 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 or advertising. If there are questions concerning the implementation of this policy in a given case, the contractor shall contact the RO coordinator.

30.2.3 - Availability Requirements

(Rev.20, Issued: 07-13-07, Effective: 05-23-07, Implementation: 07-30-07)

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

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

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

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

Contact center staffing shall be based on the pattern of incoming calls per hour and day of the week, ensuring that adequate coverage of incoming calls throughout each workday is maintained. *In 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 call may disconnect if the CSR is placed on hold for two minutes.*

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

30.2.7.1 - Quality Call Monitoring (QCM) *Program*

(Rev.20, Issued: 07-13-07, Effective: 05-23-07, Implementation: 07-30-07)

1. At a minimum, the contractor's call monitoring program shall ensure that:
2. Calls monitored are from providers and are of the type that the CSR's level typically handles (Level 1, Level 2, Congressional.)
3. *Calls 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 scorecards and chart and recorded in the QCM database.
5. *Calls are evaluated and scores are entered in the QCM database by the 10th of the month following the evaluation of the call. For example, calls answered in the month of November shall be evaluated and entered into the QCM database by December 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. Feedback is provided to CSRs.
9. PCC staff are properly educated about the program and its use.
10. *The QCM Handbook is adhered to.*

Contractors that record calls for QCM purposes shall be required to maintain such recordings for an ongoing 90-day period during the year. All recordings shall be clearly identified by date and filed in a manner that will allow 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 on the tapes.

30.3.3 - Telephone Responses

(Rev.20, Issued: 07-13-07, Effective: 05-23-07, Implementation: 07-30-07)

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

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

If the inquirer requests a copy of the Report of Contact, a response letter must be sent. It is not acceptable to send the Report of Contact itself. All information contained within the Summary of Discussion must be included in the requested response. All guidelines for a written response apply.

It is also acceptable to send the information via e-mail or facsimile, if it is suggested by the provider and the response does not contain any beneficiary or claim specific information. All guidelines for a written response apply.

The report of contact shall be retained in the same manner and time frame as the current process for written responses. The contractor shall use its discretion when identifying

which written inquiries (e.g., provider correspondence that represents simple questions) can be responded to by phone. If the contractor cannot reach the provider by phone, the contractor shall develop a written response within 45 business days from the incoming inquiry. It is not acceptable to leave a message/response on the provider's voicemail.

30.3.6.1 - Quality Written Correspondence Monitoring (QWCM) *Program*

(Rev.20, Issued: 07-13-07, Effective: 05-23-07, Implementation: 07-30-07)

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

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

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

3. Monitoring scores are recorded using the official QWCM scorecards and charts through the QWCM database -- separate scorecards and scoring criteria are used to evaluate written and telephone responses.

4. *All responses are scored no more than one month from when the response was sent.*

5. *All scores are entered into the QWCM database by the 10th 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. Feedback is provided to correspondents.

9. PCC staff is properly educated about the program and its use and each reviewer and correspondent has an up-to-date copy of the scorecard and chart for reference.

10. *The QWCM Handbook is adhered to.*

30.5.2 - Complex Beneficiary Inquiries

(Rev.20, Issued: 07-13-07, Effective: 05-23-07, Implementation: 07-30-07)

In the MAC environment, complex beneficiary inquiries will be identified and referred to the PRRS by the Beneficiary Contact Center (BCC) via the Next Generation Desktop

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

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

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

50.1 - Interactive Voice Response System (IVR)

(Rev.20, Issued: 07-13-07, Effective: 05-23-07, Implementation: 07-30-07)

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. Contractor shall have the technical capability to either require callers to listen or to allow them to bypass the message as determined by CMS. In cases where CMS makes no determination the contractor shall use its own discretion.)

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. IVRs shall be updated to address provider needs as determined by contractors' inquiry analysis staff at least once every six months.

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

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

60.2.2 - Call Completion

(Rev.20, Issued: 07-13-07, Effective: 05-23-07, Implementation: 07-30-07)

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

60.2.4 – Average Speed of Answer (ASA)

(Rev.20, Issued: 07-13-07, Effective: 05-23-07, Implementation: 07-30-07)

The contractor shall maintain an average speed of answer of 120 seconds. This standard shall be measured quarterly and will be cumulative for the quarter.

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

60.2.6 – QCM Performance Standards

(Rev.20, Issued: 07-13-07, Effective: 05-23-07, Implementation: 07-30-07)

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

- *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.20, Issued: 07-13-07, Effective: 05-23-07, Implementation: 07-30-07)

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. 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 – General Inquiries Timeliness

(Rev.20, Issued: 07-13-07, Effective: 05-23-07, Implementation: 07-30-07)

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

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

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

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

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

(Rev.20, Issued: 07-13-07, Effective: 05-23-07, Implementation: 07-30-07)

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

80.1 - Provider Transaction Access Number (PTAN)

(Rev.20, Issued: 07-13-07, Effective: 05-23-07, Implementation: 07-30-07)

The provider transaction access number (PTAN) shall be a required authentication element for all telephone and written inquiries beginning May 23, 2007. Initially, the PTAN shall be the legacy number for currently enrolled providers. Newly enrolled and re-enrolled providers will be assigned a PTAN. The PTAN will be included in the provider enrollment letters.

80.2 - Inquiry Types

(Rev.20, Issued: 07-13-07, Effective: 05-23-07, Implementation: 07-30-07)

80.2.1 - Telephone Inquiries

(Rev.20, Issued: 07-13-07, Effective: 05-23-07, Implementation: 07-30-07)

The Disclosure Desk Reference chart contains the information contractors shall use to authenticate the identity of a caller, so that the information can then be released by CSRs or inquiries answered via Interactive Voice Response (IVR.) Contractors are reminded that the guidance contained in this section does not supersede requirements in section 30.3 concerning operation of the Provider Contact Center and handling of telephone inquiries.

A. **CSR Telephone Inquiries** - CSRs shall authenticate providers with two data elements. For CSR inquiries through May 22, 2007, CSRs shall authenticate providers using the provider name and provider number. Beginning May 23, 2007, CSRs shall authenticate providers using the *PTAN* and National Provider Identifier (NPI). *Contractors shall have the discretion to use the provider name as an additional authentication element in order to ascertain the specific claim and/or beneficiary information being requested.*

B. **IVR Telephone Inquiries** - For inquiries handled by the IVR, the authentication requirements are broken down by time frames related to the implementation of the NPI. For IVR inquiries through May 22, 2007, contractors' IVRs shall authenticate providers with one data element, provider number. Beginning May 23, 2007, contractors' IVRs shall authenticate providers with two data elements, NPI and Provider Transaction Access Number (PTAN.)

C. **Authentication of Providers with No NPI** – In limited circumstances, there will be situations where providers will never be assigned an NPI. These situations may include retired/terminated providers. *There also may be situations where an inquiry is made regarding a claim submitted by a provider who has since deceased.* After NPI implementation, telephone inquiries *about claims* from these providers shall be handled by CSRs because the IVR shall require two elements (i.e., an NPI and PTAN) for authentication. *Contractors have the discretion as to which data elements to use, but suggestions include name, PTAN, provider master address, and remittance address.*

For those providers never assigned an NPI, CSRs shall authenticate these providers with two data elements. Contractors have discretion as to the data elements chosen, but suggestions include name, *PTAN,* provider master address, and remittance address.

D. **Beneficiary Authentication** - Contractors shall authenticate four beneficiary data elements before disclosure of beneficiary information no matter the type of telephone inquiry (CSR or IVR) or the date of the call (pre- or post-NPI implementation.) The data elements are (1) last name, (2) first name or initial, (3) Health Insurance Claim Number (HICN) and (4) either date of birth (eligibility, next eligible date, Certificate of Medical Necessity (CMN)/Durable Medical Equipment Medicare Administrative Contractor Information Form (DIF) (pre-claim) **or** date of service (claim status, CMN/DIF (post-claim.)) Specific guidance related to these data elements, along with any exceptions, is contained in the disclosure chart.

If the CSR or IVR determines that the authentication elements provided are insufficient or inaccurate, the inquirer will be required to provide accurate information before the information being sought is released. The CSR and, if feasible, the IVR, should relay to the inquirer which element does not match (i.e., date of birth rather than day or month or year) and instruct them 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.

As mentioned above, for situations not specifically addressed here, the CSR should use his/her discretion, taking care to protect the beneficiary's privacy and confidentiality. CSRs shall refer situations in which he/she is unsure of whether or not to release information to his/her supervisor or to the contractor's privacy official. Contractors shall forward further questions to CMS at the email address provided above.

In situations where a caller is transferred from the IVR to a CSR, if the provider data elements were authenticated in the IVR and that information is passed to the CSR, the CSR should not re-authenticate the provider before information is released. If a contractor's desktop system displays caller authentication elements when the CSR picks up the call, then only the beneficiary elements need to be authenticated. The main point is that the CSR shall have all information relating to authentication and need only request from the caller those data elements not being populated on the CSR's screen by the desktop system.

80.2.1.1 - Contractor Discretion Concerning IVR Information

(Rev.20, Issued: 07-13-07, Effective: 05-23-07, Implementation: 07-30-07)

Contractors shall have discretion about whether to offer some types of information through their IVR. If contractors decide to offer this information, the Disclosure Desk Reference offers guidelines on how to authenticate providers prior to releasing information. Contractors should review the chart in 80.4.4 for more information.

Contractors shall use, among other data, analysis and provider feedback to determine what to offer via the IVR. Additionally, contractors shall determine the information relevant to their providers that can be automated and that which, if automated, would direct the most calls to the IVR and away from the CSRs. However, contractors shall note that the information contained in the disclosure chart does not supersede any requirements for IVR operation elsewhere in this chapter (50.1.)

80.2.2 *- Written Inquiries*

(Rev.20, Issued: 07-13-07, Effective: 05-23-07, Implementation: 07-30-07)

Authentication elements for providers are determined by the date of the written inquiry as well as how the inquiry is received, although CMS allows exceptions for inquiries received on provider letterhead. Contractors shall use the guidelines in the chart to authenticate providers for written inquiries as well as the information below. Contractors are reminded that the guidance contained in this section does not supersede requirements in section 30.3 concerning handling of written inquiries.

A. **Date of Written Inquiry - Provider Authentication** - Contractors shall authenticate providers on written inquiries with two data elements. The elements differ depending upon the date of the inquiry.

   For written inquiries dated May 22, 2007, or before, contractors shall authenticate providers using provider number and provider name.

   For written inquiries dated May 23, 2007, or after, contractors shall authenticate providers using provider name and one of the following two: (1) NPI or (2) PTAN.

   Contractors shall authenticate providers for all written inquiries using the elements mentioned above, with the exceptions noted in B.

Exception: Method of Receipt – Hardcopy on Letterhead or Email with Attachment on Letterhead - For written inquiries received on the provider's official letterhead, including emails with an attachment on letterhead, authentication of the provider will be met if the provider's name and address are included in the letterhead and clearly establish the identity of the provider. No provider identification number as detailed in A. above (i.e., current provider number, NPI or PTAN) is required. If all authentication elements are met, contractors shall respond with the information requested in writing via regular mail. (Contractors shall see the information about responding to inquiries received via email and fax below.)

In the case of multiple addresses on the letterhead, as long as one of the addresses match, authentication is considered met. Providers should be educated to send in written inquiries on letterhead that contain all practice locations or to use letterhead that has the address that Medicare has on record for that provider.

Contractors shall treat requests submitted via fax on provider letterhead as written inquiries and subject to the same authentication requirements as those received in regular mail. Contractors shall not fax responses containing protected health information, but shall instead send the information via regular mail.

Method of Receipt – Hardcopy/No Letterhead, Email/No Attachment on Letterhead or Pre-formatted Inquiry Forms – For inquiries received without letterhead, including hardcopy, fax, email, pre-formatted inquiry forms or inquiries written on Remittance Advice (RAs) or Medicare Summary Notices (MSNs), contractors shall authenticate providers as detailed in A. above using provider name and the appropriate provider identification number depending upon the date of the inquiry (current provider number or NPI or PTAN.)

Special Note about Inquiries Received Via Email and Fax - For requests received via email and fax, assuming all authentication elements are present as detailed in A. or B. above, whichever is applicable, contractors shall respond as directed in section 30.3.4 in writing via regular mail with the requested information if there is protected health information in the response. In the written response on contractor letterhead, contractors shall inform the provider that beneficiary-specific information cannot be disclosed electronically via email or fax and that, in the future, the provider must send a written inquiry through regular mail or use the IVR for beneficiary-specific information. Additionally, contractors shall have discretion to respond to these requests by telephone as specified in 30.3.3.

For email requests only, contractors shall not notify the provider by email that they will be responding via paper or telephone. However, contractors have discretion to send an automated email reply to an email request as long as no protected health information is in the automated reply. Contractors shall ensure that the automated reply conveys the message that no beneficiary-specific information may be disclosed via email and that, in the future, the provider must

send a written inquiry through regular mail or use the IVR for beneficiary-specific information.

Contractors are reminded that they may respond via email to email requests not involving protected health information or beneficiary-specific information (i.e., policy questions.)

Beneficiary Authentication - Assuming provider authentication requirements are met as detailed in A. or B. above, whichever is applicable, contractors shall always authenticate beneficiary data elements before disclosure of information without regard to the date of the written inquiry or method of receipt. See the chart in 80.*5*.4 for more information about authentication of beneficiary elements.

F. Requests Received Without Authentication Elements - For any written requests received without one or more authentication elements, without regard to date of inquiry or method of receipt, contractors shall return the request in its entirety to the provider stating that the requested information will be supplied upon submission of all authentication elements. Contractors shall indicate which overall elements are missing or do not match for authentication (i.e., date of birth rather than day or month or year.) Contractors shall return the inquiry to the provider via regular mail, although if sent via email without any protected health information, the inquiry may be returned via email.

Contractors have discretion to follow up with a telephone call to obtain the rest of the authentication elements instead of returning the inquiry or to close out the written inquiry with a telephone call (see 30.3.3 in this chapter.) Contractors shall not leave a message containing protected health information on an answering machine. Contractors shall remind the provider to check its copy of the beneficiary's Medicare card and/or follow up with the beneficiary for the correct information.

For situations not specifically addressed here, the contractor should use discretion, taking care to protect the beneficiary's privacy and confidentiality. Contractors shall refer situations in which they are unsure of whether or not to release information to a supervisor or to the contractor's privacy official. Contractors shall forward further questions to CMS at CMS ProviderServices@cms.hhs.gov.

80.3 - *Special Inquiry Topics*

(Rev.20, Issued: 07-13-07, Effective: 05-23-07, Implementation: 07-30-07)

80.3.1 - Overlapping Claims

(Rev.20, Issued: 07-13-07, Effective: 05-23-07, Implementation: 07-30-07)

Contractors sometimes receive multiple claims with the same or similar dates of service or billing periods. Overlap occurs when a date of service or billing period conflicts with another, indicating that one or the other may be incorrect.

In cases where a contractor receives an inquiry from a provider or another Medicare contractor requesting provider information to resolve an overlapping claim, contractors shall work with each other. Resolution can occur through various ways. One way is for one contractor to call the other contractor with or without the provider on the line. This will allow the contractor calling to assure the other contractor that the provider has given all necessary authentication elements. The contractor shall then release the needed information.

Only the contractor who is initially contacted by the provider shall authenticate the provider. Contractors shall authenticate the provider by verifying the provider's name, PTAN or NPI, beneficiary name, HICN, and date of service for post-claim information, or date of birth for pre-claim information. Authentication does not need to be repeated when contacting the second contractor.

Contractors shall authenticate other contractors by one of three ways.
1) Both parties on the call look at the MBR record (or other beneficiary record to which they both have access.) The CSR can name a field on the MBR and ask that the other contractor to identify what is in that particular field.
2) The CSR may ask for the employee's phone number and call him/her back, making sure that the area code and exchanges matches a listed phone number for that contractor. Caller ID or a similar service may be used to verify the area code and exchange in lieu of a callback.
3) The CSR may take the name and telephone number of the contractor CSR, the name and telephone number of his/her supervisor, the date, and reason for the inquiry and post this information in the "Notes" screen, or similar screen.

Contractors shall have discretion to develop other avenues to work out overlapping claims with one another. Contractors are encouraged to share ideas with one another. However, if a contractor resolves an overlapping claim in a way other than directly calling the other contractor, the CSR shall make it clear to the inquiring provider that the information is not disseminated by CMS and CMS is not responsible for the accuracy of the information. All contractors shall work together to facilitate correct payment of all parties. In general, the servicing contractor of the inquirer should take the lead in resolving an overlapping situation.

Contractors shall release overlapping claim information whether a provider is inquiring about a claim that was rejected for overlapping information, or if the provider found overlapping information when checking eligibility for a new admittance. In situations where the provider is seeking to avoid a claim being rejected, the contractor should, at their discretion, release information prior to claim submission. An example of this is a situation where some End State Renal Disease (ESRD) facilities prefer to obtain the inpatient hospital benefit days for the month, prior to the ESRD monthly bill being generated. This allows the ESRD facility to code the claim appropriately and bill around the inpatient hospital stay/stays. This situation falls into the category of disclosing information needed to bill Medicare properly and release is appropriate as long as all authentication elements are met. Other situations may arise that fall into this category as

well, for example, skilled nursing facility and inpatient hospital stays. Contractors shall, in these situations, ensure that the request is legitimate and necessary for proper billing.

For specific information regarding the resolution of claim rejected by CWF, refer to IOM Pub. 100-04, Chapter 27, §50.

80.3.2 - Pending Claims

(Rev.20, Issued: 07-13-07, Effective: 05-23-07, Implementation: 07-30-07)

Contractors shall disclose information about pending claims to providers, preferably via the IVR, if feasible. A pending claim is one that is being processed or has been processed and is on the payment floor. As long as all authentication requirements are met, the IVR or the CSR shall provide information about pending claims, including receipt (yes/no) and the fact that the claim is still pending. Contractors shall have discretion to provide more information about pending claims, including Internal Control Number (ICN), pay date/amount or denial. If contractors choose to provide this additional information, the IVR or the CSR shall state that until payment is made or the RA issued, any information given on the call or in the written response may change. If a contractor chooses to provide this information via the IVR, providers should be educated to request this information via the IVR rather than calling the CSR.

30.3.3 – Requests for Information Available on the IVR

(Rev.20, Issued: 07-13-07, Effective: 05-23-07, Implementation: 07-30-07)

If a request for claim status or eligibility is received by a CSR or written inquiry correspondent and the requested information can be found on the IVR, the inquirer shall be directed to the IVR. If at any time during a telephone inquiry the inquirer requests information that can be found on the IVR, the CSR shall refer the inquirer back to the IVR. CSRs should not transfer callers back into the CSR queue.

30.3.4 – Requests for Information Available on the Remittance Advice

(Rev.20, Issued: 07-13-07, Effective: 05-23-07, Implementation: 07-30-07)

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/manuals/downloads/clm104c22.pdf.
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/MLNCatalog0506.pdf to assist in educating providers about how to read a RA.

Also available is a website 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 is also a Web-based training course, Understanding the Remittance Advice for Professional Providers, which is available at http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5. The course provides continuing education credits and contains general information about RAs, instructions to help interpret the RA received from Medicare and reconcile it 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.

80.4 – *Deceased Beneficiaries*

(Rev.20, Issued: 07-13-07, Effective: 05-23-07, Implementation: 07-30-07)

Although the Privacy Act of 1974 does not apply to deceased individuals, the HIPAA Privacy Rule concerning protected health information applies to individuals, both living and deceased. Therefore, contractors shall comply with authentication requirements when responding to requests for information related to deceased beneficiaries.

80.5 – *Disclosure Desk Reference for Provider Contact Centers*

(Rev.20, Issued: 07-13-07, Effective: 05-23-07, Implementation: 07-30-07)

NOTE – Contractors shall apply the guidance in 80.*5*.1, 80.*5*.2, 80.*5*.3 and 80.*5*.4 to providers/suppliers, billing services and clearinghouses unless otherwise specified. The use of provider/supplier in these charts refers to all institutional and non-institutional entities and individuals that bill the Medicare program. Because of the upcoming transition to the NPI, (see 80.5 for information concerning NPI implementation dates), the guidance below is broken down into several components: (1) authentication of provider elements for CSR inquiries, (2) authentication of provider elements for IVR inquiries, (3) authentication of provider elements for written inquiries and (4) authentication of beneficiary elements.

80.5.1 – Authentication of Provider Elements for CSR Inquiries

(Rev.20, Issued: 07-13-07, Effective: 05-23-07, Implementation: 07-30-07)

EFFECTIVE DATES:	INQUIRY TYPE:	THE FOLLOWING PROVIDER ELEMENTS SHALL BE AUTHENTICATED (all elements must match unless otherwise specified):	THEN THE FOLLOWING ELEMENTS SHOULD BE RELEASED AFTER BENEFICIARY ELEMENTS HAVE BEEN AUTHENTICATED:
Present – May 22, 2007	**CSR**	**• Provider number** **and** **• Provider name**	**Contractors shall refer to chart below.**
On or after May 23, 2007	**CSR**	• Provider NPI **and** • Provider name	**Contractors shall refer to chart below.**

80.5.2 – Authentication of Provider Elements for IVR Inquiries

(Rev.20, Issued: 07-13-07, Effective: 05-23-07, Implementation: 07-30-07)

EFFECTIVE DATES:	INQUIRY TYPE:	THE FOLLOWING PROVIDER ELEMENTS SHALL BE AUTHENTICATED (all elements must match unless otherwise specified):	THEN THE FOLLOWING ELEMENTS SHOULD BE RELEASED AFTER BENEFICIARY ELEMENTS HAVE BEEN AUTHENTICATED:
Present – May 22, 2007	**IVR**	**• Provider number**	**Contractors shall refer to chart below.**

On or after May 23, 2007	**IVR**	• Provider NPI **and** • Provider Transaction Access Number	**Contractors shall refer to chart below.**

80.5.3 – Authentication of Provider Elements for Written Inquiries

(Rev.20, Issued: 07-13-07, Effective: 05-23-07, Implementation: 07-30-07)

Present – May 22, 2007	**Written inquiries, including fax and email**	• Provider number **and** • Provider name NOTE: If the inquiry is sent on provider letterhead with the provider's name and address, clearly establishing the identity of the provider, provider number is not required for provider authentication (see 30.1.2.B.). See 30.1.2.C for information about requests on pre-formatted inquiry forms.	**Contractors shall refer to chart below.**
On or after May 23, 2007	**Written inquiries, including**	• Provider name **and one of the following two:**	**Contractors shall refer to chart below.**

	fax and email	Provider NPI **OR** Provider Transaction Access Number NOTE: If the inquiry is sent on provider letterhead with the provider's name and address, clearly establishing the identity of the provider, NPI is not required for provider authentication (see 30.1.2.B.) See 30.1.2.C for information about requests on pre-formatted inquiry forms.	

80.5.4 – Authentication of Beneficiary Elements

(Rev.20, Issued: 07-13-07, Effective: 05-23-07, Implementation: 07-30-07)

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[1]	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 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	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 • 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, *telephone number,* type, enrollment and termination dates

[1] **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.

		copy of the Medicare card, and/or follow up with the beneficiary, for the correct information.	• 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, and 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. (NOTE: Customer service contact information may be referenced at http://www.cms.hhs.gov/medicare/COBAgreement.) • 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 – Yes / No, administration date • Hepatitis B Vaccine – Yes / No, administration date • Blood Deductible • Date of Death
2. Routine Eligibility Elements[2]	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	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 • Crossover established – Yes / No • Home Health – Yes / No • Hospice – Yes / No • SNF – 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.

		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.	• 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, *telephone number*, 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, and 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 or next eligible date • Influenza Vaccine – Yes / No, administration date or next eligible date • Hepatitis B Vaccine – Yes / No, administration date or next eligible 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 • *Provider address* • *Provider telephone number* • Servicing contractor • Applicable dates ● **Hospice:** • Provider name • *Provider address* • *Provider telephone number* • 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	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	NOTE: For the elements below, contractors have discretion about whether to release this information and, if so, how to program the IVR to offer these elements. ● **ESRD:** • Renal Supplies: • ESRD effective dates • Transplant discharge date • Alternate Method Dialysis: • Method 1

so, the type of information to be released to an inquirer; the contractor shall only 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.)		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 • 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 • *Provider address* • *Provider telephone number* • Servicing contractor • Applicable dates ● **Hospice:** • Provider name • *Provider address* • *Provider telephone number* • 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	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	**Next eligible dates for professional / technical components based on HCPCS or service description provided by the inquirer:** ● Cardiovascular (80061, 82465, 83718, 84478) ● Colorectal (G0104, G0105, G0106, G0120, G0121, G0107, G0328) ● Diabetes (82947, 82950, 82951) ● Glaucoma (G0117, G0118) ● Initial preventive physical exam (G0344,

contractor shall only release this information to assist the provider in determining a beneficiary's eligibility for these services or billing Medicare properly.		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 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.	G0366, G0367, G0368) ● Mammography (76092, G0202) ● Pap test (Q0091, P3000, G0123, G0143, G0144, G0145, G0147, G0148) ● Pelvic and clinical breast exam (G0101) ● Prostate (G0102, G0103) ● Bone density (G0130) ● Smoking and tobacco-use cessation counseling (G0375, G0376)—remaining sessions for coverage period *• Abdominal Aortic Aneurysm (G0389)* NOTE: HCPCS codes are accurate as of the publication date of this document and provided for informational purposes only. If codes change before the desk reference is updated, contractors shall use the most updated codes. See http://www.cms.hhs.gov/MedHCPCSGenInfo/ for HCPCS information. **NOTE: If a description of the service is used instead of a HCPCS code, the CSR shall confirm the exact service being referenced to ensure that the information being disclosed is what is being requested. For example, there are several codes for colorectal screening. Depending upon the services the beneficiary has already received, the next eligible date will be specific to a particular service.**
6. Preventive Services -Next Eligible Date -	IVR (involves touchtone or	• Beneficiary last name – first 6 letters (no special characters); if using speech recognition technology, may use entire last	**Next eligible dates for professional / technical components based on HCPCS provided by the inquirer:**

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.	speech recognition technology)	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 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	• Cardiovascular (80061, 82465, 83718, 84478) • Colorectal (G0104, G0105, G0106, G0120, G0121, G0107, G0328) • Diabetes (82947, 82950, 82951) • Glaucoma (G0117, G0118) • Initial preventive physical exam (G0344, G0366, G0367, G0368) • Mammography (76092, G0202) • Pap test (Q0091, P3000, G0123, G0143, G0144, G0145, G0147, G0148) • Pelvic and clinical breast exam (G0101) • Prostate (G0102, G0103) • Bone density (G0130) • Smoking and tobacco-use cessation counseling (G0375, G0376)—remaining sessions for coverage period *• Abdominal Aortic Aneurysm (G0389)* **NOTE: HCPCS codes are accurate as of the publication date of this document and provided for informational purposes only. If codes change before the desk reference is updated, contractors shall use the most updated codes. See http://www.cms.hhs.gov/MedHCPCSGenInfo/ for HCPCS information.**

		copy of the Medicare card, and/or follow up with the beneficiary, for the correct information.	
7. Processed claims information NOTE – Contractors should release information prior to claim submission only with the 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.	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 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.	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 and the reason the claim was not crossed over, as 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 and the reason the claim was not crossed over, as applicable. However, see note below. 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 Records 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 State or local custody under a penal authority. The contractor shall direct the inquirer to follow up with the State Department of Corrections. **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	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	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

beneficiaries or deported beneficiaries via the IVR.		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.	the claim was crossed over and the reason the claim was not crossed over, as 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 and the reason the claim was not crossed over, as applicable.

<table>
<tr>
<td>9. DME MAC Information Form (DIF) – DME MAC ONLY</td>
<td>Call to CSR or written inquiry</td>
<td>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 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</td>
<td>Contractors shall use discretion in determining what information to release. Contractors should release information about 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 DIF.
• Initial date
• Recertification date
• Length of need
• Other elements necessary to properly bill Medicare

Contractors shall confirm whether or not the answers to the question sets on the DIF on file match what the supplier has in his/her records.</td>
</tr>
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		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 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. DME MAC Information Form (DIF) – DME MAC ONLY	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	Contractors shall use discretion in determining what information to release. Contractors should release information about 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 DIF. • Initial date

		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 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	• Recertification date • Length of need • Other elements necessary to properly bill Medicare

		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.	

90 - Provider Inquiry Standardized Categories

(Rev.20, Issued: 07-13-07, Effective: 05-23-07, Implementation: 07-30-07)

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

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

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

CMS Standardized Provider Inquiry Chart

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

CMS Standardized Provider Inquiry Chart

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

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		Anesthesia Fee Schedule	Contact is asking for the Anesthesia Fee Schedule payment amount for a particular item or service provided to a Medicare beneficiary.
		Critical Access Hospitals	Contact is asking for the Critical Access Hospitals payment amount for a particular item or service provided to a Medicare beneficiary.
		Clinical Lab Fee Schedule	Contact is asking for the Clinical Laboratory Fee Schedule payment amount for a particular item or service provided to a Medicare beneficiary.
		Drug Average Sales Price (ASP) Resource	Contact is asking about the Medicare Part B Drug Average Sales Price Resource payment amounts. This extensive listing of drugs is a guide. It may not include all drugs that could be considered for payment by Medicare.
		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.

CMS Standardized Provider Inquiry Chart

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

CMS Standardized Provider Inquiry Chart

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

CMS Standardized Provider Inquiry Chart

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

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		LCD	Contact is asking about a claim(s) that was denied or reduced based on a local coverage determination (LCD) by the contractor. Coverage determinations reflect the local contractor decision as to whether a product, service, or device is reasonable and necessary.
		Life Time Days Met	Contact is asking about claim(s) denied because a particular benefit is disallowed for a Medicare beneficiary due to the lifetime days limit exhausted.
		Medical Necessity	Contact is asking about a claim(s) denied because the information presented did not indicate services or supplies are reasonable and necessary for the diagnosis and treatment of the illness or injury.
		MSP	Contact is asking about a claim(s) denied due to other insurance existing on the beneficiary file that is primary to Medicare.
		NCD	Contact is asking about a claim(s) that was denied or reduced based on a national coverage determination (NCD) by CMS. Coverage determinations reflect national Medicare coverage policies governing specific medical service, procedure or device.
		Statutory Exclusion	Contact is asking about a claim(s) that items or services were denied by law.
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.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		ATP Amount/Check Information	Contact is asking for current Approved to Pay (ATP) amount, current pending claims totals and/or payment information on a claim (i.e., status of check, check number, check amount and issued date).
		Crossover	Contact is asking for information on a claim that is covered by a supplemental insurer, such as Medigap or other private insurance.
		Not on File	Contact is asking for a claim that Medicare does not have on file or that has not been received by the contractor.
		Paid in Error	Contact is asking about a claim that they believe was paid in error.
		Payment Explanation/Calculation	Contact is asking for explanation on how the claim was paid or how the payment amount was calculated. Includes "reimbursement" questions.
		Suspended	Contact is asking about the status of a claim that is pending while waiting for information needed to complete processing.
Coding	Any set of codes used to encode data elements, such as tables of terms, medical concepts, medical diagnostic codes or medical procedure codes. Includes the codes, their descriptions, and how to use them.	*CCI Edits*	Contact is asking about Correct Coding Initiative edits that identify types of inappropriate coding combinations, such as comprehensive and component code combinations and code combinations of services or procedures that could not be performed together.
		Condition Codes	Contact is asking about billing codes that indicate whether the claimant meets a condition of the service.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		Procedure Codes	Contact is asking about the numeric representation of a procedure code used to determine reimbursement for services rendered on a claim or for other medical documentation. Includes CPT-4 codes, which belong to the American Medical Association and indicate physician services, physical and occupational therapy services, radiology procedures, clinical laboratory tests, medical diagnostic services, and hearing and vision services. Also, includes HCPCS Codes Level II that determines reimbursement for equipment and medical supplies.
		Diagnosis codes	Contact is asking about the numeric representation of a disease, injury, impairment, or other health problem that providers must use to report the diagnosis for each service and /or item they provide.
		Evaluation & Management Codes (E&M)	Contact is asking about codes that explain how the physician gathered and analyzed patient information, determined a condition, and advised the best treatment. Examples are: care plan oversight, office visits, hospital visits and consultations. E&M codes are a part of the AMA's CPT-4 coding system.
		Modifiers	Contact is asking about two digit codes used in conjunction with a procedure code that provides additional information about the service. The modifier may affect the reimbursement rate of a service.
		MSP Payer/Value Codes	Contact is asking about codes used to designate that another insurer is responsible for full or partial payment where Medicare has no payment or secondary payment responsibility.
		Revenue Codes	Contact is asking about codes that identify specific accommodations or ancillary charges that are provided in a hospital, (e.g., blood, cardiology, radiology, laboratory services, etc.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		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.
		Medicare Program	Contact is expressing dissatisfaction due to issues with the Medicare program. Includes provider expressions of intentions of leaving the Medicare program.
		Provider Education and Outreach	Contact is expressing dissatisfaction with educational activities, education staff performance or availability of educational resources or activities for Medicare providers.
		Self Service Technology	Contact is expressing dissatisfaction due to content, functionality, instability, formatting and processes related to Provider Self Service tools such as CMS or contractor website, online tools for eligibility inquiries or claim submissions, IVR, etc.
		Staff	Contact is expressing dissatisfaction due to CSR or Staff attitude, incorrect information given or non response to an inquiry.

CMS Standardized Provider Inquiry Chart

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

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		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.
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.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		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.
		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.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		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 transaction rules.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
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.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		ERA Election	Contact is asking for information about how to access and/or receive remittance notices electronically.
		How to read RA	Contact is asking for assistance in reviewing and/or understanding their remittance notice. Includes explanation of the Claim Adjustment Reason Codes and Remittance Advice Remark Codes on the Remittance Notice.
RTP/Unprocessable Claim	A claim(s) with incomplete, invalid, or missing information will be returned to the provider as unprocessable. This action cannot be appealed and the corrected claim(s) needs to be submitted as a new claim. Includes "W Status of Claim" and status of claims to be returned to provider.	*1500 / UB-92 Form Item*	Contact is asking about a claim(s) that was returned because the CMS claim form was not completed with the required information, such as, missing or invalid HICN, name, date of birth or sex. Includes the explanation of narrative of reason codes in the contractor's claims correction file, claims processing system and reports.
		Clinical Laboratory Improvement Act (CLIA)	Contact is asking about a claim(s) that was returned because the claim had a missing or incorrect CLIA number.
		Contractor Error	Contact is asking about a claim(s) that was returned to provider as unprocessable due to a contractor error.
		Contractual Obligation Not Met	Contact is asking about a claim(s) rejected because the provider did not comply with his or her Medicare contractual obligation. For example, the claim was presented with missing information (other than codes or modifiers), the 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.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		Place of Service	Contact is asking about a claim(s) that was returned due to invalid place of service or the place of service was not related to the procedure.
		Provider Information	Contact is asking about a claim(s) that was returned due to an incorrect or missing UPIN/NPI.
		Submitted to Incorrect Program	Contact is asking about a claim(s) that was returned because it was submitted to the incorrect program (FI, Carrier or DMERC).
		Truncated Diagnosis	Contact is asking about a claim(s) that was returned due to incorrect, invalid or missing diagnosis information.
Systems Issues	Medicare electronic systems, including the Medicare Claims Processing Systems and/or customer self-service applications (I.e. CMS website, contractor website, IVR, etc).	*Medicare Claims Processing System Issues*	Contact is presenting situation related to issues with the Medicare Processing Systems; for example, issues due to an aged claim, recycling claim and release of claims, etc.
		Website Issues	Contact is reporting problems with the functionality, stability or use of the CMS and contractor website.
		IVR Issues	Contact is reporting problems with the functionality or use of the contractor's IVR.
Temporary Issues	Includes inquiries that CMS would like to track temporarily due to special circumstances. CMS will provide specific timeframes for the monitoring of temporary issues. For contractor specific temporary issues, please follow instructions on IOM 100-9, Chapter 3, Section 20.5 or Chapter 6, Sections 30.1.1 – 30.1.1.2.	*Part D Drug Coverage*	Contact is presenting situation related to issues with the implementation of the Part D Medicare Prescription Drug Coverage.
		CD-ROM Initiative	Contact is requesting a hard-copy of the Annual Disclosure Statement, the "Dear Provider" letter and provider enrollment material in CD-ROM form, or asking for clarification of the CD-ROM content. Includes logging of

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
			CD-ROM related problems that providers encountered.
		CERT	Contact is asking information related to the Comprehensive Error Rate Testing (CERT) Program.
		Competitive Acquisition Program (CAP)	Contact is asking general questions about the CAP.
		HIGLAS	Contact is presenting a situation due to the implementation of HIGLAS, the new financial accounting system. Includes inquiries about HIGLAS's training material, its impact on claim processing, recoup overpayments, demand letters, settlements and penalty withholdings, HIGLAS changes on remittance advices and checks (voided/reissued).
		PQRI	*Contact is asking for information about the Physician Quality Reporting Initiative.*
		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.