Medicare Contractor Beneficiary and Provider Communications Manual

Chapter 6 - Provider Customer Service Program

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(Rev. 22, 08-08-08)

Transmittals for Chapter 6

Provider Customer Service Program

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

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

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

10 – Introduction to Provider Customer Service Program (PCSP)

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

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

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

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

20 – Provider Outreach and Education (POE)

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

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

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

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

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

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

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

20.1 - POE Goals

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.

20.1.1 - Internal Development of Provider Issues

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

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

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

20.1.2 – Partnering with External Entities

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

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

Partnering entities may be medical, professional or trade groups and associations, government organizations, educational institutions, trade and professional publications, specialty societies, and other interested or affected groups. By establishing collaborative information dissemination efforts, providers will be able to obtain Medicare program

information through a variety of sources. Partnering or collaborative provider information and education efforts can include:

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

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

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

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

20.2.1 – 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.

20.2.2 - Inquiry Analysis

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

For provider inquiry analysis, contractors shall maintain a systematic and reproducible provider inquiry analysis program that will produce a monthly list of the most frequently asked questions (FAQs) beyond claims status and eligibility for telephone inquiries and written inquiries. Contractors shall utilize information or instructions furnished by CMS to classify or categorize provider inquiries. (See § 30.6, 90 and Chapter 3, § 20.5) Educational efforts shall be developed and implemented to address the needs of providers as identified by this program.

20.2.3 - Claims Submission Errors

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

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

20.2.4 - Coordination with Medical Review

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

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

1. Provider Notification and Feedback Letters - When medical review does a probe, it sends a letter to the provider about the probe. These notification letters may include an offer for provider education to address the issues found in the probe. POE staff is

responsible for providing the education when requested by a provider in response to these letters. The contractor shall ensure that POE staff has ready access to copies of the probe notification letters so that POE staff shall have this information available should a provider contact POE requesting education. POE staff also monitor the probe letters sent by medical review and determine whether broader education to the provider community may be warranted. See § 20.3.4.2 for further information.

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

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

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

20.3 - Provider Education

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

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

20.3.1 - Provider Bulletins/Newsletters

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

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

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

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

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

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

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

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

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

2. Total number of providers/suppliers who are receiving paper bulletins after six months; and

3. Total number of provider praises and complaints along with a description of praises and complaints.

20.3.2 - Training for New Medicare Providers
(Rev. 18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06)

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

20.3.3 - Training Tailored for Small Providers
(Rev. 18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06)

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

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

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

20.3.4.1 – Local Coverage Determinations
(Rev. 18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06)

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

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

20.3.4.2 - Education Resulting from Medical Review Referrals
(Rev. 18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06)

The contractor is under no obligation to provide specific education in response to all medical review referrals. The education provided as a result of medical review shall be

determined in the context of the contractor's goal of reducing the provider compliance error rate within the resources available. The type of education and the involvement of clinical staff are at the discretion of the contractors.

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

20.3.4.3 - Medicare Preventive Service Benefits

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

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

20.3.4.4 - Electronic Claims Submissions

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

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

20.3.4.5 - Remittance Advice

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

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

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

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

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

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

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

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

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

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

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

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

20.4 - POE Advisory Groups

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

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

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

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

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

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

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

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

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

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

20.5 - POE Reporting

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

20.5.1 - Provider Service Plan (PSP)

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

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

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

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

20.5.2 – Education Activity Report (EAR)
(Rev. 18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06)

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

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

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

20.5.3 – Error Rate Reduction Plan (ERRP)
(Rev. 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 - Charging Fees to Providers for Medicare Education and Training Activities

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

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

20.6.1 – No Charge

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

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

20.6.2 – Fair and Reasonable Fees

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

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

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

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

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

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

associated with participation in education and training activities absent specific authority from CMS.

20.6.3 - Considerations and Record Keeping for Fee Collection
(Rev. 18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06)

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

Contractors shall keep records per event per contract year of the actual costs incurred, i.e., facility rental, audio/visual equipment, light refreshments, development and/or duplication of materials, and all fees charged to, and collected from, registrants. Contractors shall keep records for at least one year from the date of the educational event and shall document actual costs used to support the fees charged.

20.6.4 - Excess Revenues from Participant Fees
(Rev. 18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06)

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

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

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

year to CMS CO and the RO Coordinator explaining the amount of excess revenue, and prepare to refund the entire excess revenue equally to everyone who attended any of the contractor's fee-based training events.

20.6.5 - Refunds/Credits for Cancellation of Events

(Rev. 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.

20.6.6 - Recording of Training Events

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

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

30 - Provider Contact Center (PCC)

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

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

With the exception of technologies discussed in § 30.5.2 and 50, CMS is not requiring the use of any specific technologies, as long as the contractor is able to meet all performance standards and requirements in a cost-effective and efficient manner while providing a high level of quality customer service to providers that includes accurate and timely information. To ensure that inquiries receive accurate and timely handling, contractors shall ensure, at a minimum, that contact center staff have readily-accessible information

and tools (i.e., access to claims-related information, the contractor's and CMS' Web sites, a computer, and an outbound telephone line).

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

30.1 - Inquiry Triage Process

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

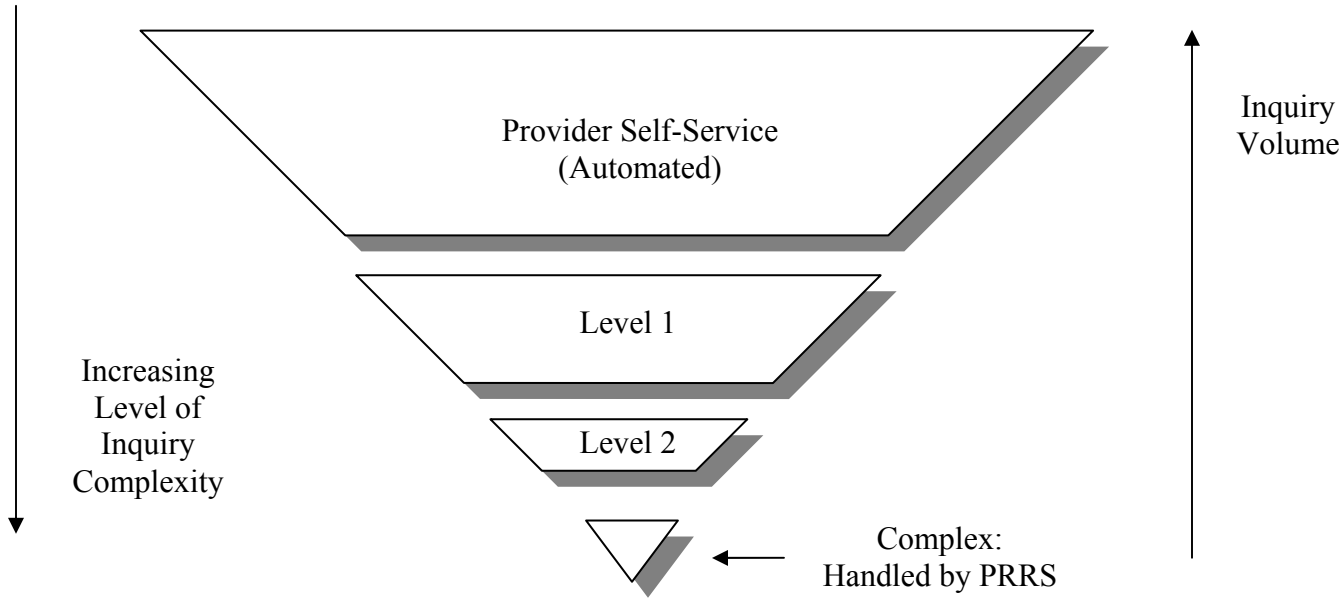
Provider inquiries may require varying degrees of expertise to answer. Using a triage mechanism, the contact center shall be able to route general inquiries within the PCC to the system or person best equipped to respond, with a minimal degree of transfer. The triage procedures shall be used for telephone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

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

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

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

Figure 1



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

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

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

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

4. The American Hospital Association's Coding Clinic for HCPCS responds to questions related to CPT-4 codes for hospital providers and Level II HCPCS codes, specifically A-codes for ambulance service and radiopharmaceuticals, C-codes, G-codes, J-codes, and

Q-codes (except Q0136 through Q0181), for hospitals physicians and other health professionals who bill Medicare. Details about this resource are available at www.ahacentraloffice.org. Additional information can be found about these resources at: http://www.cms.hhs.gov/MedHCPCSGenInfo/20_HCPCS_Coding_Questions.asp#TopOfPage

30.2 - Telephone Services

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

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

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

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

30.2.1 - Inbound Calls

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

The CMS will pay for the rental of inbound T-1/PRI lines and all connect time charges for FTS-2001 services. The costs associated with the installation and monthly fees for these services will be paid by CMS and shall not be considered by contractors in their budget requests. However, contractors shall remain responsible for all other internal telecommunications costs and devices such as agent consoles, handsets, internal wiring and equipment (ACD, IVR, PBX, etc.) and any local or outbound telephone services and

line charges. Since these costs are not specifically identified in any cost reports, contractors shall maintain records for all costs associated with providing telephone service to providers (e.g., costs for headsets) and shall provide this information upon request by CMS.

30.2.2 - Troubleshooting Problems

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

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

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

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

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

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

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

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

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

30.2.3 - Availability Requirements

(Rev. 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.

30.2.3.1 - Providing Busy Signals

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

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

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

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

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

30.2.3.3 – General Inquiries Line
(Rev. 18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06)

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

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

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

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

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

1. Online access to a computer terminal for each CSR responsible for claims-related inquiries. The computer terminal shall be physically located so that representatives can research data without leaving their desks/seats;

2. Access to the contractor's Web site and http://www.cms.hhs.gov/

3. An outgoing line for callbacks; and,

4. A supervisory console for monitoring CSRs.

30.2.4.2 – Sign-in Policy
(Rev. 18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06)

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

1. The CSRs available to answer telephone inquiries shall sign-in to the telephone system to begin data collection;

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

3. The CSRs shall sign-off the telephone system at the end of their workday.

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

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

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

Contractors shall provide remote access to their incoming provider inquiries toll free lines to CMS. CMS monitoring personnel shall have the capability to monitor live provider calls in their entirety by specific workstation (CSR), next call from the network or next call from the CSR queue, and/or specific business line. Whenever possible, CMS prefers to remotely monitor calls based upon next call in queue. This approach facilitates the

monitoring process and increases the ability to monitor various CSRs. CMS will take reasonable measures to ensure the security of this access (e.g., passwords will be controlled by one person.)

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

30.2.6 - Disaster Recovery

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

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

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

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

30.2.7 - Contractor Guidelines for High Quality Response to Telephone Inquiries

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

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

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

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.

30.2.7.2 – QCM Calibration

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

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

30.3 – Contractor Guidelines for Written Inquiries

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

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

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

30.3.1 - Controlling Written Inquiries

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

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

unit to which the inquiry was referred. Documentation shall be kept in the provider inquiry tracking system to identify that the inquiry was referred and/or forwarded to another unit (see §30.6).

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

30.3.2 - Written Inquiry Storage

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

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

30.3.3 - Telephone Responses

(Rev. 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.

30.3.4 - E-mail and Fax Responses

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

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

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

30.3.5 - Check Off Letters

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

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

30.3.6 - Contractor Guidelines for High Quality Response to Written Inquiries

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

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

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.

1. The QWCM Handbook is adhered to.

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

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

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

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

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

1. Name of inquirer;
2. Time of arrival;
3. Time service was provided;
4. Name of the person handling the inquiry; and,

A statement indicating whether the inquiry is closed or still pending.

30.4.1 – Guidelines for Walk-In Service
(Rev. 18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06)

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

1. After contact with a receptionist, the inquirer shall meet with a service representative;
2. Waiting room accommodations shall provide seating;

3. Inquiries shall be completed during the initial interview to the extent possible;
4. Current Medicare publications shall be available to the provider (upon request); and

Contractors shall maintain a log or record of walk-in inquiries during the year.

30.5 - Provider Relations Research Specialists (PRRS)
(Rev. 18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06)

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

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

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

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

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

http://www.cms.hhs.gov/MedHCPCSGenInfo/20_HCPCS_Coding_Questions.asp#TopOfPage

30.5.2 - Complex Beneficiary Inquiries
(Rev. 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.

30.6 - Inquiry Tracking
(Rev. 21, Issued: 01-11-08, Effective: 10-01-07, Implementation: 02-11-08)

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

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

Tracking information on referrals to the PRRS shall include details of the inquiry and information about how to reach the provider in case there is a need to clarify the question. Contractors have discretion to determine the additional minimum referral information needed by the PRRS. Data from the tracking system shall be used to analyze the number

and types of inquiries in order to generate FAQs to be posted on the Web site, identify areas for telephone CSR training, and identify areas for broader provider education. The tracking system will also be used to generate quarterly reports for CMS use.

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

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

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

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

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

2. Contractors shall not report under "General Information" – "Others" inquiries that belong to other categories if those inquiries do not belong to "General Information."

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

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

4. In regards to the tracking of general inquiries that belongs exclusively to the "General Information" category, contractors shall select the "Other Issues" subcategory to log an inquiry if the inquiry fell outside of the 5 existing/predefined subcategories of the "General Information" category.

Contractors shall use the Quarterly Contractor Inquiry Tracking Report template available, at http://www.cms.hhs.gov/FFSContReptMon/05_CMSStandardizedProviderInquiryChart.asp#TopOfPage when reporting to CMS their inquiry types. This report shall be submitted to

the ProviderServices@cms.hhs.gov, and it is due at the end of the month following the end of each calendar quarter (January 31, April 30 July 31, and October 31.

30.6.1 - Updates to Chart

(Rev. 21, Issued: 01-11-08, Effective: 10-01-07, Implementation: 02-11-08)

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

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

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

A. Contractor-Specific Subcategories

Contractors shall follow the following requirements when adding contractor-specific subcategories to the Quarterly Contractor Inquiry Tracking Report:

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

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

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

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

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

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

30.7 - Provider Contact Center User Group (PCUG)
(Rev. 18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06)

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

30.8 - Fraud and Abuse
(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

Contractors shall ensure that when a provider inquiry or complaint of potential fraud and abuse is received, it is immediately sent, along with a referral package, to the Program Safeguard Contractor (PSC) or Medicare fee-for-service Benefit Integrity Unit (BIU). The referral package shall consist of the following information:

1. Provider name and address;
2. Type of provider involved in the allegation and the perpetrator, if an employee of a provider;
3. Type of service involved in the allegation;
4. Relationship to the provider (e.g., employee or another provider);
5. Place of service;
6. Nature of the allegation(s);
7. Timeframe of the allegation(s);
8. Date of service, procedure code(s);
9. Name and telephone number of the Medicare fee-for-service contractor employee who received the complaint;
10. Beneficiary name who received the service, if known;
11. HIC number of the beneficiary receiving the service, if known; and
12. Date the referral is forwarded to the PSC or BIU.

The Medicare contractor shall keep a record of the cost and workload associated for all provider inquiries of potential fraud and abuse that are referred to the Program Safeguard Contractor (PSC) or Medicare fee-for-service contractor Benefit Integrity Unit using Activity Code 13201 in the Beneficiary Inquiries function.

30.9 – Surveys
(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

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

30.9.1 - Customer Service Operations Surveys
(Rev. 18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06)

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

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

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

30.9.2.1 - Contractor Activities Related to the Medicare Contractor Provider Satisfaction Survey (MCPSS)
(Rev. 18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06)

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

Contractors shall:

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

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

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

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

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

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

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

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

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

B. Contractor Use of MCPSS Results

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

C. Information for Contractors

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

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

2. Survey Results: The results of the survey will be available via an interactive online reporting system. A model of the online reporting system is currently available to provide an example of the functions and analysis capabilities of the system. Please note that the site does not include real data; the information is for illustrative purpose s only.

3. Study updates, fact sheets, FAQs and media messages. As the project progresses, we will continue to update the MCPSS Study Web site with new materials (e.g., fact sheets, frequently asked questions (FAQs), media messages). Contractors may access their secure Web page at any time to download relevant project information.

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

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

40 - PCSP Staff Development and Education

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

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

Contractors shall ensure that educational opportunities are afforded the PCC staff, and that staff are afforded promotion pathways through the design and implementation of the PCC. Contractors may elect to have a small number of provider inquiry staff cross-trained to answer either provider or beneficiary inquiries to assist with disaster recovery or during periods of unusually high inquiry activity. Contractors shall not use such staff on a regular basis, such as to cover the lunch period. It is only permissible to use such

staff to assist with beneficiary workload if the provider inquiries performance requirements are being met. Please be aware that MACs will not handle beneficiary inquiries, except for the complex inquiries referred by the BCC to the PRRS (outlined in § 30.5.2).

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

40.1 - POE Staff Training

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

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

40.2 - PCC Staff Development and Training

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

The contractor shall train the PCC staff on provider issues and shall equip them with the knowledge and tools to meet CMS' performance requirements for provider inquiries. The PRRS shall be involved in the development of training materials for the general inquiries staff. CMS will also continue to increase and improve the consistent national training information available to CSRs. Training shall be tailored to the level/degree of specialization of the CSR.

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

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

posted at
http://www.cms.hhs.gov/ContractorLearningResources/02_Training.asp#TopOfPage

40.2.1 - General Requirements
(Rev. 21, Issued: 01-11-08, Effective: 10-01-07, Implementation: 02-11-08)

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

Upon receipt of CMS developed standardized CSR training materials, contractors shall implement these materials for all CSRs on duty and those hired in the future. Since the development of these materials will be done by CMS, it is not expected that there will be any costs to the contractors to use these training materials. Standardized training materials and other training information will be posted to the following Web site:

http://www.cms.hhs.gov/ContractorLearningResources/02_Training.asp#TopOfPage

Contractors may supplement the standard materials with their own materials as long as there is no contradiction of policy or procedures.

All contractors shall train their CSRs about how to find, navigate and fully use their Provider Web site and http://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.

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

Contractor staff working with telephone and written inquiries shall be trained to understand the CMS Standardized Inquiry Chart categories, subcategories and definitions and shall be trained to log their inquiry types according to the CMS Standardized Inquiry Chart in the tracking system used by the contractor. By January 31, 2008, Medicare PCCs shall notify CMS of the date of their staff training in using the CMS Standardized Provider Inquiry Chart by submitting an e-mail with the information to the providerservices@cms.hhs.gov mailbox with the subject line "CMS Standardized Provider Inquiry Chart Training."

40.2.2 - Provider Contact Centers Training Program
(Rev. 18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06)

The CMS recognizes the need for provider CSR training. The goal is to help CSRs improve the consistency and accuracy of their answers to provider questions, to increase their understanding of issues, and to facilitate CSRs' retention of the facts of their training by increasing its frequency. To accomplish this goal, all Medicare Provider

Contact Centers may close for up to 8 hours per month for CSR training and/or staff development with the following limitations:

1. The 8 hours approved by CMS for contact center closure shall be used for training time only.

2. The training time shall not be used for corporate meetings.

3. Contractors shall request permission to close according to § 40.2.5 and 40.2.6 of this chapter.

4. Training time not used within a specific month shall not be carried over to the next month.

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

40.2.3 - Closure Determination

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

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

40.2.4 - Provider Complaints

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

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

40.2.5 - Training Schedule

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

Contractors shall submit to CMS a training schedule, including dates, times, topics, sub-topics and contact information by the 15th of the month prior to when the training will be performed via **ProviderServices@cms.hhs.gov** using the subject line "Training Schedule". CMS will post training schedules and contact information submitted by all provider Medicare contractors at http://www.cms.hhs.gov/ContractorLearningResources/02_Training.asp#TopOfPage

Upon receipt of the training schedule, CMS will send an acknowledgement e-mail. Contractors shall assume approval of closures of 4 hours or less unless they receive notification to the contrary.

40.2.6 - Training Closures of More than Four Hours

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

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

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

40.2.7 - Provider Notifications

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

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

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

40.2.8 - CSR Feedback

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

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

40.2.9 – Reports

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

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

40.2.10 - CMS Monitoring

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

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

40.3 - PRRS Staff Training

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

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

50 - Provider Self-Service Technology

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

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

materials, educational seminars, listserv messages, and instructions on the contractor's Web site and IVR.

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

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

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

50.1 - Interactive Voice Response System (IVR)

(Rev. 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.

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

50.2.1 – General Requirements and Content
(Rev. 18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06)

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

To reduce costs, the contractor shall use existing resources and technologies whenever possible. Contractors are ultimately responsible for the structure of their provider Web site, but are encouraged to design it so that it is clear to providers that they are accessing a provider Web site for their particular interest (specifically, A/B MAC, Part A, Part B, DMERC, DME MAC, etc.). To maintain the quality of the site, contractors shall

periodically ensure that information posted is current and does not duplicate information posted at http://www.cms.hhs.gov/ and http://www.medicare.gov/.

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

50.2.2 – Webmaster and Attestation Requirements

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

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

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

1. CMS Contractor Guidelines; and

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

Contractors may submit these attestations separately or together.

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

50.2.3 – Feedback Mechanism

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

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

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

50.2.4 – Contents

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

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

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

2. Information on how to join contractor provider listservs;

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

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

5. Ability to register for contractor sponsored education events;

6. Search engine functionality;

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

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

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

10. Information for providers on electronic claims submission;

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

12. An IVR operating guide;

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

14. A feedback mechanism as described in 50.2.3.

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

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

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

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

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

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

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

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

8. CMS' Competitive Acquisition Program page at http://www.cms.hhs.gov/CompetitiveAcquisforBios/

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

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

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

50.2.4.1 - Information from CMS

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

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

50.2.4.2 – FAQs

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

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

50.2.4.3 - Quarterly Provider Update (QPU)

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

The Quarterly Provider Update (QPU) is a listing of the regulations and program instructions issued by CMS that impact Medicare providers. The QPU is maintained by CMS and available to providers through the CMS Web site. Providers may elect to join a CMS electronic mailing list, to be notified periodically, of additions to the QPU. Contractors shall promote the existence and usage of the QPU and its electronic mailing list/listserv to their provider community.

50.2.4.4 - Internet-based Provider Educational Offerings

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

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

50.2.5 - Web Site Promotion

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

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

50.3 - Electronic Mailing List/Listserv

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

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

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

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

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

50.3.1 - Targeted Electronic Mailing Lists/Listservs

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

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

50.3.2 - Listserv Promotion

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

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

60 - PCSP Performance Management

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

60.1 - POE - Listserv Membership

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

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

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

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

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

60.2.2 - Call Completion
(Rev. 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.

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

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

60.2.4 – Average Speed of Answer (ASA)
(Rev. 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.

60.2.5 – Callbacks

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

Between January 2005 and January 31, 2006, the callback requirement was 5 days. Contractors shall make 3 attempts to reach a provider for a callback. The contractor may leave a message requesting a return call, including the patient's name if appropriate, but no PHI should be left on the message. If the provider does not respond after 3 callbacks, the contractor has the discretion to prepare a written response, completed within 10 business days of the original inquiry. The contractor shall not close out the inquiry without any type of response to the caller. Contractors shall not leave the responses on provider voicemails. All callbacks shall be completed and closed out within 10 business days of the original inquiry and documented in the inquiry tracking system, discussed in § 30.6 and 90.

60.2.6 – QCM Performance Standards

(Rev. 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 – Written Inquiries

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

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

60.4 – PRRS Timeliness

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

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

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

70 - 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.

70.1 - Definition of Contact Center for CSAMS

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

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

70.2- Data to Be Reported Monthly

(Rev. 21, Issued: 01-11-08, Effective: 10-01-07, Implementation: 02-11-08)

Contractors shall capture and report the following data each month:

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

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

After Call Work Time	This includes the time that CSRs need to complete any administrative work associated with a call after the customer disconnects.
Status of Calls Not Resolved at First Contact	Report as follows: 1. Number of callbacks required. This number is based on calls received for the calendar month and represents the number requiring a callback as of the last workday of the month. 2. Number of callbacks closed within 10 workdays. This number is based on calls received for the calendar month and represents the number closed within 10 workdays even if a callback is closed within the first 10 workdays of the following month.
IVR Handle Rate	For contact centers with <u>combined</u> CSR and IVR lines , this includes: 1. The number of calls offered to the IVR (defined as the total number of calls receiving a prompt offering the use of the IVR during or after business hours); and 2. The number of calls handled by the IVR. For contact centers with <u>separate</u> CSR and IVR lines this includes: 1. The number of calls offered to the IVR (defined as the total number of IVR-only calls receiving a prompt offering the use of the IVR during or after business hours) plus the total number of calls offered to CSRs, and 2. The number of calls handled by the IVR (defined as the number of calls where the caller selected and played at least one informational message).
Calls in CSR queue	This is the total number of calls delivered to the CSR queue.
Calls Answered by CSRs	This represents the total number of calls answered by all CSRs for the month from the CSR queue.
Calls Answered <= 60 Seconds	This represents the total number of calls answered by all CSRs within 60 seconds from the CSR queue.

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

80 - Disclosure of Information

(Rev. 16, Issued: 07-21-06, Effective: 10-01-06, Implementation: 10-02-06)

The main purpose of this Disclosure Desk Reference chart is to protect the privacy of Medicare beneficiaries by ensuring that contractors disclose protected health information to providers only when appropriate. Contractors shall protect an individual's privacy to the extent possible by using authenticating elements that must be given by the inquirer prior to the release of any beneficiary-specific information. Contractors shall authenticate providers in addition to authenticating four beneficiary data elements before disclosure of beneficiary information. The specific authentication elements are contained within the chart. Contractors shall authenticate each telephone and written inquiry with the elements shown.

Contractors should always remember that access and disclosure involve looking at Medicare data, such as claims or eligibility data, and releasing information. Access and disclosure rules do not apply in situations where contractors do not have to look at beneficiary specific information (for example, explaining a Remittance Advice). Contractors shall discuss general (non-beneficiary-specific) information without obtaining authentication of the caller/writer. Contractors shall continue to respond to policy/non-protected health information related questions without having to authenticate the inquirer.

Contractors are reminded that the authentication and disclosure guidelines contained in this section do not supersede any requirements for the operation of the contractor's Provider Customer Service Program, including requirements for handling telephone and written inquiries.

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. If the contractor needs to refer the inquiry to another entity for response, the contractors shall inform the caller or writer of the referral and close out the inquiry.

Where the Disclosure Desk Reference is silent, contractors should use discretion to determine release of the information. Contractors shall keep in mind the following key

question: Does this provider need this information in order to properly bill Medicare? If, after internal discussion by supervisors and/or the contractor's privacy official, questions remain, contractors shall send an email requesting clarification to ProviderServices@cms.hhs.gov.

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.

80.1 - *Provider Authentication Elements*

(Rev. 22, Issued: 08-08-08, Effective: 03-01-09, Implementation: 01-05-09)

The requirements to authenticate providers who use the IVR system or call a CSR are the National Provider Identifier (NPI), Provider Transaction Access Number (PTAN), and the last 5-digits of the tax identification number (TIN).

80.1.1 - *National Provider Identifier (NPI)*

(Rev. 22, Issued: 08-08-08, Effective: 03-01-09, Implementation: 01-05-09)

The NPI is the first authentication data element the contractor will use to identify the provider. The contractor shall validate there is an association between the NPI and the caller/writer. In scenarios where the crosswalk cannot validate this information, refer to subsection 80.2.1.C for clarification. The NPI is included in the provider enrollment letters.

80.1.2 - *Provider Transaction Access Number (PTAN)*

(Rev. 22, Issued: 08-08-08, Effective: 03-01-09, Implementation: 01-05-09)

The PTAN is the second authentication data element the contractor will use to identify the provider. The contractor shall validate there is an association between the PTAN and the caller/writer. In scenarios where the crosswalk cannot validate this information, refer to subsection 80.2.1.C. for clarification. The CSR shall accept any valid PTAN provided by the inquirer where there is a one-to-many relationship. The PTAN will be included in the provider enrollment letters.

80.1.3 – Tax Identification Number (TIN)

(Rev. 22, Issued: 08-08-08, Effective: 03-01-09, Implementation: 01-05-09)

The last 5-digits of the TIN is the third authentication data element the contractor will use to identify the provider. The contractor shall ensure there is an association between the NPI, PTAN, and the last 5-digits of the TIN to the provider prior to releasing any beneficiary or claim specific information, as well as financial data.

80.2 - Inquiry Types

(Rev. 22, Issued: 08-08-08, Effective: 03-01-09, Implementation: 01-05-09)

Telephone and written inquiries are addressed in the following subsections.

80.2.1 - Telephone Inquiries

(Rev. 22, Issued: 08-08-08, Effective: 03-01-09, Implementation: 01-05-09)

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*s* 30.*2 and 50.1* concerning operation of the Provider Contact Center and handling of telephone inquiries.

A. CSR Telephone Inquiries - *CSRs shall authenticate providers with three data elements - NPI, PTAN, and last 5-digits of the TIN.* 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 – *Contractors' IVRs shall authenticate providers with three data elements - NPI, PTAN, and last 5-digits of the TIN.*

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. *If a provider enters an NPI or NPI/PTAN pair that has been deactivated in the system, the IVR may be unable to authenticate the provider at the front end. Additionally, the provider may be able to be authenticated by the IVR, but if the claim was processed using a different NPI/PTAN pair that has since been deactivated, the IVR may not be able to find the claim and return claims status information. In such instances, since CSRs also authenticate using the NPI, CSRs shall authenticate on at least two additional data elements available in the provider's record, such as provider name, remittance address, and provider master address before releasing information to the provider.*

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).* 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 *shall* 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. 22, Issued: 08-08-08, Effective: 03-01-09, Implementation: 01-05-09)

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 shall review the charts in section 80.5 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 (*section* 50.1).

80.2.2 - Written Inquiries

(Rev. 22, Issued: 08-08-08, Effective: 03-01-09, Implementation: 01-05-09)

Authentication elements for providers are determined by how the inquiry is received, as 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. *Written Inquiry - Provider Authentication - Contractors shall authenticate providers on written inquiries with three data elements - NPI, PTAN, and last 5-digits of the TIN.*

Contractors shall authenticate providers for all written inquiries using the elements mentioned above, with the exceptions noted in *subsection* 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. *Therefore, the provider's practice location and name on the letterhead must match the information in the contractor's file for this provider.*

In addition, the letter or email shall match one of the following elements mentioned above - NPI, PTAN, or last 5-digits of the TIN. Providers shall also be educated to send in written inquiries on letterhead that include at least one of the following - NPI, PTAN, or last 5-digits of the TIN. 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*es the information in the contractor's file*, authentication is considered met. Providers shall 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 subsection A. above.*

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 *subsections* 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 *section* 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.)

E. Beneficiary Authentication - Assuming provider authentication requirements are met as detailed in *subsections* 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 *section 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 *section* 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 *shall* 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. 22, Issued: 08-08-08, Effective: 03-01-09, Implementation: 01-05-09)

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 NPI, PTAN, and last 5-digits of the TIN, as well as the 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 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 exchange 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 *shall* 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 *the* release *of such information* 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.

80.3.3 – 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.

80.3.4 – Requests for Information Available on the Remittance Advice

(Rev. 22, Issued: 08-08-08, Effective: 03-01-09, Implementation: 01-05-09)

If a CSR or written inquiry correspondent receives an inquiry about information that can be found on a remittance advice (RA), the CSR/correspondent sh*all* 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 sh*all* advise the inquirer that the RA is needed in order to answer any questions for which answers are available on the RA. Providers sh*all* 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/MLNCatalog.pdf to assist in educating providers about how to read a RA.

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

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

80.4 – 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. 22, Issued: 08-08-08, Effective: 03-01-09, Implementation: 01-05-09)

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:
May 23, 2008 – February 28, 2009	CSR	• Provider NPI **-AND-** • Provider PTAN	Contractors shall refer to chart below.
March 1, 2009	*CSR*	• *Provider NPI* • *Provider PTAN* ***-AND-*** • *Provider's last 5-digits of TIN*	*Contractors shall refer to chart below.*

80.5.2 – Authentication of Provider Elements for IVR Inquiries

(Rev.22, Issued: 08-08-08, Effective: 03-01-09, Implementation: 01-05-09)

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:
May 23, 2008 – February 28, 2009	IVR	• Provider NPI	Contractors shall refer to chart below.

		-AND- • Provider PTAN	
March 1, 2009	*IVR*	• *Provider NPI* • *Provider PTAN* *-AND-* • *Provider's last 5-digits of TIN*	*Contractors shall refer to chart below.*

80.5.3 – Authentication of Provider Elements for Written Inquiries

(Rev. 22, Issued: 08-08-08, Effective: 03-01-09, Implementation: 01-05-09)

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:**
May 23, 2008 – February 28, 2009	Written inquiries, including fax and email	• Provider Name **and one of the following two:** • Provider NPI **-OR-** • Provider PTAN NOTE: If the inquiry is sent on provider letterhead with the provider's name and address clearly establishing the identity of the provider, the NPI or PTAN is not required for provider authentication. See *subsection* 80.1.2.C for information about requests on pre-formatted inquiry forms.	Contractors shall refer to chart below.
March 1, 2009	*Written inquiries,*	• *Provider NPI*	*Contractors shall refer to chart below.*

	including fax and email	• *Provider PTAN* *-AND-* • *Provider's last 5-digits of TIN* *NOTE: If the inquiry is sent on provider letterhead with the provider's name, address and at least one of the following elements – NPI, PTAN, or last five digits of the provider's TIN, authentication is considered met.* *See subsection 80.2.2.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[2]	Call to CSR or written inquiry	• Beneficiary full last name (including hyphenated names, suffixes (i.e., Jr., Sr.) and abbreviation of titles (i.e., Fr. for Father, Sr. for Sister) NOTE: Because systems limitations sometimes prevent full last names and suffixes from showing on contractor records, an exact name match is not required; however, the CSR shall be certain that the beneficiary surname given by the provider is a match to the name on the beneficiary record being displayed. • Beneficiary first name or first initial • Current or previously assigned HICN, including both alpha and numerical	Contractors have the discretion to routinely release all elements or only release when requested. Contractors shall use inquiry and rejected/denied claims analysis results to decide what elements to routinely release. • Part A current and previous entitlement and termination dates • Part B current and previous entitlement and termination dates • Deductible Met – Yes / No • Managed Care – Yes / No • MSP – Yes / No • Crossover established – Yes / No • Home Health – Yes / No

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

		characters (if a new HICN displays when the provider supplies the HICN, then the CSR may disclose the new number) • Date of birth NOTE: If there is an error, the CSR should tell the inquirer which overall element (for example, date of birth instead of day, month and year) does not match and to check the beneficiary's record, which should include a copy of the Medicare card, and/or follow up with the beneficiary, for the correct information.	• Hospice – Yes / No • SNF – Yes / No • Pneumoccocal Vaccine – Yes / No --- When prompted by the inquirer: • Deductible amount remaining (Part A) or applied (Part B) • Managed Care – plan #, name, address, 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[3]	IVR (involves touchtone or speech recognition technology)	• Beneficiary last name – first 6 letters (no special characters); if using speech recognition technology, may use first 6 letters or entire last name, including hyphenated last names, suffixes (i.e., Jr., Sr.) and abbreviation of titles (i.e., Fr. for Father, Sr. for Sister) NOTE: Because systems limitations sometimes prevent full last names and	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

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

		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 copy of the Medicare card, and/or follow up with the beneficiary, for the correct information.	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, 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	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	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

(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 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		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 copy of the Medicare card, and/or follow up with the beneficiary, for the correct information.	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:** ● Provider name ● Provider address ● Provider telephone number ● Servicing contractor ● Applicable dates ● **Hospital:** ● Days remaining ● Deductible amount ● Co-insurance days remaining

practice, but the specialty is not identified, contractors have discretion as to whether data should be released.)			● 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. 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	IVR (involves touchtone or speech recognition technology)	• Beneficiary last name – first 6 letters (no special characters); if using speech recognition technology, may use first 6 letters or entire last name, including hyphenated last names, suffixes (i.e., Jr., Sr.) and abbreviation of titles (i.e., Fr. for Father, Sr. for Sister) NOTE: Because systems limitations sometimes prevent full last names and suffixes from showing on contractor records, an exact name match is not required; however, the contractor shall program the IVR to ensure that the beneficiary surname given by the provider is a good match to the name on the beneficiary record being accessed. For surnames of less than 6 letters, contractors should program their IVRs to match names of less than 6 letters or should include instructions for callers in the IVR operating guide on how to input spaces or blanks so 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: 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 ● **Hospice:** ● Provider name ● Provider address ● Provider telephone number ● Servicing contractor ● Applicable dates ● **Hospital:** ● Days remaining ● Deductible amount

multiple physician practice, but the specialty is not identified, contractors have discretion as to whether data should be released.)		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.	● 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) • 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.	**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 • 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 release this information to assist the provider in determining a beneficiary's eligibility for these services or billing Medicare properly.	IVR (involves touchtone or speech recognition technology)	• Beneficiary last name – first 6 letters (no special characters); if using speech recognition technology, may use entire last name, including hyphenated last names, suffixes (i.e., Jr., Sr.) and abbreviation of titles (i.e., Fr. for Father, Sr. for Sister) NOTE: Because systems limitations sometimes prevent full last names and suffixes from showing on contractor records, an exact name match is not required; however, the contractor shall program the IVR to ensure that the beneficiary surname given by the provider is a good match to the name on the beneficiary record being accessed. For surnames of less than 6 letters, contractors should program their IVRs to match names of less than 6 letters or should include instructions for callers in the IVR operating guide on how to input spaces or blanks so that 6 digits are input. • Beneficiary first name or first initial • Currently or previously assigned HICN,	**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) ● 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**

		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.	**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 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	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	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

rejected claim.		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.	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 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)	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.

		• 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 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)	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.

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

		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.	

90 - Provider Inquiry Standardized Categories
(Rev. 21, Issued: 01-11-08, Effective: 10-01-07, Implementation: 02-11-08)

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

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

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

CMS Standardized Provider Inquiry Chart

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

CMS Standardized Provider Inquiry Chart

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

CMS Standardized Provider Inquiry Chart

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

CMS Standardized Provider Inquiry Chart

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

CMS Standardized Provider Inquiry Chart

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

CMS Standardized Provider Inquiry Chart

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

CMS Standardized Provider Inquiry Chart

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

CMS Standardized Provider Inquiry Chart

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

CMS Standardized Provider Inquiry Chart

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

CMS Standardized Provider Inquiry Chart

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

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		Medicare Program	Contact is expressing dissatisfaction due to issues with the Medicare program. Includes provider expressions of intentions of leaving the Medicare program.
		Provider Education and Outreach	Contact is expressing dissatisfaction with educational activities, education staff performance or availability of educational resources or activities for Medicare providers.
		Self Service Technology	Contact is expressing dissatisfaction due to content, functionality, instability, formatting and processes related to Provider Self Service tools such as CMS or contractor website, online tools for eligibility inquiries or claim submissions, IVR, etc.
		Staff	Contact is expressing dissatisfaction due to CSR or Staff attitude, incorrect information given or non response to an inquiry.
Direct Data Entry (DDE)	The Direct Data Entry system is an on-line application that allows direct on-line access to Medicare claims, such as: claim entry, error correction, eligibility inquiry, claims status, claim adjustment and roster billing.	Connectivity/Installment/Processing Issues	Contact is requesting assistance with the connection, installment, password resets, claim processing and adjustments through DDE.
		Orientation Package	Contact is requesting information or an orientation package related to DDE.
Electronic Data Interchange (EDI)	The system for submitting claims electronically and retrieving Electronic Remittance Advices.	Connectivity/Installment Issues	Contact is requesting assistance with the connection, installment and password resets through EDI.
		Front End or Vendor Editing	Contact is requesting information or assistance with errors in the transmission or status of claims submitted electronically.
		Information package/HIPAA Compliant Billing Software	Contact is requesting information or an orientation package related to EDI.

CMS Standardized Provider Inquiry Chart

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

CMS Standardized Provider Inquiry Chart

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

CMS Standardized Provider Inquiry Chart

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

CMS Standardized Provider Inquiry Chart

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

CMS Standardized Provider Inquiry Chart

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

CMS Standardized Provider Inquiry Chart

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

CMS Standardized Provider Inquiry Chart

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

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		Part D Drug Coverage	Contact is presenting situation related to issues with the implementation of the Part D Medicare Prescription Drug Coverage.
		PQRI	Contact is asking for information about the Physician Quality Reporting Initiative.
		Recovery Audit Contractor (RACs)	Contact is asking information about a CMS initiative using RACs to identify underpayments and overpayments and to recoup overpayments. Includes inquiries related to demand letters and records requested by RACs.

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
R22COM	08/08/2008	Implementation of the New Provider Authentication Requirements for Medicare Contractor Provider Telephone and Written Inquiries	01/05/2009	6139
R21COM	01/11/2008	Instructions Related to the CMS Standardized Provider Inquiry Chart for FY2008	02/11/2008	5848
R20COM	07/13/2007	IOM Pub. 100-09, Chapters 3- Provider Inquiries and Chapter 6- Provider Customer Service Program Updates	07/30/2007	5597
R19COM	06/29/2007	IOM Pub. 100-09, Chapters 3- Provider Inquiries and Chapter 6- Provider Customer Service Program Updates - Replaced by Transmittal 20	07/30/2007	5597
R18COM	09/08/2006	Provider Customer Service Program	10/02/2006	5277
R16COM	07/21/2006	Disclosure Desk Reference for Provider Contact Centers	10/02/2006	5089
R15COM	11/18/2005	Initial Issuance of Chapter	12/19/2005	4137