CMS Manual System

Pub. 100-20 One-Time Notification

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 113 **Date: September 10, 2004**

CHANGE REQUEST 3376

SUBJECT: Implementation of § 921 of the Medicare Modernization Act (MMA) – Provider Customer Service Program

I. SUMMARY OF CHANGES: This change request implements section 921 of the MMA. It creates the Provider Customer Service Program.

NEW/REVISED MATERIAL - EFFECTIVE DATE: January 1, 2005
***IMPLEMENTATION DATE: Unless otherwise indicated in instruction, January 5, 2005**

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

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
N/A	

***III. FUNDING:**

Funding is available through the regular budget process for costs required for implementation, as indicated in the one-time notification.

IV. ATTACHMENTS:

	Business Requirements
	Manual Instruction
	Confidential Requirements
X	**One-Time Notification**
	Recurring Update Notification

***Medicare contractors only**

Attachment - Business Requirements

Pub. 100-20	Transmittal: 113	Date: September 10, 2004	Change Request 3376

SUBJECT: Implementation of § 921 of the Medicare Modernization Act (MMA) – Provider Customer Service Program

I. GENERAL INFORMATION

A. Background: Fee-for-service (FFS) providers who are enrolled in, and bill the Medicare program shall be educated and trained about the Medicare program. Information tools must be available to assist providers in understanding the Medicare program's operations, policy, and billing procedures. Providers shall be able to have their questions answered accurately, consistently, and timely through various communication channels, offered both at the national and local levels. At times providers may require special technical assistance in areas such as billing and coding. To meet these goals Medicare contractors are required to implement an integrated Provider Customer Service Program designed to meet provider information and educational needs.

B. Policy: The Provider Customer Service Program (PCSP) flows from provisions in §921 of the MMA that strengthen and enhance Medicare's ongoing efforts associated with provider inquiries and education. Section 921 of the MMA explicitly adds "Provider Education and Technical Assistance" to the Social Security Act requiring education and training activities tailored to small providers (which may include technical assistance). Unless otherwise superceded by this instruction, all manual requirements in the Medicare Contractor Beneficiary and Provider Communications Manual, Pub. 100-9, chapters 3 and 4 remain in effect. Pub 100-09 will be revised within a year of release of this instruction to incorporate the requirements set forth in this instruction.

The PCSP is designed to improve accuracy, completeness, consistency and timeliness by ensuring that staff with the appropriate levels of expertise addresses provider issues. Medicare contractors shall have staff, including telephone customer service representatives (CSRs), who are dedicated to provider-related work.

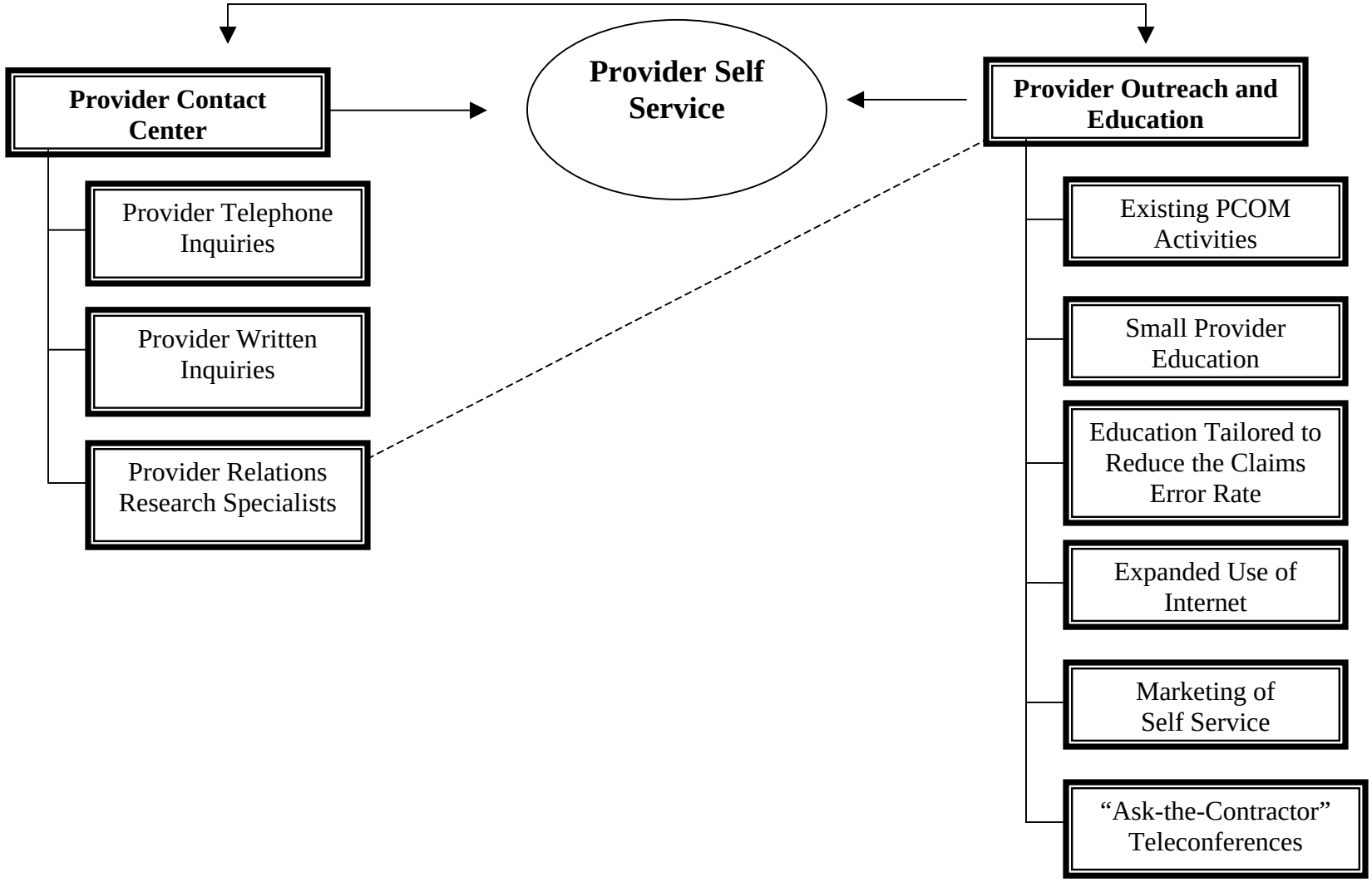
The PCSP adds new functions to existing inquiry and provider communication contractor activities creating a comprehensive, coordinated, and integrated program. The PCSP also includes a cross-cutting function that should also be highlighted, the Provider Relations Research Specialists. The PCSP has three major components:

1. Provider Self-Service Technology (PSS)
2. Provider Contact Center (PCC)
3. Provider Outreach and Education (POE)

Figure 1 illustrates the workload, but not necessarily the organizational structure of the PCSP.

Figure 1: Provider Customer Service Program

Illustration of workload only, not a required management structure



1. Provider Self-Service Technology (PSS)

With an increasing claims volume comes an increasing number of Medicare provider inquiries. One important way to successfully manage the 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-serve technology will enable 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 improve the quality and number of self-service options they make available to providers (e.g., IVR, direct data entry, website enhancements). In the future and in keeping with a strategy to increase self-service options, CMS plans to support internet-based provider claims transactions such as transactions for eligibility information and claims status. Contractors will receive further instructions on internet-based transactions at the appropriate time.

Contractor-offered self-service technology options shall include:

a. **Interactive voice response units (IVRs) for telephone inquiries**

The IVRs shall, at a minimum, provide information about claims status, beneficiary eligibility, and at least the top 100 remittance advice code definitions, as well as helpful information to assist providers resolve issues that can be automated. Eligibility inquiries must meet the privacy requirements outlined in the provider desk reference in chapter 3, section 30, of Pub. 100-09. Contractors shall require Medicare providers to use the IVR to access this information (and/or the Internet, if Internet-based transactions are available, as approved by CMS). Provider telephone CSRs are not intended to answer questions that can be answered on the IVR; they shall refer the callers to the IVR. Contractors shall identify and contact providers who repeatedly call CSRs for information that is available on the IVR to assist them to effectively use the IVR, including transferring providers back into the IVR. At a minimum, such education should happen at the time of the inquiry to the CSR, but may, in some cases, require post-call reinforcement.

b. **Website**

The contractor website shall include:

- Link to http://www.cms.hhs.gov/providers for national provider information, customized provider web pages, and CMS sponsored listservs
- Local contractor information posted in a way that is easy to use and easily searchable
- Information concerning subscribing to local contractor provider listservs for disseminating information
- Frequently Asked Questions (FAQs) based on high volume inquiries and updated at least quarterly
- A glossary of up-to-date and complete remittance advice code sets (requirement can be fulfilled with a link to www.wpc-edi.com/codes)
- CMS products and messages posted, as directed
- CMS-produced information about the new Provider Customer Service Program with any local contractor supplemental information.

The contractor shall assign a Webmaster responsible for maintaining and updating the provider outreach portions of the contractor's website in a timely manner.

c. **Electronic Copies of Provider Bulletins**

The bulletins must be written clearly and concisely. They shall be published at least quarterly and posted on the contractor website.

2. Provider Contact Center Operations

Providers make telephone and written inquiries about billing, coding, claims, coverage and other issues. Telephone inquiries are presently the predominant method used by providers. Due to recent changes in the law, the level of written inquiries will increase. Pursuant to §921(c) of the MMA, inquiries made through "electronic transmission" shall be considered written inquiries.

Because of the various communication channels available to providers today, it is important that all communication be coordinated to ensure consistent responses. Therefore, Medicare contractors shall develop a Provider Contact Center (PCC) offering a range of Medicare expertise to respond to inquiries from the following sources:

- telephone,
- letters,
- fax, and
- email.

The PCC includes both the provider call center and the general written inquiries unit. The PCC serves as the backbone for assuring a positive business relationship with the Medicare providers. The model described below shall not apply to those inquiries handled and funded by other units within the contractor (e.g., appeals, fraud, and Medicare secondary payer). The provider toll free numbers installed for Part A, Part B, DMERC, and RHHI general provider inquiry traffic shall not be used for other business functions (e.g., MSP, medical review, EDI, provider enrollment, and other non-claim related provider inquiries) beyond answering general questions for each of those functions. At a minimum, these general provider inquiry lines shall be used to handle questions related to billing, claims, eligibility, and payment.

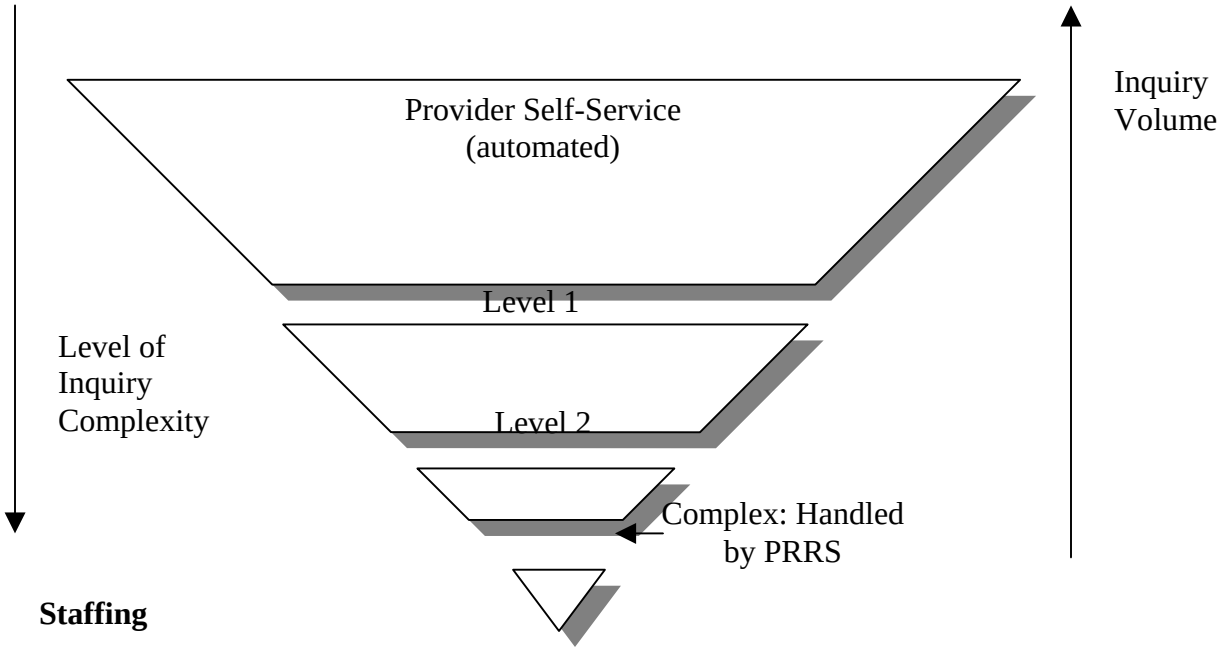
Section 903(c) of the MMA adds protections from interest or penalties for providers who submit claims based on written guidance from a Medicare contractor that was in error. This requirement will probably lead to an increase in the volume of written inquiries. It also elevates the importance of accuracy of responses from contractors.

a. Inquiry Triage Process

Provider inquiries may require varying degrees of expertise to answer. Using a triage mechanism, the contact center needs to be able to route the general inquiries within the PCC to the system or person best equipped to respond, with a minimal degree of transfer. Figure 2 illustrates the levels of complexity and the corresponding provider inquiry volume. Each contractor shall organize its dedicated provider telephone CSRs into at least two levels to handle questions of varying complexity. Contractors may also choose to specialize CSRs within levels or across contact centers (if the contractor has more than one) to take full advantage of skill-based routing. Contractors may use technology to intelligently route callers to the appropriate level of CSR. The most complex inquiries shall be routed to the Provider Relations Research Specialists (described below). 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.

The PCSP is designed and should be implemented in a way creating promotion pathways for the CSRs. Studies have shown that CSRs who see opportunities for advancement are more likely to stay, thereby decreasing the turnover rate and increasing the overall level of expertise of the contact center.

Figure 2



b. Staffing

The provider contact center shall be staffed with individuals who are dedicated to respond to provider inquiries. Contractors may elect to have a small number of provider staff that is 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.

Telephone Inquiries

Contractors shall divide their telephone inquiry staff dedicated to responding to general provider inquiries into at least two levels of CSRs. A contractor may also choose to have staff rotate duties as a way to meet this requirement. 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, first level CSRs shall handle questions that do not require substantial research and easily can be answered during the initial call. Contractors must determine what types of inquiries are best answered by first level CSRs. Some examples of this level of inquiry may include 1) eligibility, claims status or Medicare secondary payer (MSP) status inquiries not adequately handled by the IVR; 2) straight-forward claim denial questions that cannot be handled by the IVR; 3) questions with well-documented, nationally consistent and easily accessible answers. First level CSRs shall have the authority to refer more complex questions to second level CSRs.

Second level CSRs have more experience and expertise enabling them to answer more complex questions. These questions may include telephone inquiries concerning local coverage determinations not requiring referral to medical review, calls resulting in the need for simple claims adjustments that can be handled by telephone CSRs, or dissatisfied callers who require a higher level of service. Contractors may organize second level CSRs in any configuration that best suits the nature of the inquiries received. Second level CSRs may serve as consultant subject matter experts for first level CSRs and, therefore, do not always have to speak directly to a provider. Second level CSRs may be used to answer first level CSR questions, if the workload demands. Second level CSRs may also handle callbacks. All callbacks shall be completed within 5 business days of the original inquiry and documented in the tracking system described below. Inquiries that require additional time or a yet higher degree of expertise and/or research shall be referred to the Provider Relations Research Specialists (PRRS).

Although it is preferable that providers not be limited in the number of inquiries they make during a single call, contractors may limit the number of inquiries but shall allow a minimum of three inquiries per call, whether they are answered by level one CSRs, level two CSRs, or a combination of both levels of CSRs. For CROWD and CSAMS reporting purposes, if a call is transferred between the two CSR levels, the inquiry shall remain open until it is fully resolved (or transferred to the PRRS) and shall only be counted once.

Contractors shall monitor a total of 5 calls per CSR per month for QCM purposes. The calls monitored shall be randomly selected and of the type that the CSR level typically handles. All CSRs, regardless of level, shall meet the following quality standards:

- Knowledge Skills Assessment standard of 93% per quarter for all CSRs, but no less than 85% in any given month.
- Adherence to Privacy Act standard for 93% per quarter for all CSRs, but no less than 85% in any given month.
- Customer Skills Assessment standard of 93% per quarter for all CSRs, but no less than 85% in any given month.

<u>General Written Inquiries</u>

Contractors have the discretion to develop a tiered approach to answering general written inquiries. Written inquiries shall include letters, faxes, and e-mail. All written inquiries, regardless of the form in which it is received, must be handled consistently for accuracy and timeliness. Contractors shall develop triage mechanisms to quickly identify those complex inquiries needing referral to the PRRS. A tiered approach may be appropriate given the expected increase in volume of written inquiries and the new MMA requirement that all written inquiries (including those referred to the PRRS) shall be responded to in final within 45 business days. For those written inquiries 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 (regional office or central office), a shared systems maintainer, or other non-contractor entity. Interim responses shall not comprise more than 5% of all written responses (general responses and PRRS responses). Final responses shall be issued within 5 business days of receipt of the information necessary to complete the response. The 45-business day timeframe begins the day the inquiry is originally received and date-stamped by the contractor and ends the day the contractor sends the response from the mailroom. Contractors shall ensure that e-mail responses do not include beneficiary-identifiable information or protected healthcare

information. If the response must contain protected healthcare information, it shall be mailed in hardcopy to the provider, rather than e-mailed.

Provider Relations Research Specialists (PRRS**)**
Given the complexities of the Medicare program, it is not unusual for providers to raise complicated issues requiring an understanding of the nuances of Medicare policy that affect a particular provider type and particular service. Complex inquiries that cannot be answered by the contractor's telephone or written inquiries staff and require significant research shall be referred to the Provider Relations Research Specialists (PRRS). The PRRS is staffed and designed to answer questions beyond the expertise of the CSRs or general written inquiry staff and requiring more time to adequately research the issue.

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 contractor resources (e.g., contractor medical director, contractor Web sites, bulletins, medical review staff, LPET staff, claims processing staff, etc), and CMS resources (Internet-Only Manual, contractor instructions, training packages, Medicare law and regulations, the www.cms.hhs.gov Web site, *Medlearn Matters* articles, provider specific web pages, and Regional Office staff) when researching answers to complex inquiries. Although the PRRS is not charged with responding to LPET inquiries, a contractor may choose to use this model to fulfill the medical review/LPET strategy requirement that there be mechanism to monitor and improve the accuracy and consistency of the contractor staff's responses to specific telephone or written inquiries regarding subjects related to medical review findings and education on local coverage determinations as identified through the PCA process.

The PRRS workload is generated by referral from either a second level CSR or the general written inquiries unit, unless the contractor chooses to allow other referral mechanisms. The referral shall come to the PRRS via the tracking system described below. All responses from these specialists are written, unless the provider has requested a call back or the inquiry is best handled with a provider callback. For PRRS inquiries that are closed using a telephone call back, the response provided must be documented in the tracking system.

The PRRS staff shall provide clear and accurate written answers within 10 business days for at least 75 percent of cases referred by the telephone CSRs, 20 business days for 90 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 inquiries area). The 45 business days begins the day the inquiry was originally received by the contractor, either by telephone or in writing, and ends the day the contractor sends the response from the mailroom. For those 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 (regional office or central office), a shared systems maintainer, or other non-contractor entity. Interim responses shall not comprise more than 5% of all written responses (general written inquiries and PRRS responses). Final responses shall be issued within 5 business days of receipt of the information necessary to complete the response.

The PRRS shall include at least one certified coder to ensure adequate coding expertise for this function. Examples of coder certification programs include the American Health Information Management Association, the American Academy of Professional Coders, and the Practice Management Institute. Such

coding expertise shall be available within the contractor, but does not have to be assigned exclusively to the PRRS function. Durable Medical Equipment Regional Carriers (DMERCs) are exempt from the requirement to have a coding expert on staff because the SADMERC resolves DMERC coding questions. The coding questions appropriately answered by the PRRS are those asking questions of the underlying Medicare payment or coverage policy. Contractors shall educate providers that the PRRS is not an extension of or a replacement for billing staff. The PRRS is not to provide coding guidance. The straightforward pure coding questions should be answered with referrals to the correct organizations such as the American Medical Association and the American Hospital Association's Coding Clinic.

PRRS answers should be considered for provider job aids enabling CSRs to answer similar inquiries in the future. Job aids should serve as talking points for CSRs. CMS will be increasing the number of national job aids provided to the contact centers. These job aids will be distributed via a contractor-only listserv to all FIs, carriers, and DMERCs. To facilitate this process, contractors shall submit PRRS-generated job aids to CMS, on a monthly basis, to ProviderServices@cms.hhs.gov. If a contractor does not have any job aids to submit, it shall submit an e-mail simply stating "nothing to submit." Within one week of receipt, CMS will distribute those job aids determined to be applicable nationally via the contractor-only listserv.

In addition to responding to complex inquiries, the PRRS shall serve as the point of contact for Medicare Advantage (MA) plans about Medicare program coordination issues.

Contractors may expand the functions of the PRRS beyond the minimum requirements stated in this instruction.

Quality of Written Correspondence (QWCM) standards will apply to both the general written inquiries and PRRS responses. The QWCM standards will be released once the tool is available for general contractor use, currently projected to be no later than April 1, 2005. Once the tool is in use by all contractors, it will assist in ensuring national consistency in the accuracy of written responses by contractors.

Upon referral of a telephone inquiry to the PRRS, the telephone inquiry shall be closed and a written inquiry is opened. Although this may be considered to be double counting of a single inquiry, the workload shifts from telephone to written and CMS wants to capture the change in workload. For reporting purposes, all work of this team is included in the written inquiry workload (CMS 1566 and 1565) and all costs shall be reported using CAFM Activity Code 33002. Time spent by the professional relations staff to answer complex provider inquiries shall also be allocated to the PRRS ongoing costs.

c. Inquiry Tracking

Contractors shall maintain a tracking and reporting system that identifies: the type of inquiry (telephone, letter, e-mail, etc.); the person responsible for answering the provider inquiry (by name or other unique identifier); category of the inquiry using CMS-provided categories (specified in a subsequent instruction); the disposition of the inquiry, including referral to other PCSP areas or areas elsewhere at the contractor (e.g., appeals, medical review, MSP, etc.); and the timeliness of the response. The tracking system must not include any beneficiary-identifiable information, including the health insurance claim number. Internally generated claim numbers that do not use beneficiary identifiable information are permitted. 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. A contractor may choose to develop a tracking system that meets this requirement as well as the LPET/MR provider tracking system requirement if it determines that a combined approach is feasible and beneficial.

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, such as those needed to meet the PSP/QAR reporting requirements.

d. Training

The contractor shall train the CSRs on provider issues and shall equip them with the knowledge and tools to meet CMS' performance requirements for telephone provider inquiries. The PRRS should 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 should be tailored to the tier/degree of specialization of the CSR.

PRRS staff will need specialized training in the use of the CMS Internet-Only Manual, the CMS Web sites, the contractor Web sites, regulation, law, and other information tools to do the necessary research to accurately and completely respond to complex inquiries. CMS will provide supplemental PRRS training materials in FY05.

3. **Provider Outreach and Education (POE)**

Provider outreach and education regarding billing, coding, and other appropriate items includes all existing provider outreach, education and training activities in chapter 4 of Pub. 100-09 plus some additional requirements and activities. The new areas are:

- Training tailored for small providers
- Enhanced use of internet
- "Ask-the-Contractor" Teleconferences
- Training tailored to reduce the claims error rate
- Marketing of self-service technology

POE activities will be described on the annual Provider/Supplier Service Plan (PSP) as well as reported on the Quarterly Activity Reports (QARs). New formats for these reports will be available online by October 8, 2004. Contractors shall download these formats from http://www.cms.hhs.gov/contractors/providercomm/default.asp. Contractors shall use these formats and submit the PSPs and QARs electronically to their Regional Office contact and to the ProviderServices@cms.hhs.gov mailbox. For FY05, contractors shall submit their PSPs no later than November 30, 2004.

All contractors shall ensure that all educational materials are clear, accurate, and have little room for provider interpretation.

a. Training Tailored for Small Providers

Medicare contractors shall tailor education to 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.

Contractors shall not be required to identify and validate providers meeting the definition of small provider. By April 1, 2005, contractors shall offer to all providers at least 2 educational programs tailored to the needs of the small providers/suppliers in their jurisdiction. Thereafter, contractors shall offer at least one educational event tailored to small providers per quarter with a minimum total of 6 events per state per fiscal year (therefore some quarters will have more than one event). These educational events shall involve interactive communication such as face-to-face trainings or web-based seminars.

Such 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.) For those contractors who choose to offer technical assistance, it must be offered at no cost to the provider, and it does not need to be a face-to-face activity.

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.

b. Expanded Use of Internet

Under POE, contractors shall expand their use of the Internet for education activities. They should encourage providers to use the CMS and contractor Web sites as well as sign-up for listservs offered on both sites. Webcasting, web-based conferencing, and computer-based trainings made available on the contractor website are three possible approaches to expanding Internet use. By January 1, 2005, all contractors shall have at least one Internet educational offering and offer at least one per quarter thereafter with a minimum total of 6 events per fiscal year (therefore some quarters will have more than one event).

All contractors shall maintain regularly updated FAQs on their Web sites and a link to CMS FAQs (http://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std_alp.php). On a quarterly basis, contractors shall submit one or more FAQs appropriate for the national FAQ database. The suggested FAQs shall be submitted on the QARs. National FAQs address issues that are national in scope and are not open to local contractor interpretation. Once CMS has adopted the FAQ nationally and notified the contractor, the contractor shall remove the FAQ from its own Web site and link the question to the specific answer on the CMS website. As FAQs are added to the CMS Web site, CMS will notify all contractors using the contractor-only listserv.

Contractors must find solutions for providers who lack Internet access and demonstrate a need for such solutions (e.g., host sites for Web-based training, faxed materials, CD-ROMs, mailed paper copies of materials). Contractors may charge providers modest amounts to defray the expenses associated with making such solutions available, such as printing & postage.

c. "Ask-the-Contractor" Teleconferences (ACT)

The Open Door Forums offered by CMS have opened communication channels with providers on a national basis. They serve to identify problems in a timely way, provide methods of sharing information, and are an excellent tool to listen to our customers. Contractors shall adopt a similar approach to communicating with their enrolled providers. Contractors shall-organize toll-free "Ask the Contractor" Teleconferences (ACT) to complement, but not replace, the work of the PCOM Advisory Group(s).

Contractors should use their PCOM Advisory Group(s) to assist in establishing the size, topics, provider types included, timing, and frequency of ACTs. In designing ACTs, contractors should consider other technological approaches, such as web-chat capabilities. Contractors shall also invite CMS Regional Office staff to participate in ACTs. Contractors shall offer ACTs at least quarterly.

d. Training Tailored to Reduce the Claims Error Rate

Medicare contractors are required to use error rate information to design appropriate provider education. Contractors shall evaluate and analyze their Comprehensive Error Rate data, specifically the Provider Compliance Error Rate. Using the data analysis, the contractor shall design and implement a provider education methodology that leads to a reduction in the claims error rate. The education activities shall focus on those areas of the error rate that represent high dollar impact to the Medicare program. The Error Rate Reduction Plan (ERRP) shall identify POE provider education activities. Contractors shall also describe in their ERRPs internal systems and strategies to address identified errors as well as innovative education and training that will be implemented to reduce these errors. CMS will be reviewing the ERRPs and the CERT data to ensure that contractors are effectively implementing targeted provider education under this requirement.

e. Marketing of Self Service Technology

Contractors shall take every opportunity to educate and encourage the use of self-service technology (e.g., use of CMS and contractor Internet Web sites, web pages, listserv, IVRs, etc.). Such educational opportunities shall incorporate including the message to providers in marketing materials, educational seminars, listserv messages, and instructions on the website and IVR.

C. Provider Education: CMS will create an educational article outlining the Provider Customer Service Program. This article shall serve as the basis for all provider education about the new program by both CMS and the contractors and will be available by early November 2004. CMS will issue additional instructions pertaining to provider education following evaluation of the supplemental budget requests.

II. BUSINESS REQUIREMENTS

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

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3376.1	Contractors shall improve the quality and number of self-service options for Medicare providers.	x	x	x	x					
3376.1.1	Contractors shall maintain interactive voice response units (IVRs) that, at a minimum, provide information about claims status, beneficiary eligibility, and at least the top 100 remittance advice code definitions, as well as helpful information to assist providers resolve issues that can be automated. Eligibility inquiries must meet the privacy requirements outlined in the provider desk reference in chapter 3, section 30, of Pub. 100-09.	x	x	x	x					
3376.1.2	Contractors shall require Medicare providers to use the IVR to access this information (and/or the Internet, if Internet-based transactions are available, as approved by CMS). Provider telephone CSRs are not intended to answer questions that can be answered on the IVR. Contractors shall identify and contact providers who repeatedly call CSRs for information that is available on the IVR to assist them to effectively use the IVR, including transferring providers back to the IVR. At a minimum, such education should happen at the time of the inquiry to the CSR, but may, in some cases, require post-call reinforcement.	x	x	x	x					

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3376.1.3	The contractor Web site shall include: • Link to http://www.cms.hhs.gov/providers for national provider information, customized provider web pages, and CMS sponsored listservs • Local contractor information posted in a way that is easy to use and easily searchable • Information concerning subscribing to local contractor provider listservs for disseminating information • Frequently Asked Questions (FAQs) based on high volume inquiries and updated at least quarterly • A glossary of up-to-date and complete remittance advice code sets (requirement can be fulfilled with a link to www.wpc-edi.com/codes) • CMS products and messages posted, as directed • CMS-produced information about the new Provider Customer Service Program with any local contractor supplemental information.	x	x	x	x					
3376.1.4	The contractor shall assign a Webmaster responsible for maintaining and updating the provider outreach portions of the contractor's website in a timely manner.	x	x	x	x					
3376.1.5	Contractors shall publish provider bulletins at least quarterly. They shall be written clearly and concisely and posted on the contractor Web site.	x	x	x	x					

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3376.1.6	Contractors shall implement business requirements 3376.1 – 3376.1.5 within their current budgets. Funding may be available to expand IVR capabilities. Contractors shall submit Supplemental Budget Requests with sufficient justification no later than 4 weeks after issuance of this CR.	x	x	x	x					
3376.2	Medicare contractors shall develop a Provider Contact Center offering a range of inquiry expertise to respond to inquiries from the following sources: ➢ telephone ➢ letters ➢ fax, and ➢ email.	x	x	x	x					
3376.2.1	The Provider Contact Center model requirements shall not apply to those inquiries handled and funded by other units within the contractor (e.g., appeals, fraud, and Medicare secondary payer). The provider toll free numbers installed for Part A, Part B, DMERC, and RHHI general provider inquiry traffic shall not be used for other business functions (e.g., MSP, medical review, EDI, provider enrollment, and other non-claim related provider inquiries) beyond answering general questions for each of those functions. At a minimum, these general provider inquiry lines shall be used to handle questions related to billing, claims, eligibility, and payment.	x	x	x	x					

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3376.2.2	The provider contact center shall be staffed with individuals who are dedicated to respond to provider inquiries. Contractors may elect to have a small number of provider staff that is 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. Contractors shall only use such staff to assist with beneficiary workload if the provider inquiries performance requirements are being met.	x	x	x	x					
3376.2.3	The PCSP should be implemented in a way creating promotion pathways for the CSRs.	x	x	x	x					
3376.2.4	Contractors shall organize their dedicated provider telephone CSRs into at least two levels to handle questions of varying complexity. Contractors may adopt their own naming conventions for the different levels. A contractor may also choose to have staff rotate duties as a way to meet this requirement. Contractors may also choose to specialize CSRs within levels or across contact centers (if the contractor has more than one) to take full advantage of skill-based routing. Using a triage mechanism, the contact center shall route the inquiries to the system or person best equipped to respond, with a minimal degree of transfer. Contractors may use technology to intelligently route callers to the appropriate level of CSR. The most complex inquiries shall be routed to the Provider Relations Research Specialists (described in business requirement 3376.2.6). 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.	x	x	x	x					

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3376.2.4.1	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, first level CSRs shall handle questions that do not require substantial research and easily can be answered during the initial call. Contractors shall determine what types of inquiries are best answered by first level CSRs. Some examples of this level of inquiry may include 1) eligibility, claims status or Medicare secondary payer (MSP) status inquiries not adequately handled by the IVR; 2) straight-forward claim denial questions that cannot be handled by the IVR; 3) questions with well-documented, nationally consistent and easily accessible answers. First level CSRs shall have the authority to refer more complex questions to second level CSRs.	x	x	x	x					

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3376.2.4.2	Second level CSRs shall have more experience and expertise enabling them to answer more complex questions. These questions may include telephone inquiries concerning local coverage determinations not requiring referral to medical review, calls resulting in the need for simple claims adjustments that can be handled by telephone CSRs, or dissatisfied callers who require a higher level of service. Contractors may organize second level CSRs in any configuration that best suits the nature of the inquiries received. Second level CSRs may serve as consultant subject matter experts for first level CSRs and, therefore, do not always have to speak directly to a provider. Second level CSRs may be used to answer first level CSR questions, if the workload demands. Second level CSRs shall also handle callbacks. All callbacks shall be completed within 5 business days of the original inquiry and documented in the tracking system described in business requirement 3376.2.8. Inquiries that require additional time or a yet higher degree of expertise and/or research shall be referred to the Provider Relations Research Specialists (PRRS).	x	x	x	x					
3376.2.4.3	Although it is preferable that providers not be limited in the number of inquiries they make during a single call, contractor may limit the number of inquiries but shall allow a minimum of three inquiries per call, whether they are answered by level one CSRs, level two CSRs, or a combination of both levels of CSRs. For CROWD and CSAMS reporting purposes, if a call is transferred between the two CSR levels, the inquiry shall remain open until it is fully resolved (or transferred to the PRRS) and shall only be counted once.	x	x	x	x					

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3376.2.4.4	Contractors shall monitor a total of 5 calls per CSR per month for QCM purposes. The calls monitored shall be randomly selected and of the type that the level typically handles. All CSRs, regardless of level, shall meet the following quality standards: • Knowledge Skills Assessment standard of 93% per quarter for all CSRs, but no less than 85% in any given month. • Adherence to Privacy Act standard for 93% per quarter for all CSRs, but no less than 85% in any given month. • Customer Skills Assessment standard of 93% per quarter for all CSRs, but no less than 85% in any given month.	x	x	x	x					
3376.2.5	All provider general written inquiries shall be answered within 45 business days. Contractors have the discretion to develop a tiered approach to answering general written inquiries. Written inquiries shall include letters, faxes, and e-mail. All written inquiries, regardless of the form in which it is received, must be handled consistently for accuracy and timeliness. Contractors shall develop triage mechanisms to quickly identify those complex inquiries needing referral to the PRRS (see business requirement 3376.2.6).	x	x	x	x					
3376.2.5.1	For those written inquiries 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 (regional office or central office), a shared systems maintainer, or other non-contractor entity. Interim responses shall not comprise more than 5% of all written responses (general responses and PRRS responses).	x	x	x	x					

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3376.2.5.1.1	Final responses shall be issued within 5 business days of receipt of the information necessary to complete the response.	x	x	x	x					
3376.2.5.2	The 45-business day timeframe shall begin 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.	x	x	x	x					
3376.2.5.3	Contractors shall ensure that e-mail responses do not include beneficiary-identifiable information or protected healthcare information. If the response must contain protected health information, it shall be mailed in hardcopy to the provider, rather than e-mailed.	x	x	x	x					
3376.2.6	Contractors shall have Provider Relations Research Specialists (PRRS). The PRRS shall be staffed and designed to answer questions beyond the expertise of the CSRs or general written inquiry staff and requiring more time to adequately research the issue. The PRRS staff shall respond to the more complex provider questions including those related to coverage policy, coding, and payment policy.	x	x	x	x					
3376.2.6.1	PRRS shall use the full contractor resources (e.g., contractor medical director, contractor Web sites, bulletins, medical review staff, LPET staff, claims processing staff, etc), and CMS resources (Internet-Only Manual, contractor instructions, training packages, Medicare law and regulations, the www.cms.hhs.gov Web site, *Medlearn Matters* articles, provider specific web pages, and Regional Office staff) when researching answers to complex inquiries.	x	x	x	x					

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3376.2.6.2	The PRRS workload shall be generated by referral from either a second level CSR or the general written inquiries unit, unless the contractor chooses to allow other referral mechanisms. The referral shall come to the PRRS via the tracking system described in business requirement 3376.2.8. All responses from these specialists are written, unless the provider has requested a call back or the inquiry is best handled with a provider callback. For PRRS inquiries that are closed using a telephone call back, the response provided must be documented in the tracking system.	x	x	x	x					
3376.2.6.3	The PRRS staff shall provide clear and accurate written answers within 10 business days for at least 75 percent of cases referred by the telephone CSRs, 20 business days for 90 percent of cases referred by the telephone CSRs, and 45 business days for 100% of all cases (referred by telephone CSR or from the general inquiries area).	x	x	x	x					
3376.2.6.3.1	The 45 business days begins the day the inquiry was originally received, either by telephone or in writing, and ends the day the contractor sends the response from the mailroom.	x	x	x	x					

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3376.2.6.3.2	For those 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 (regional office or central office), a shared systems maintainer, or other non-contractor entity. Interim responses shall not comprise more than 5% of all written responses (general written inquiries and PRRS responses). Final responses shall be issued within 5 business days of receipt of the information necessary to complete the response.	x	x	x	x					
3376.2.6.4	The PRRS shall include at least one certified coder to ensure adequate coding expertise for this function. Examples of coder certification programs include the American Health Information Management Association, the American Academy of Professional Coders, and the Practice Management Institute. Such coding expertise shall be available within the contractor, but does not have to be assigned exclusively to the PRRS function. The coding questions appropriately answered by the PRRS are those asking questions of the underlying Medicare payment or coverage policy. Contractors shall educate providers that the PRRS is not an extension of or a replacement for billing staff. The PRRS shall not provide coding guidance. The straightforward pure coding questions shall be answered with referrals to the correct organizations such as the American Medical Association and the American Hospital Association's Coding Clinic.	x	x	x						

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3376.2.6.5	PRRS answers shall be considered for provider job aids enabling CSRs to answer similar inquiries in the future. Job aids should serve as talking points for CSRs. Contractors shall submit PRRS-generated job aids to CMS, on a monthly basis, to ProviderServices@cms.hhs.gov with a subject line indicating job aid. If a contractor does not have any job aids to submit, it shall submit an e-mail simply stating "nothing to submit." Within 1 week of receipt, CMS will distribute those job aids determined to be applicable nationally via the contractor-only listserv.	x	x	x	x					
3376.2.6.6	In addition to responding to complex inquiries, the PRRS shall serve as the point of contact for Medicare Advantage (MA) plans about Medicare program coordination issues.	x	x	x	x					
3376.2.6.7	Upon referral of a telephone inquiry to the PRRS, the telephone inquiry shall be closed and a written inquiry is opened. For reporting purposes, all work of this team is included in the written inquiry workload (CMS 1566 and 1565) and all costs shall be reported using CAFM Activity Code 33002. Time spent by the professional relations staff to answer complex provider inquiries shall be allocated to the PRRS ongoing costs.	x	x	x	x					
3376.2.7	Quality of Written Correspondence (QWCM) standards shall apply to both the general written inquiries and PRRS responses. The QWCM standards will be released once the tool is available for general contractor use, currently projected to be no later than April 1, 2005. Once the tool is in use by all contractors, it will assist in ensuring national consistency in the accuracy of written responses by contractors.	x	x	x	x					

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3376.2.8	Contractors shall maintain a tracking and reporting system that identifies: the type of inquiry (telephone, letter, e-mail, etc.); the person responsible for answering the provider inquiry (by name or other unique identifier); category of the inquiry using CMS-provided categories (specified in a subsequent instruction); the disposition of the inquiry, including referral to other PCSP areas or areas elsewhere at the contractor (e.g., appeals, medical review, MSP, etc.); and the timeliness of the response. The tracking system shall not include any beneficiary-identifiable information.	x	x	x	x					
3376.2.8.1	Tracking information on referrals to the PRRS shall include details of the inquiry and information about how to contact the provider in case there is a need to clarify the question. Contractors have the discretion to determine the additional minimum referral information needed by the PRRS.	x	x	x	x					
3376.2.8.2	Data from the tracking system shall be used to analyze the number and types of inquiries in order to generate FAQs to be posted on the website, identify areas for telephone CSR training, and identify areas for broader provider education. The tracking system shall be used to generate quarterly reports for CMS use, such as those needed to meet the PSP/QAR reporting requirements.	x	x	x	x					

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3376.2.9	The contractor shall train the CSRs on provider issues and shall equip them with the knowledge and tools to meet CMS' performance requirements for telephone provider inquiries. The PRRS should be involved in the development of training materials for the general inquiries staff. Training should be tailored to the tier/degree of specialization of the CSR. PRRS staff shall receive specialized training in the use of the CMS Internet-Only Manual, the CMS Web sites, the contractor Web sites, regulation, law, and other information tools to do the necessary research to accurately and completely respond to complex inquiries. CMS will provide supplemental PRRS training materials in FY05.	x	x	x	x					
3376.2.10	Within 4 weeks of issuance of the CR, contractors shall submit Supplemental Budget Requests for the funding necessary to implement business requirements 3376.2 – 3376.2.9.	x	x	x	x					
3376.3	Contractors shall offer expanded provider outreach and education regarding billing, coding, and other appropriate items All contractors shall ensure that all educational materials are clear, accurate, and have little room for provider interpretation.	x	x	x	x					

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3376.3.1	POE activities will be described on the annual Provider/Supplier Service Plan (PSP) as well as reported on the Quarterly Activity Reports (QARs). New formats for these reports will be available online by October 8, 2004. Contractors shall download these formats from http://www.cms.hhs.gov/contractors/providercomm/default.asp. Contractors shall use these formats and submit the PSPs and QARs electronically to their Regional Office contact and to the ProviderServices@cms.hhs.gov mailbox.	x	x	x	x					
3376.3.1.1	For FY05 only, contractors shall submit their PSPs no later than November 30, 2004.	x	x	x	x					
3376.3.2	Medicare contractors shall tailor education to 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. Contractors shall not be required to identify and validate providers meeting the definition of small provider.	x	x	x	x					
3376.3.2.1	By April 1, 2005, contractors shall offer to all providers at least 2 educational programs tailored to the needs of the small providers/suppliers in their jurisdiction. Thereafter, contractors shall offer at least one educational event tailored to small providers per quarter with a minimum total of 6 events per State per fiscal year (therefore some quarters will have more than one event). These educational events shall involve interactive communication such as face-to-face trainings or web-based seminars.	x	x	x	x					

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3376.3.2.2	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.) For those contractors who choose to offer technical assistance, it must be offered at no cost to the provider, and it does not need to be a face-to-face activity. 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 can include assistance from EDI support staff since much of the billing system technical expertise at the contractor resides with that staff.	x	x	x	x					
3376.3.3	Contractors shall expand their use of the Internet for education activities. They should encourage providers to use the CMS and contractor Web sites as well as sign-up for listservs offered on both sites. Webcasting, web-based conferencing, and computer-based trainings made available on the contractor website are three possible approaches to expanding Internet use. By January 1, 2005, all contractors shall have at least one Internet educational offering and offer at least one per quarter thereafter with a minimum total of 6 events per fiscal year (therefore some quarters will have more than one event).	x	x	x	x					

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3376.3.3.1	All contractors shall maintain regularly updated FAQs on their Web sites and a link to CMS FAQs (http://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std_alp.php). On at least a quarterly basis, contractors shall submit one or more FAQs appropriate for the national FAQ database. The suggested FAQs shall be submitted on the QARs. National FAQs address issues that are national in scope and are not open to local contractor interpretation. Once CMS has adopted the FAQ nationally and notified the contractor, the contractor shall remove the FAQ from its own Web site and link to the answer on the CMS Web site.	x	x	x	x					
3376.3.3.2	Contractors shall find solutions for providers who lack Internet access and demonstrate a need for such solutions (e.g., host sites for Web-based training, faxed materials, CD-ROMs, mailed paper copies of materials). Contractors may charge providers modest amounts to defray the expenses associated with making such solutions available, such as printing & postage.	x	x	x	x					
3376.3.4	Contractors shall-organize toll-free "Ask the Contractor" Teleconferences (ACT) to complement, but not replace, the work of the PCOM Advisory Group(s). Contractors should use their PCOM Advisory Group(s) to assist in establishing the size, topics, provider types included, timing, and frequency of ACTs. In designing ACTs, contractors should consider other technological approaches, such as web-chat capabilities. Contractors shall also invite CMS Regional Office staff to participate in ACTs. Contractors shall offer ACTs at least quarterly.	x	x	x	x					

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3376.3.5	Contractors shall evaluate and analyze their Comprehensive Error Rate data, specifically the Provider Compliance Error Rate. Using the data analysis, the contractor shall design and implement a provider education methodology that leads to a reduction in the claims error rate. The education activities shall focus on those areas of the error rate that represent high dollar impact to the Medicare program. The Error Rate Reduction Plan (ERRP) shall identify POE provider education activities. Contractors shall also describe in their ERRPs internal systems and strategies to address identified errors as well as innovative education and training that will be implemented to reduce these errors. CMS will be reviewing the ERRPs and the CERT data to ensure that contractors are effectively implementing targeted provider education under this requirement.	x	x	x	x					
3376.3.6	Contractors shall take every opportunity to educate and encourage the use of self-service technology (e.g., use of CMS and contractor Internet Web sites, web pages, listserv, IVRs, etc.). Such educational opportunities shall involve including the message to providers in marketing materials, educational seminars, listserv messages, and instructions on the website and IVR.	x	x	x	x					
3376.3.7	Within 4 weeks after issuance of the CR, contractors shall submit Supplemental Budget Requests for the funding necessary to implement business requirements 3376.3 – 3376.3.6.	x	x	x	x					
3376.4	Contractors shall submit waivers for any requirements they cannot meet using the regular waiver request process.	x	x	x	x					

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions:

X-Ref Requirement #	Instructions
3376.1.6, 3376.2.10, 3376.3.7	The implementation of the PCSP requires contractors to perform additional activities above the level of requirements contained in the current manual and future FY05 Budget and Performance Requirements. Funding for the new activities contained in the PCSP will be funded from a separate Medicare Modernization Act implementation budget and not the normal Program Management or Medicare Integrity Program budgets. Contractors are not to include the costs of any new MMA work in their FY05 budget requests. The need for additional funding to implement all components of the PCSP will be handled by the Supplemental Budget Request (SBR) process. All SBRs will be thoroughly reviewed before additional funds are released. Therefore, a contractor shall not assume that the submission of an SBR is a guarantee of additional funds. Contractors shall develop and submit all SBRs according to a format to be found on http://www.cms.hhs.gov/contractors/providercomm/default.asp. The format will be available no later than September 15, 2004. All SBRs shall be submitted electronically within 4 weeks after the issuance of this CR to ProviderServices@cms.hhs.gov with a copy to the appropriate regional office budget contact. The e-mail submission must use "CR 3376 SBR" in the subject line. CMS will act on the requests within 8 weeks after issuance of the CR.

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: Unless specified in instruction, January 1, 2005 **Implementation Date:** Unless specified in instruction, January 5, 2005 **Pre-Implementation Contact(s):** Shana Olshan, 410-786-3122 **Post-Implementation Contact(s):** Regional Offices	**Funding for Medicare contractors is available through the regular budget process for costs required for implementation.**

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