Medicare
Carriers Manual
Part 2 - Program Administration

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

Transmittal 147 **Date: MARCH 28, 2003**

CHANGE REQUEST 2379

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
5104 – 5104 (Cont.)	2-104.1 - 2-104.7.8 (15 pp.)	2-104.1 - 2-104.8 (10 pp.)

NEW/REVISED MATERIAL--*EFFECTIVE DATE: March 28, 2003*
IMPLEMENTATION DATE: April 11, 2003

Section 5104, Beneficiary Services, is revised to reflect Budget Performance Requirements (BPRs) implemented in FY 2003 for beneficiary telephone customer service.

These instructions should be implemented within your current operating budget.

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.

5104. BENEFICIARY SERVICES

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

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

Each contractor should prioritize its work and meet standards for inquiry workloads in the following order of precedence:

1. Beneficiary Telephone Inquiries;
2. Written Inquiries;
3. Walk-In Inquiries; and
4. Beneficiary Outreach to Improve Medicare Customer Service (i.e., customer service plans).

A. Telephone Inquiries.--The guidelines established below apply to all calls to telephone numbers established as beneficiary inquiry numbers. To ensure all inquiries are handled as expeditiously as possible, inbound beneficiary inquiry numbers (and the lines) must be separate from provider inquiry numbers. Providers cannot use numbers established for inquiries from beneficiaries.

1. Availability of Telephone Service.--

a. Service handled by Customer Service Representatives (CSRs).--

o **Hours of Operation**.--Make CSR telephone service available to callers continuously during normal business hours, including lunch and breaks. There are no required standard hours of operations; however, "the preferred" normal business hours for CSR telephone service are defined as 8:00 a.m. through 4:30 p.m. for all time zones of the geographical area serviced (within the continental United States), Monday through Friday. Contractors should notify the Beneficiary Network Services (BNS) of their normal hours of operation for CSR service and provide advance notice of any deviation from these hours. The BNS will notify CMS Regional and Central Offices of any changes to a call center's hours of operations. In any situation where CSRs are not available to service callers, CMS reserves the right to re-route call traffic within the network to ensure that callers receive the best possible service.

o **Federal Holiday Service**.--On Federal holidays, in lieu of answering telephone inquiries, contractors may choose to perform other appropriate call center work, e.g., provide CSR training. Contractors shall notify CMS via the BNS at the start of the fiscal year for any planned call center closures. Changes to the schedule should be reported to BNS no later than 60 days in advance. The BNS can be reached by calling 1-866-804-0685.

o **Call Center Staffing**.--Call center staffing should be based on the pattern of incoming calls per hour and day of the week, ensuring that adequate coverage of incoming calls throughout each workday is maintained.

b. Automated Services-Interactive Voice Response (IVR)--

o **General Instructions**.--Although the beneficiary should have the ability to transfer to and be connected directly with a CSR during normal call center operating hours, automated "self-help" tools, such as IVRs, must also be used to assist with inquiries. IVR service is intended to assist beneficiaries in obtaining answers to various Medicare questions, including those listed below. **NOTE:** IVRs should be updated to address areas of beneficiary confusion as determined by contractors' inquiry analysis staff and CMS best practices.

1. Contractor hours of operation for CSR service;

2. General Medicare program information and publications (both should be referred to 1-800-Medicare); and

3. General information about appeal rights and actions required of a beneficiary to exercise these rights.

o **IVR Call Flow**.--Call centers that are using IVRs for beneficiary telephone inquiries must submit to CMS a call flow document that outlines their IVR scripts and call flow, clearly showing all beneficiary inquiry transactions that they are performing through their IVR. Contractors must also indicate how they are authenticating the call when claims specific information is involved. The contractors can deliver this document in Visio, Paintbrush, Word, or PowerPoint. A copy should be sent to both the contractor's Regional Office, Beneficiary Services Office and to Glenn Keidel in the Center for Beneficiary Choices at Gkeidel@cms.hhs.gov. If the contractor changes the IVR script or call flow, they must submit the revised document to these parties within two weeks of implementing the changes.

o **Transition to Network IVR**.--CMS is transitioning to a network IVR during FY 2003, i.e., CMS will begin using the FTS-2001 network to provide IVR services. CMS will not purchase premise-based equipment, but will purchase IVR services that are available on the FTS-2001 contractor's network contract. As the transition takes place, services offered via the network IVR, such as those listed above, will be discontinued on the contractor's premise-based equipment. CMS will provide instructions at the appropriate time. Even after the transition to the network IVR service, contractors are encouraged to continue providing claims status information on the premise-based IVRs. CMS will work with contractors on a case-by- case basis to implement the network IVR once the schedule for transition is completed. Once transition is completed the contractor shall modify their printed Medicare Summary Notice (MSN) to display only CMS' branded 800 number, 1-800-Medicare (1-800-633-4227), **based on instructions from CMS**. Transition to network IVRs for TDD callers will begin once all the voice traffic has been transitioned. Once TDD transition is completed the contractor shall modify their printed MSNs to add CMS' branded TDD 800 number, 1-877-486-2048.

o **Hours of Operation**.--The IVR shall be available to beneficiaries from 6 a.m. to 10 p.m. in their local prevailing time, Monday through Friday; and from 6 a.m. to 6 p.m. on weekends and holidays (if the call center normally does not answer calls on holidays). Waivers shall be granted as needed to allow for normal IVR and system maintenance.

o **IVR Operating Guide**.--Contractors should print and distribute a readily understood IVR operating guide to Medicare beneficiaries upon request.

c. Telephone Service for the Hearing Impaired.--Maintain and operate a telephone device teletypewriter (TTY) using an FTS 2001 toll free number. Each call center should have its own FTS 2001 TTY number.

d. Bilingual Services:--Maintain the ability to respond directly (via CSR and automated service) to telephone inquiries in both English and Spanish.

2. Toll Free Network Services.--

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

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

c. Problem Reporting.--

o **Level 1 Problems**: The call center is responsible for resolving problems with call center and telecommunications equipment located on the premises, such as Private Branch Exchange (PBX), Automatic Call Distributor (ACD), and IVR equipment. This includes problems with headsets, phones, computer hardware, and desktop. Reporting, monitoring, and maintenance of their customer based premise equipment and Customer Service Assessment and Management System's (CSAMS) self reported data.

o **Level 2 Problems**: Report all other problems with the FTS 2001 telephone network service to the BNS at 1-866-804-0685.

o **Change Requests:**--All change requests regarding the FTS 2001 lines, (e.g., adding or removing channels or T-1 circuits, office moves, routing changes), must be processed through the BNS toll-free number. The BNS can also be contacted at bnsadmin@bah.com for situations that are not time-critical.

d. Inbound Service Costs:--CMS will pay for the rental of inbound T-1/PRI lines and all connect time charges for FTS-2001 toll-free service. These costs will be paid centrally by CMS and only for these telephone service costs. All other costs involved in providing telephone service (e.g., internal wiring, local telephone services and line charges) to Medicare beneficiaries will be born by the contractor. Since these costs are not specifically identified in any cost reports, contractors must maintain records of all costs associated with providing telephone service to beneficiaries (e.g., costs for headsets) and provide this information upon request by CMS regional or central offices.

3. Publication of Toll Free Numbers.--

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

b. Printing Toll Free Numbers on Beneficiary Notices.--Any toll-free Medicare beneficiary customer service number provided and paid for by CMS must be printed on all beneficiary notices, (MSNs, etc.) immediately upon activation. Display this toll-free number prominently so the reader will know whom to contact regarding the notice.

4. Call Handling Requirements.--

a. Call Acknowledgement:--Program all systems related to inbound beneficiary calls to the center to acknowledge each call within 20 seconds (4 rings) before a CSR, IVR or ACD prompt is reached. This measure must be substantiated and/or reported upon request by CMS.

b. Providing "Hard Busy" Signals:--Contractor call centers shall only provide hard busy signals to the Federal Telephone System (FTS) network. ACD or PBX system shall not accept

the call from the FTS network, thereby allowing the FTS network to provide the busy signal to the caller. At no time, shall any software, gate, vector, application, IVR, and/or accept the call by providing answer back supervision to the FTS network and then providing the busy signal to the caller. Providing a hard busy signal will keep the call in the FTS –2001 network and provide CMS with the opportunity to send the call to another site for answering if circumstances warrant. The contractor should optimize their inbound toll-free circuits to ensure the proper ratio of circuits to existing FTEs. Contact the BNS on 1-866-804-0685 for assistance with the optimization.

c. Queue Message:--Provide a recorded message that informs callers waiting in queue to speak with a CSR of any temporary delay before a CSR is available. Use the message to inform the beneficiary to have certain information readily available (e.g., Medicare card or health insurance claim number) before speaking with the CRS. The queue message should also be used to indicate non-peak time frames for callers to call back when the call center is less busy.

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

e. Sign-in Policy.--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 will include the following:

- CSRs available to answer telephone inquiries will sign-in to the telephone system to begin data collection;

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

- CSRs should sign-off the telephone system at the end of their workday.

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

g. Initial Call Resolution.--Handle no less than 80 percent of calls to completion during the initial contact with a CSR. A call is considered resolved during the initial contact if it does not require a return call by a CSR.

h. Productivity.--Answer a minimum of 1100 calls per each CSR full time equivalent (FTE) position per month for Non-Medicare Customer Service Center (MCSC) call centers and 1000 calls per month per CSR FTE for MCSC calls centers.

i. Quality Call Monitoring.--

- **Frequency of Monitoring**.—Monitor an average of three calls per CSR per month. In centers where CSRs answer both beneficiary and provider calls, monitor a total of three calls, including at least one of each type, during the month. Any deviation from this requirement must be requested and justified to the CMS regional office in order to determine if a waiver is warranted.

o **Performance Standards for Quality**.--

1. Of all calls monitored each month, the number of CSRs scoring as "Pass" for Adherence to Privacy Act should be no less than 85 percent.

2. Of all calls monitored each month, the percent of CSRs scoring as "Meets Expectation" or higher should be no less than 90 percent for Customer Skills Assessment.

3. Of all calls monitored each month, the percent of CSRs scoring as "Meets Expectation" or higher should be no less than 85 percent for Knowledge Skills Assessment

j. Equipment Requirements.--

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

1. On-line access to a computer terminal for each CSR responsible for claims-related inquiries to retrieve information on specific claims. Locate the computer terminal so that representatives can research data without leaving their seats;

2. An outgoing line for callbacks; and

3. A supervisory console for monitoring CSRs.

o Any contractor call center purchases or developmental costs for hardware, software or other telecommunications technology that equal or exceed $10,000 must first be approved by CMS. Contractors shall submit all such requests to the servicing CMS regional office (RO) for review. The RO shall forward all recommendations for approval to CMS central office for a final decision.

5. Customer Service Assessment and Management System (CSAMS) Reporting Requirements.--CSAMS is an interactive Web-based software tool used by CMS to collect and display Call Center Telephone Performance data. Each call center site must 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 must inform CMS central office via CSAMS at csams@cms.hhs.gov. Definitions, calculations and additional information for each of the required telephone customer service data elements as well as associated standards are posted on the CMS' telephone customer service Web site at https://bizapps.cms.hhs.gov/csams.

a. Definition of Call Center for CSAMS.--All contractors must ensure that monthly CSAMS data are being reported by individual call centers and that the data are not being consolidated. CMS wants telephone performance data reported at the lowest possible physical location in order to address performance concerns. A call center is defined as a location where a group of CSRs are answering similar type calls (A, B, DMERC, A&B, MCSC, or some breakout or consolidation of these calls). The physical location could be in the same room, building, or complex but not in a separate geographic location, city, state, etc.

b. Data To Be Reported Monthly.--Capture and report the following data each month:

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

o **Number of Failed Attempts**.--This represents the number of calls unable to access the call center via the toll-free line. This data should also be taken from reports produced by

FTS Toll-Free service provider.

o **Call Abandonment Rate**.--This is the percentage of beneficiary calls that abandon from the ACD queue. This should be reported as calls abandoned up to and including 60 seconds.

o **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.

o **Total Sign-in Time (TSIT)**.--This is the amount of time the CSRs were available to answer telephone inquiries. This time includes the time that CSRs were plugged-in, logged-in, handling calls, making outgoing calls, in the after call workstate or in an available state.

o **Number of Workdays**.--This is the number of calendar days for the month that the call center is open and answering telephone inquiries. For reporting purposes, a call center is considered open for the entire day even if the call center was closed for a portion of the day and/or not able to answer telephone inquiries for a portion of the day.

o **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.

o **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).

o **ACW**.--This includes the time that CSRs need to complete any administrative work associated with a call after the customer disconnects.

o **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 five workdays. This number is based on calls received for the calendar month and represents the number closed within five workdays even if a callback is closed within the first five workdays of the following month. For call centers that have transitioned to the Next Generation Desktop (NGD), the collection of this data point will be automated and will be based on seven calendar days rather than five workdays.

o **IVR Handle Rate**.--Report data needed to calculate the IVR handle rate. This includes:

1. The number of calls offered to the IVR; and

2. The number of calls handled by the IVR as defined by CMS.

o **Calls in CSR queue**.--This is the total number of calls delivered to the CSR queue.

o **Calls Answered by CSRs**.--This represents the total number of calls answered by all CSRs for the month from the CSR queue.

o **Calls Answered <= 60 Seconds**.--This represents the total number of calls

answered by all CSRs within 60 seconds from the CSR queue.

- **Quality Call Monitoring (QCM)-Number of CSRs Available for Monitoring**.—This is the number of CSRs (not FTEs) that take calls on a regular basis, both full-time and part-time CSRs. This number is obtained from the QCM Database.

- **QCM-Number of Completed Scorecards**.--This number is obtained from the QCM Database.

- **QCM-Customer Skills Assessment**.--This is the percent of calls monitored that scored greater than or equal to Meets Expectations. This number is obtained from the QCM Database.

- **QCM-Knowledge Skills Assessment.--**This is the percent of calls monitored that scored greater than or equal to Meets Expectations. This number is obtained from the QCM Database.

- **QCM-Privacy Act**.--This is the percentage of calls that scored as pass. This number is obtained from the QCM Database.

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

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

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

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

- Medicare policy and procedures;
- Use of the Medicare Carriers Manual (MCM);
- Customer service skills, including special needs of the Medicare population;
- Telephone techniques; and
- The use of a computer terminal.

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

Contractors are required to implement standardized CSR training materials, including job aids, for

all CSRs on duty and those hired in the future upon receipt from CMS. The development of the materials will be done by CMS and it is not expected that there will be any costs to the contractors to use these training materials. Standardized training materials and other training information will be posted to the following Web site: http://www.cms.hhs.gov/callcenter, under the Call Center Learning Resources portion. Contractors should check this Web site monthly for updated training materials. Contractors may supplement the standard materials with their own materials as long as there is no contradiction of policy or procedures.

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

The above-mentioned Web site also contains frequently asked questions and answers for call center management and inquiry staff. This information is to be used in responding to beneficiary inquiries. As CMS develops additional questions and answers, they will continue to be posted on this site and all call center managers will be notified directly through e-mail. If the call center manager would like to designate another individual to receive their e-mail notifications, they may unsubscribe and provide another name and e-mail address.

8. Quality Call Monitoring (QCM).--

a. Process and Tools.--Monitor, measure and report the quality of service continuously by utilizing the CMS-developed QCM process. Monitor all CSRs throughout the quarter, using a sampling routine. The sampling routine must ensure that all CSRs are monitored at the beginning, middle and end of each month (ensuring that assessments are distributed throughout the week), and during morning and afternoon hours. Record all monitored calls on the standard scorecard, using the QCM chart as a guideline. Copies of the scorecard and chart may be obtained at the telephone customer service Web site at http://www.cms.hhs.gov/callcenters. Use only the official versions of the scorecard and chart that are posted on the Web site. The QCM reporting tools and format, also posted on the Web site, must be used to collect monitoring results which will be reported monthly in CSAMS. Train every CSR and auditor on the scorecard and chart and ensure that each person has a copy of the chart for reference. If there is more than one auditor, rotate the CSR monitoring assignments regularly among the auditors. Analyze individual CSR data frequently to identify areas needing improvement, document and implement corrective action plans. Also analyze QCM data to determine where training is indicated, whether at the individual, team, or call center level and provide such training.

b. Frequency of Monitoring.--

o **Experienced CSRs**.--Monitor an average of three calls per CSR per month. In centers where CSRs answer both beneficiary and provider calls, monitor a total of three calls, including at least one of each type, during the month. Any deviation from this requirement must be requested and justified to the CMS regional office in order to determine if a waiver is warranted.

o **New CSRs**.--Contractors are encouraged to heavily monitor CSR trainees that have just completed classroom instruction before they begin to handle calls independently. Scores for these trainees may be excluded from CSAMS reporting on QCM performance for a period up to one month following the end of formal classroom training.

c. Type.--Monitor the calls in one or more of the following ways: **LIVE** remote; **LIVE** side by side (shadow); or taped.

d. Giving Feedback to CSRs.--Complete the scorecard in its entirety and give written feedback to the CSR within two working days for calls monitored **LIVE** or seven

working days for taped calls. Coach and assist the CSR to improve in areas detected during monitoring.

e. Calibration.--Participate in all national and regional QCM calibration sessions organized by CMS. (Calibration is a process to help maintain fairness, objectivity and consistency in scoring calls by staff within one or more call centers or throughout CMS. Instructions on how to conduct calibration are posted at the telephone customer service Web site.) National sessions are held on the first Wednesday of February, May, August and November at 1:30 Eastern Standard Time. Conduct regular calibration sessions within the call center or between multiple centers. Monthly calibration sessions within the call centers are recommended.

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

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

9. Disclosure of Information (Adherence to the Privacy Act).--Contractors are to follow the guidelines for disclosure of information that are provided at www.cms.hhs.gov/callcenters, under Call Center Learning Resources, Job Aids. CMS developed standardized training to assist Medicare contractors and CMS employees comply with disclosure guidelines for beneficiary-specific information via telephone. This Privacy and Disclosure of Information Training is mandatory for employees of Medicare contractors, fiscal intermediaries, regional home health intermediaries, and durable medical equipment contractors who respond to, monitor, or train on beneficiary telephone inquiries. This includes all current and future CSRs, managers, supervisors, CSR trainers, and quality assurance staff. The Privacy and Disclosure of Information Training is computer-based training designed to be self-directed and self-paced. Therefore, employees are encouraged to take this training at their workstations or in a designated space where computer workstations are available. It is not necessary to conduct classroom training. The lessons in the training module include many features designed to aid the CSRs in responding to beneficiary inquiries. For example, a toolkit is provided that contains job aids, examples, CMS policy, and a glossary of relevant terminology and acronyms. After training has been completed, the lessons can be accessed on an as needed basis. **NOTE:** A text version is available for users who require assistive devices. Future updates to the training module, including the CSR toolkit, will be distributed as needed for clarification of content or as new regulations are issued.

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

11. Next Generation Desktop (NGD).--CMS is developing a new Medicare Customer Service Center (MCSC) NGD application to be deployed at Medicare contractor sites. The new desktop will allow CSRs to answer written, telephone, and walk-in inquiries from both providers and beneficiaries. The NGD application will enable CSRs to address, at a minimum, the same general Medicare and claims inquiries currently handled, but in a more user-friendly and efficient manner. Listed below are the minimum personal computer (PC) requirements for the MCSC NGD

for CSRs. (**NOTE:** Contractors are required to capitalize and depreciate equipment valued at over $500.)

Minimum Requirements for an NGD Personal Computer

Processor:	Pentium II 233MHz or comparable AMD or Cyrix
Disk Space:	10MB available
Memory:	64 MB (more recommended for running multiple applications simultaneously with the NGD)
Operating System:	One of the following 4 options: •Windows 98 SE •Window ME •Windows NT Workstation 4.0 with Service Pak 6a •Windows 2000
Browser:	Internet Explorer 5.5 Service Pack 2
Monitor:	15" (17" or larger is preferable)
Pointing Device:	Mouse
Network Interface	Network Interface Card compatible with the call center LAN, which will ultimately allow workstation access to AGNS

Organizations that will be procuring new PCs because they currently do not have PCs or because they need to upgrade for reasons other than the new NGD application, may want to procure more current PC technology. While the minimum PC requirements should be used to evaluate if existing desktops systems are adequate, the following suggested configurations provides guidance when new hardware is purchased.

Guidance for New PCs If and Only If Existing PCs Do Not Meet Minimum Requirements

Processor:	1.0 GHz Processor (Pentium, Celeron, or AMD)
Disk Space:	20 GB Hard Drive
Memory:	256 MB minimum
Operating System:	Windows 2000
Browser:	Internet Explorer 5.5 Service Pack 2
Monitor:	17" or larger
Pointing Device	Mouse with scroll
Network Interface	Network Interface Card compatible with the call center LAN, which will ultimately allow workstation access to AGNS

This hardware should provide good performance running the combination of applications expected of typical NGD users.

These applications include, but are not limited, to:

- o Next Generation Desktop (using Internet Explorer);
- o Microsoft Word;
- o Microsoft Outlook (or other email/calendar packages); and

- Adobe Acrobat Reader, Folio, other document viewing software.

Personal Computer Software.--

- Web browser (Internet Explorer 5.5, Service Pack 2); and
- Microsoft Word 97 (or higher version) – Required only for generation of correspondence.

Contractors will be required to implement the new desktop application as it is rolled out. CMS will provide additional information on roll-out dates and associated activities through normal operating channels and contractors will be given a minimum of 90 days advance notice of desktop implementation. Contractors are responsible for providing the necessary support to implement the desktop. These support activities will vary in scope from one contractor to another based on the various technologies and operational practices employed at each site. Examples of support activities may include additional systems testing, connecting to contractor specific applications, pre and post deployment activities, training needs and other issues. Contractors should include implementation and all associated costs for the CSR desktop in the Beneficiary Telephone Inquiries activity code (AC 13005). Since Beneficiary Telephone Inquiries is the first priority, this implementation must be given priority over all other Beneficiary Inquiries activities (Written, Walk-In, CSP).

12. Publication Requests.--If a CSR has Internet access, then all requests for CMS beneficiary –related Medicare publications and alternative CMS products should be ordered on-line at www.medicare.gov for callers. The CSR is to use the Web site to place the order for the beneficiary. If a CSR does not have Internet access, then callers with such requests should be referred to www.medicare.gov for on-line ordering or to the 1-800-MEDICARE Help line at 1-800-633-4227. Contractors should retain a minimum number of CMS publications for outreach/education efforts or for unique or extenuating circumstances, e.g., an outreach event or and event when you have a quest speaker. Contractors will maintain their in-house developed materials and products.

13. Medicare Participating Physicians and Suppliers Directory (MEDPARD).--Contractors shall provide callers with participating physicians and suppliers directory (MEDPARD) information upon request. MEDPARD information shall be provided to callers verbally. Written or printout forms shall be provided only if the beneficiary insists on receiving a hard copy or if giving the list of participating physicians via telephone would significantly lengthen the call. Contractors should use judgment to determine how to narrow the number of physicians names provided and when it is more efficient and cost-effective to provide the MEDPARD directory. For example, the contractor could narrow the list geographically (e.g., to zip code or county) or by special type. If for example, it would be more cost-effective to provide by telephone the names/ telephone numbers for four psychiatrists in a zip code than to mail a large directory with thousands of physicians' names. Conversely, if the beneficiary wants all physicians ' names for a large city and the search results in a large number of physicians, the contractor should mail the directory. The contractor may, at its discretion, use the www.medicare.gov Participating Physicians Directory, if its current system does not easily facilitate searches by various criteria for narrowing the number of physicians.

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

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

B. Written Inquiries.--

1. Guidelines for Handling Written Inquiries.--Stamp all written inquiries with the date of receipt in the corporate mailroom and control them until you send final answers.

In addition:

- o Answer inquiries timely;
- o Do not send handwritten responses;
- o Contractors must include a contact's name and telephone number in the response;
- o The majority of Medicare contractors currently retain all written inquiries on site. Some contractors house files at a remote location during the year due to cost and space constraints. Those contractors housing written inquiries off site must notify CMS within 6 weeks of the final BPR date of the exact address/location of their off site written inquiries. This information should be sent electronically to the servicing RO Beneficiary Branch Chief. This notification is necessary in the event an onsite CPE review is conducted. Contractors are required to allow CMS access to all written inquiries stored off site within one day of notification to the contractor so that cases can be retrieved timely;

All written inquiries, whether maintained on site or off site, must be clearly identified and filed in a manner that will allow for easy selection for the CPE review. Identification data must be kept that will allow electronic production of a sequential listing of the universe of written inquiries.

- o Consider written appeal requests as valid if all requirements for filing are met. These requests need not be submitted on the prescribed forms in order to be considered valid. If appeal requests are valid, they are not to be considered written inquiries for workload reporting;
- o Keep responses in a format from which reproduction is possible; and
- o The CMS Alpha Representation must be on all responses, except for e-mail responses.

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

a. Accuracy.--Content is correct with regard to Medicare policy and your data. Overall, the information broadened the inquirer's understanding of the issues which prompted the inquiry.

b. Responsiveness.--The response addresses the inquirer's concerns and states an appropriate action to be taken.

c. Clarity.--Letters have good grammatical construction, sentences are of varying length, and paragraphs generally contain no more than five sentences. Use CMS-provided model language and guidelines, where appropriate. All written inquiries are to be processed using a font size of 12, and a font style of Universal or Times New Roman, or another similar style for ease of reading by the beneficiary.

Contractors must make sure that responses to beneficiary correspondence are clear; language must be below the 8th grade reading level, unless it is clear that the incoming request contains language written at a higher level. Contractors may use a software package to verify that responses to beneficiary inquiries are written at the appropriate reading level. Whenever possible, written replies

should contain grammar comparable to the level noted in the incoming inquiry.

d. Timeliness.--Substantive action is taken and an interim or final response is sent within 45 calendar days from receipt of the inquiry. In instances where a final response cannot be sent within 45 calendar days (e.g., inquiry must be referred to a specialized unit for response), send an interim response acknowledging receipt of the inquiry and the reason for any delay.

If you are responsible for handling both Part A and Part B claims, inquiries requiring response from both of these areas share the same timeframe for response (i.e., the 45-day period starts on the same day for both responses). 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 your conditions. If you respond separately, each response must refer to the fact that the other area of inquiry will be responded to separately. Every contractor will have the flexibility to respond to beneficiary written inquiries by phone within 45 calendar days. A report of contact should be developed for tracking purposes. The report of contact should include the following information:

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

Upon request, send the beneficiary a copy of the report of contact that results from the telephone response. The report of contact should be retained in the same manner and time frame as the current process for written responses. Use your discretion when identifying which written inquiries (i.e., beneficiary correspondence that represent simple questions) can be responded to by phone. Use the correspondence which includes the requestor's telephone number or use a requestor's telephone number from internal records if more appropriate for telephone responses. If you cannot reach the requestor by phone, do not leave a message for the beneficiary to return the call. A written response should be developed within 45 calendar days from the incoming inquiry.

e. Tone.--Tone is the touch that brings communication to a personal level and removes the appearance that a machine-produced response was used. Appraise all responses, including computer-generated letters and form letters, for tone to make them user-friendly and comprehensible by the reader.

f. E-mail Inquiries.--Any e-mail inquiry received can be responded to by e-mail, **with the exception shown below.** Since e-mail represents official correspondence with the public, it is paramount that contractors use sound e-mail practices and proper etiquette when communicating electronically. However, ensure that e-mail responses utilize the same guidelines that pertain to

written inquiries (i.e., timeliness, accuracy, clarity, tone, comprehension,). **Exception:** Responses that are personal in nature (contain financial information, HICN, etc.) cannot be answered by e-mail.

C. Walk-In Inquiries.--

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

If a beneficiary inquires about a denied or reduced claim, give him/her the same careful attention given during a "hearing," i.e., the opportunity to understand the decision made and an explanation of any additional information which may be submitted when a review is sought. Make the same careful recording of the facts as for a telephone response, if it appears further contact or a review will be required.

2. Guidelines for High Quality Walk-In Service.--

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

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