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# CMS Manual System

## Pub. 100-09 Medicare Contractor Beneficiary and Provider Communications

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

Transmittal 3

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### I. SUMMARY OF CHANGES:

This is a correction to Transmittals 1 and 2, released on October 1, 2003, and November 28, 2003, respectively, for the Medicare Contractor Beneficiary and Provider Communications Manual. Chapters 2, 3 and 5 were renumbered and Chapter 4 was renumbered and revised to clarify contractors doing fiscal intermediary provider communications work and contractors doing Part B carrier provider communications work. The manual may be accessed from the CMS Web site:

<http://www.cms.hhs.gov/manuals/>.

**NEW/REVISED MATERIAL - EFFECTIVE DATE: Not Applicable**

**\*IMPLEMENTATION DATE: Not Applicable**

*Disclaimer: The revision date and transmittal numbers apply only to red italicized material. Any other material was previously published and remains unchanged.*

### II. CHANGES IN MANUAL INSTRUCTIONS:

**(R = REVISED, N = NEW, D = DELETED)**

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	2/Table of Contents
R	2/10, 20, 30 - Beneficiary Customer Services
R	3/Table of Contents -
R	3/10, 20 - Provider Customer Services
R	4/Table of Contents
R	4/10, 20, 30 - Provider Communications
R	5/Table of Contents
R	5/10, 20 Correct Coding Initiative

**III. FUNDING: \*Medicare contractors only:**

**These instructions should be implemented within your current operating budget.**

**IV. ATTACHMENTS:**

	<b>Business Requirements</b>
<b>X</b>	<b>Manual Instruction</b>
	<b>Confidential Requirements</b>
	<b>One-Time Special Notification</b>

# Medicare Contractor Beneficiary and Provider Communications Manual

## Chapter 2 - Beneficiary Customer Services

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## **10 - Introduction**

**(Rev. 1, 10-01-03)**

This chapter contains general instructions and requirements for Medicare carriers, including DMERCs and intermediaries for processing correspondence. Normally, the term “contractor” is used in this manual to mean any or all of these. If an instruction should apply to only one type of contractor, this will be specified.

## **20 - Beneficiary Services**

**(Rev. 3, 12-09-03)**

**A2- 2958, B2-5104**

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. The 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 the 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).

## **20.1 - Guidelines for Telephone Service**

*(Rev. 3, 12-09-03)*

### **A2- 2958.A, B2-5104.A**

Contractors must 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.

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.

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.

### **A - Automated Services-Interactive Voice Response (IVR)**

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.

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](mailto: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.

The CMS is transitioning to a network IVR during FY 2003, i.e., CMS will begin using the FTS-2001 network to provide IVR services. The 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. The 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. The 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.

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.

Contractors should print and distribute a readily understood IVR operating guide to Medicare beneficiaries upon request.

### **B - Telephone Service for the Hearing Impaired**

Contractors must 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.

### **C - Bilingual Services**

Contractors must maintain the ability to respond directly (via CSR and automated service) to telephone inquiries in both English and Spanish.

## **20.1.1 - Toll Free Network Services**

*(Rev. 3, 12-09-03)*

### **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 [bensadmin@bah.com](mailto:bensadmin@bah.com).

### **C. Problem Reporting -**

**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.

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

**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 [bensadmin@bah.com](mailto:bensadmin@bah.com) for situations that are not time-critical.

### **D - Inbound Service Costs**

The CMS will pay for the rental of inbound T-1/PRI lines and all connect time charges for FTS-2001 toll-free service. 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.

## **20.1.2 - Publication of Toll Free Numbers**

*(Rev. 3, 12-09-03)*

### **A - Directory Listings**

Contractors will not be responsible for the publication of their inbound 800 services in any telephone directory. The 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. Contractors display this toll-free number prominently so the reader will know whom to contact regarding the notice.

## **20.1.3 - Call Handling Requirements**

*(Rev. 3, 12-09-03)*

### **A. - Call Acknowledgement**

Contractors program all systems related to inbound beneficiary calls to the center to acknowledge each call within 20 seconds (four 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. The contractor contacts the BNS on 1-866-804-0685 for assistance with the optimization.

### **C - Queue Message**

Contractors provide a recorded message that informs callers waiting in queue to speak with a CSR of any temporary delay before a CSR is available. They 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**

Contractors must 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, contractors 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**

Contractors handle no less than 80 percent of the calls to completion during the initial contact with a CSR. A call is considered resolved during the initial contact if it does not require a return call by a CSR.

## **H - Productivity**

Contractors 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 call centers.

## **I - Quality Call Monitoring**

- **Frequency of Monitoring:** Contractors 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.
- **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:**

- To ensure that inquiries receive accurate and timely handling, contractors must provide the following equipment:
  1. Online 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.
- 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.

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

*(Rev. 3, 12-09-03)*

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](mailto: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. The CMS wants telephone performance data reported at the lowest possible physical location in order to address performance concerns. A call center is defined as a location where a group of CSRs 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**

Contractors capture and report the following data each month:

- **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/>
- **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.
- **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.
- **Average Speed of Answer** - This is the amount of time that all calls waited in queue before being connected to a CSR. It includes ringing, delay recorder(s), and music. This time begins when the caller enters the CSR queue and includes both calls delayed and those answered immediately.
- **Total Sign-in Time (TSIT)** - This is the amount of time the CSRs were available to answer telephone inquiries. This time includes the time that CSRs were plugged-in, logged-in, handling calls, making outgoing calls, in the after call workstate or in an available state.
- **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.

- **Total Talk Time** - This is the total amount of time that all CSRs were connected to callers and includes any time the caller is placed on hold by the CSR during the conversation.
- **Available time** - Available time is the amount of time that CSRs were signed-in on the telephone system waiting for a call to be delivered (i.e., the CSR is not handling calls, making outgoing calls, or in the After Call Work (ACW) state).
- **ACW** - This includes the time that CSRs need to complete any administrative work associated with a call after the customer disconnects.
- **Status of Calls Not Resolved at First Contact** - Report as follows:
  1. Number of callbacks required. This number is based on calls received for the calendar month and represents the number requiring a callback as of the last workday of the month.
  2. Number of callbacks closed within 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 7 calendar days rather than five workdays.
- **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.
  - **Calls in CSR queue** - This is the total number of calls delivered to the CSR queue.
  - **Calls Answered by CSRs** - This represents the total number of calls answered by all CSRs for the month from the CSR queue.
  - **Calls Answered <= 60 Seconds** - This represents the total number of calls answered by all CSRs within 60 seconds from the CSR queue.
  - **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.

### **20.1.5 - CSR Qualifications**

*(Rev. 3, 12-09-03)*

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.

### **20.1.6 - CSR Training**

*(Rev. 3, 12-09-03)*

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/callcenters>, 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 <http://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.

### **20.1.7 - Quality Call Monitoring (QCM)**

*(Rev. 3, 12-09-03)*

Contractors must:

#### **A - Process and Tools**

Monitor, measure and report the quality of service continuously by utilizing the CMS-developed QCM process. They 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>. Contractors 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. They 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. Contractors 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**

- **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.
- **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 1 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 7 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. The 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.).

### **20.1.8 - Disclosure of Information (Adherence to the Privacy Act)**

*(Rev. 3, 12-09-03)*

Contractors are to follow the guidelines for disclosure of information that are provided at <http://www.cms.hhs.gov/callcenters>, under Call Center Learning Resources, Job Aids. The 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.

### **20.1.9 - Fraud and Abuse**

*(Rev. 3, 12-09-03)*

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.

### **20.1.10 - Next Generation Desktop (NGD)**

*(Rev. 3, 12-09-03)*

The 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: <ul style="list-style-type: none"> <li>• Windows 98 SE</li> <li>• Window ME</li> <li>• Windows NT Workstation 4.0 with Service Pak 6a</li> <li>• Windows 2000</li> </ul>
Browser:	Internet Explorer 5.5 Service Pack 2
Monitor:	15" (17" or larger is preferable)
Pointing Device:	Mouse
Network	Network Interface Card compatible with the call center LAN, which

Interface	will ultimately allow workstation access to AGNS
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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:

- Next Generation Desktop (using Internet Explorer);
- Microsoft Word;
- 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. The 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).

### **20.1.11 - Publication Requests**

*(Rev. 3, 12-09-03)*

If a CSR has Internet access, then all requests for CMS beneficiary –related Medicare publications and alternative CMS products should be ordered online at <http://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 <http://www.medicare.gov/> for online 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 an event when there is a guest speaker. Contractors will maintain their in-house developed materials and products.

### **20.1.12 - Medicare Participating Physicians and Suppliers Directory (MEDPARD)**

*(Rev. 3, 12-09-03)*

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

<http://www.medicare.gov/> Participating Physicians Directory, if its current system does not easily facilitate searches by various criteria for narrowing the number of physicians.

### **20.1.13 - Call Center User Group (CCUG)**

*(Rev. 3, 12-09-03)*

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.

### **20.1.14 - Performance Improvements**

*(Rev. 3, 12-09-03)*

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

## **20.2 - Guidelines for Handling Written Inquiries**

*(Rev. 3, 12-09-03)*

### **A2- 2958.B, B2-5104.B**

The contractor stamps all written inquiries with the date of receipt in the corporate mailroom and controls them until it sends final answers (For MSP Situations, see the Medicare Secondary Payer (MSP) Manual, Chapter 4, §§10, 80, 110; and Chapter 5, §10). In addition, the contractor:

- Answers inquiries timely;
- Does not send handwritten responses;
- Includes a contact's name and telephone number in the response;
- 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 six 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 1 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.

- Considers written appeal requests as valid if all requirements for filing are met. These need not be submitted on the prescribed forms in order to be considered valid. If appeal requests are valid, they are not considered written inquiries for workload reporting. (See the Medicare Claims Processing Manual, Chapter 31 for instructions on Appeals Processing.);
- Keeps responses in a format from which reproduction is possible; and
- Includes the CMS alpha representation on all responses, except for email responses.

### **20.2.1 - Contractor Guidelines for High Quality Written Responses to Inquiries**

*(Rev. 3, 12-09-03)*

#### **A2-2958.A, B2-5104.B**

Contractors maintain a correspondence Quality Control Program (containing written policies and procedures) that is designed to improve the quality of written responses. In addition, contractors 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:

1. **Accuracy** - Content is correct with regard to Medicare policy and contractor data. Overall, the information broadened the inquirer's understanding of the issues that prompted the inquiry.
2. **Responsiveness** - The response addresses the inquirer's concerns and states an appropriate action to be taken.
3. **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 points, and a font style of Universal or Times 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 eighth 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.

4. **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), the contractor must send an interim response acknowledging receipt of the inquiry and the reason for any delay.

Contractors using Interactive Correspondence Online Reporting (ICOR) to document inquiries received from beneficiaries and others should record the correspondence in the electronic environment in a timely manner.

If the contractor is responsible for handling both Part A and Part B claims, inquiries requiring response from both of these areas share the same time frame for response (i.e., the 45-day period starts on the same day for both responses). The contractor ensures that the inquiry is provided to both responding units as quickly as possible. The response to these inquiries may be combined, or separate, depending on which procedure is most efficient for the contractor's conditions. If a contractor responds separately, each response 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 include the following information:

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

Upon request, the contractor should send the beneficiary a copy of the report of contact that results from the phone response. The report of contact should be retained in the same manner and time frame as the current process for written responses. The contractor should use its discretion when identifying which written inquiries (i.e., beneficiary correspondence that represents simple questions) can be responded to by phone. Use the correspondence that includes the requester's

telephone number or use a requester's telephone number from internal records if more appropriate for telephone responses. If the contractor cannot reach the requester by phone, it should not leave a message for the beneficiary to return the call. It should develop a written response within 45 calendar days from the incoming inquiry.

5. **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.
6. **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, etc.). Exception: Responses that are personal in nature (contain financial information, HICN, etc.) cannot be answered by e-mail.

## **20.2.2 - Replying to Correspondence from Members of Congress**

*(Rev. 3, 12-09-03)*

### **A3-3736**

Contractors follow these instructions when preparing replies to correspondence from Members of Congress.

#### **A - Congress Recessed**

Generally, the contractor sends the original and the courtesy copy of the reply to the Washington office of the Member of Congress. However, if it is clear that the inquiry was sent from a home office, the contractor directs the original and the courtesy copy there.

#### **B - Replying to a Letter Signed by More Than One Member of Congress**

When replying to a letter signed by more than one Member of Congress, the contractor prepares a reply for each Member and encloses a courtesy copy with each. The contractor states in the opening paragraph that the same reply is being sent to each person who signed the letter and makes an official file copy for each Member of Congress.

#### **C - Replying to More Than One Member of Congress on Same Case**

The contractor releases the replies to each Member of Congress at the same time. The contractor indicates that similar information is being sent to the other Member. The contractor may use the following in its final reply:

Similar information is being sent to (Senator or Representative) (name of Member of Congress) who also inquired on behalf of (name of beneficiary).

#### **D - Replying to a Letter Signed by an Employee in a Congressional Office**

The contractor addresses replies to the Members of Congress even when the inquiries are signed by staff members.

#### **E - Replying Directly to a Constituent at the Request of a Member of Congress**

When addressing a reply to a constituent, the contractor sends a tissue letterhead copy to the Member of Congress, along with a copy of the constituent's letter.

#### **F - Replies to Inquiries from Former Members of Congress**

Unless the former Member of Congress requests otherwise, the contractor addresses the reply to the constituent.

#### **G - Replying to Congressional and Noncongressional Inquiries**

The contractor releases the congressional reply one working day before the release of the noncongressional reply. The contractor indicates in the reply to the Member of Congress that similar information is being sent to the constituent (or third party, if applicable) in response to an inquiry sent directly to us by that person.

#### **H - Teletyping and Telephoning Award Information**

As a general rule, the contractor should not call or write a congressional office about a check that was released more than one week previously. Instead, the contractor sends a letter.

#### **I - Forms of Address**

When replying to the Washington office, address the letter:

Honorable \_\_\_\_\_  
United States Senate  
Washington, D.C. 20510

or Honorable \_\_\_\_\_  
House of Representatives  
Washington, D.C. 20515

Dear Senator \_\_\_\_\_:  
Address replies to the home office:

Dear Mr. or Ms. \_\_\_\_\_:



Honorable \_\_\_\_\_  
United States Senator

or

Honorable \_\_\_\_\_  
Member, United States House of  
Representatives

(local address)  
City, State, ZIP Code

(local address)  
City, State, ZIP Code

Dear Senator \_\_\_\_\_:

Dear Mr. or Ms. \_\_\_\_\_:

### **J - Courtesy Copies**

The contractor prepares a courtesy copy for each congressional response (including those requiring special handling).

### **K - Constituent's Letter**

Members of Congress frequently forward the constituent's letter for assistance in replying. The contractor should return the constituent's letter, if it is an original, with their first written response.

When the constituent's letter is the only enclosure, on the courtesy copy and all other copies of the reply (but NOT ON ORIGINAL), the contractor types:

Enclosure:

Constituent's inquiry

When an enclosure in addition to the constituent's letter is forwarded to the Member of Congress:

- On the original only, at the left margin two lines below the signer's title, the contractor types:

Enclosure

- On the copies, beginning at the same place (at the left margin), the contractor types:

Enclosures 2:

Including constituent's inquiry

The contractor does not mention the constituent's inquiry in the body of the response.

## **20.2.3 - Content of Request for Refund Letter**

*(Rev. 3, 12-09-03)*

### **A3-3711.5**

Any correspondence with a beneficiary concerning an overpayment must contain a clear and complete explanation of the overpayment. An overpayment that is not clearly explained is less likely to be refunded. Furthermore, lack of clarity may deprive the individual of sufficient information to decide whether there is a basis for questioning the contractor determination. Clarity is important because CMS and SSA may eventually use the letter for further recovery attempts. The contractor's letter and the referral form (Form CMS-2382) are usually the only sources available to CMS and the SSA for information regarding the overpayment.

The following is the minimum information to include in refund letters sent to a beneficiary:

- The name and address of the provider;
- Dates and type of services for which the overpayment was made;
- A clear explanation of why the payment was not correct;
- The amount of the overpayment and how it was calculated;
- A statement that the provider was without fault and that the individual is responsible for refunding overpayments where the provider was without fault;
- The refund should be by check or money order and how it should be made out (enclose preaddressed envelope);
- The refund can be made by installments (See Medicare Financial Management Manual.);
- That unless a refund is made, the overpayment will be referred to SSA for further recovery action;
- Possible recovery from other insurance (if applicable);
- An explanation of the beneficiary's right to a reconsideration or hearing as appropriate; and
- An explanation of the CMS/SSA waiver of recovery provisions. (See Medicare Financial Management Manual.)

## **20.2.3.1 - Sample Request for Refund Letter**

*(Rev. 3, 12-09-03)*

### **A3-3711.6**

The contractor may use or adapt the following model letter for requesting refunds of overpayments:

Dear Mr. \_\_\_\_\_:

#### **A - Opening Paragraph:**

In (month and year) we paid (provider's name and location) \$\_\_\_\_\_ as reimbursement for (inpatient) (outpatient) services provided to you from \_\_\_\_\_ through \_\_\_\_\_ on \_\_\_\_\_. We have reviewed the payment and determined that it was incorrect. The correct payment should have been \$\_\_\_\_\_. (Include a clear and complete explanation of how the overpayment arose (see [§20.2.3.2](#) for some suggested explanations), the amount of the overpayment, and how it was calculated.)

Add if applicable:

We have recovered \$\_\_\_\_\_ from (specify source). Thus, the total remaining overpayment is \$\_\_\_\_\_.

#### **B - Liability of Beneficiary**

Under the Medicare law, you are responsible for overpayments made on your behalf if the provider of services was not at fault in causing the overpayment. In this case, (provider's name) was not at fault. Therefore, you are liable for the \$\_\_\_\_\_ incorrectly paid for the services you received.

#### **C - Request for Refund**

Please send us a check or money order for \$\_\_\_\_\_, within 30 days. Make the check or money order payable to (contractor name), and mail it in the enclosed self-addressed envelope. If you do not repay this amount, this overpayment will be referred to the Social Security Administration (or Railroad Retirement Board) for further recovery action, which among other actions, may result in the overpayment being deducted from any monthly social security (or railroad retirement) benefits to which you may be entitled.

## **D - Installment Payments**

If you are unable to refund this amount in one payment, you may make regular installments. To refund in installments, you are required to pay a minimum of \$ \_\_\_\_\_ each month for \_\_\_\_\_ months. However, we urge you to pay more each month so that this matter can be settled as soon as possible. If you prefer to repay this overpayment through installments, please notify us promptly how much you are able to pay and how often.

## **E - Possible Recovery from Other Insurance**

(Do not use where it has been determined that the private insurer will not pay.)

If you carry private health insurance to supplement your Medicare benefits, you may be able to recover the amount of this overpayment by claiming benefits from the other plan, or (name of provider) may be able to submit such a claim on your behalf. If you plan to file a claim with a supplemental plan and use the proceeds to refund this overpayment, please let us know. If you need help in filing such a claim, please contact any Social Security office.

## **F - Notification of Appeal Rights**

The notification of appeal rights must be in accordance with the Appeals Chapter of the Medicare Claims Processing Manual.

**NOTE:** If the overpayment was for medically unnecessary services or for custodial care, begin the first sentence of the appeals paragraph:

If you believe that this determination is not correct, or if you did not know that Medicare does not pay for these services.

## **G - Notification of Waiver of Recovery Provision**

The law requires that you must repay an overpayment of Medicare benefits unless you meet **both** of the following conditions:

- You were without fault in causing the overpayment in that the information you furnished in connection with the claim was correct and complete to the best of your knowledge, and you had a reasonable basis for believing that the payment was correct, **and**
- Paying back the overpayment would keep you from meeting your ordinary and necessary living expenses **or** would be unfair.

If you claim that repayment will cause you serious financial hardship, it will be necessary to submit a statement to the Social Security Administration regarding your income, assets, and expenses.

If you believe that both conditions for waiver of this overpayment apply in your case, please let us know, giving a brief statement of your reasons. You may contact your Social Security office. You will be notified if recovery of this overpayment is waived. If waiver cannot be granted, you will have the opportunity to present your case at a personal conference. The conference will be conducted by an employee of the Social Security Administration who did not participate in the initial waiver determination.

### **20.2.3.2 - Optional Paragraphs for Inclusion in Refund Letters**

*(Rev. 3, 12-09-03)*

#### **A3-3711.7**

We suggest contractors use or adapt the following paragraphs in explaining how the overpayment occurred.

#### **A - Inpatient Hospital Deductible or Coinsurance Not Properly Assessed**

##### **1 - General**

Medicare pays all costs of covered services furnished during the first 60 days of hospitalization except for the first \$\_\_\_\_\_ (the inpatient deductible). For the 61st through the 90th days Medicare pays all costs except for a coinsurance of \$\_\_\_\_\_ per day. After 90 days of benefits have been used, an additional 60 lifetime reserve days are available. There is \$\_\_\_\_\_ per day coinsurance for each lifetime reserve day used.

##### **2 - Deductible Overpayment**

Our records show that the claim for the inpatient services you received at (provider's name) was improperly processed. Benefits were mistakenly paid for full \_\_\_\_\_ days. However, since these were the first inpatient hospital services furnished in this benefit period, the \$\_\_\_\_\_ inpatient hospital deductible should have been subtracted from the reimbursement paid (provider's name) on your behalf. Thus, (provider's name) was overpaid by \$\_\_\_\_\_.

##### **3 - Coinsurance Overpayment**

Our records show that the claim for the inpatient services you received at (provider's name and address) was improperly processed. Benefits were mistakenly paid for \_\_\_\_\_ full days (less the \$\_\_\_\_\_ deductible). However, since you had previously been hospitalized for \_\_\_\_\_ days at (name of provider where previously hospitalized) during that benefit period, your claim should have been processed as \_\_\_\_\_ full days and coinsurance days (and/or

lifetime reserve days). Therefore, (provider's name) has been overpaid on your behalf for \_\_\_\_\_ coinsurance days at \$\_\_\_\_\_ per day and/or lifetime reserve days at \$\_\_\_\_\_ per day less \$\_\_\_\_\_ for the inpatient hospital deductible which was improperly applied to your claim). The total overpayment is \$\_\_\_\_\_.

### **B - Payment Made Under WC**

We paid \$\_\_\_\_\_ in benefits for services furnished you by (provider's name and location) from \_\_\_\_\_ to \_\_\_\_\_. However, these payments were in error since these services were covered under the (State) workers' compensation law and Medicare may not pay for services which are covered under workers' compensation. Since (provider's name) was not at fault in causing this overpayment, you are required to refund the \$\_\_\_\_\_ Medicare paid on your behalf. You may wish to submit the bill for these services to your employer or his workers' compensation carrier for payment under the State workers' compensation provisions.

### **C - Beneficiary Not Entitled to Medicare Benefits**

The Social Security Administration's records show that you were not entitled to (specify Part A hospital insurance and/or Part B medical insurance) benefits when these services (item(s)) were furnished. Your "Medicare and You" Handbook explains the difference between Part A (hospital) and Part B (medical) insurance. The decision that you were not entitled to these benefits was made by the Social Security Administration, and not by (contractor name). Therefore, if you disagree with this decision or if you have any questions about your entitlement to Medicare benefits, contact your Social Security office. If you go to the Social Security office, take this letter with you.

## **20.2.3.3 - Recovery Where Beneficiary Is Deceased**

*(Rev. 3, 12-09-03)*

### **A3-3711.8**

When a beneficiary who is liable for an overpayment dies, the contractor attempts to recover from such sources as State welfare agencies, or private insurance plans (see MSP Manual, Chapter 7, Contractor MSP Recovery Rules), or withholds the overpayment from any underpayments due to the beneficiary's estate or due to a surviving relative.

If the entire overpayment cannot be recovered by the above methods, the contractor sends a letter (see sample below) addressed to the estate of the deceased at the address of the legal representative, if known, or to the last known address of the deceased. The contractor includes the basic information in [§20.2.3](#), but does not mention the possibility of installment payments or the possibility of offset against monthly benefits.

The contractor does not direct recovery efforts against a person who answered a recovery letter concerning an overpayment unless it is known that the individual represents the beneficiary's estate. The contractor does not recover by offset against underpayments payable to a provider of services or to a person (other than the beneficiary's estate) who paid the bill.

If a refund is not received within 30 days after writing to the estate, the contractor refers the case to CMS according to the rules in the Medicare Financial Management Manual, Chapter 3, "Overpayments," §140. The contractor includes any information it has about the appointment of a legal representative, copies of any correspondence with survivors or others concerning the overpayment, and any instructions received for filing a claim against the estate. The contractor annotates item 13, Remarks, of the referral form (Form CMS-2382) as follows: "Expedite. Case involves deceased beneficiary." If the file contains instructions for filing a claim against the estate, the contractor mentions this also.

When forwarding the overpayment to CMS, the contractor notifies any party that responded to its recovery letter that the case is being transferred to the Social Security Administration and that further recovery action will be taken by the agency.

**Model Refund Request to Estate of Deceased Beneficiary (Adapt to Fit the Situation)**

Estate of (deceased beneficiary) (or, if known, Representative of the Estate of (deceased beneficiary)).

Dear Sir (or Dear Ms. \_\_\_\_\_ if estate representative's name is known):

On (date) we paid (provider's name and location) \$\_\_\_\_\_ more than was due for inpatient services provided to (deceased beneficiary) from \_\_\_\_\_ through \_\_\_\_\_. (Include a clear and complete explanation of how the overpayment arose (see [§20.2](#) for some suggested explanations), the amount of the overpayment, how it was calculated, and why the payment was not correct.)

Add if applicable:

We have recovered \$\_\_\_\_\_ from (specify source). Thus, the total remaining overpayment is \$\_\_\_\_\_.

If other Medicare benefits become payable to the estate and you have not refunded the incorrect payment, we will withhold the amount owed from those benefits.

Under the Medicare law, the beneficiary is responsible for overpayments made on his behalf if the provider was not at fault in causing the overpayment. In this case, (provider's name) was not at fault. Therefore,

the estate of (deceased beneficiary) is liable for the \$\_\_\_\_\_ incorrectly paid to (provider's name) for the services it furnished (deceased beneficiary).

Please send us a check or money order in the amount of \$\_\_\_\_\_ payable to (contractor name) in the enclosed, self-addressed envelope within 30 days.

If we do not hear from you within 30 days, we will be required to refer this matter to the Social Security Administration (or Railroad Retirement Board) for further recovery action.

**NOTE:** Contractors undertake notification of appeal rights in accordance with the Appeals Chapter in the Medicare Claims Processing Manual.

If you believe that (deceased beneficiary) was without fault in causing this overpayment and that recovery of the overpayment would be unfair, you may request that recovery of the overpayment be waived. Your request should include a brief statement of your reasons for requesting waiver.

## **20.3 - Walk-In Inquiries**

*(Rev. 3, 12-09-03)*

### **A2-2958.C, B2-5104.C**

Contractors do not actively publicize the walk-in function. However, they give individuals making personal visits the same high level of service they 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, the contractor gives the beneficiary the same careful attention given during an "appeal," i.e., the opportunity to understand the decision made and an explanation of any additional information which may be submitted when an appeal is sought.

The contractor makes the same careful recording of the facts as for a telephone response, if it appears further contact or an appeal will be required.

### **20.3.1 - Guidelines for High Quality Walk-In Service**

*(Rev. 3, 12-09-03)*

#### **A2-2958.C.2, B2-5104.C.2**

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



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

## **20.4 - Surveys**

*(Rev. 3, 12-09-03)*

### **A2-2958.C, B2-5104.D**

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

**30 - Disclosure Desk Reference Guide for Call Centers**

*(Rev. 3, 12-09-03)*

**PM - AB-02-094**

<b>If The Contact Is:</b>	<b>And:</b>	<b>The Contractor Must:</b>	<b>Then Contractor Can:</b>	<b>Reference</b>
The beneficiary		Verify it is the beneficiary by asking for his/her: <ul style="list-style-type: none"><li>• Full name,</li><li>• Date of birth,</li><li>• HIC number,</li><li>• One additional piece of information such as:<ul style="list-style-type: none"><li>◦ SSN,</li><li>◦ Address,</li><li>◦ Phone number,</li><li>◦ Effective date(s),</li><li>◦ Whether he/she has Part A</li></ul></li></ul>	Release any entitlement and claim information and answer any questions pertaining to the beneficiary's Medicare coverage, except information related to diagnosis.	<a href="#">§20.2</a> above

If The Contact Is:	And:	The Contractor Must:	Then Contractor Can:	Reference
		and/or Part B coverage.		
The beneficiary	<p>The beneficiary makes a mistake on the information (name, Date of birth, HIC number or additional piece of information) used to verify his/her identity.</p> <p>Note: There is a 2-year tolerance for the year of birth (e.g., for a beneficiary born on 3/12/31, the years 1929, 1930, 1931, 1932 or 1933 may be accepted as the year of birth – 2 years prior and 2 years after the correct year of birth.) The month and day, must match exactly.</p>	<p>Explain to the beneficiary that the information does not match the information in the records. Ask him/her to repeat the information, and if still incorrect, suggest that the beneficiary look at his/her Medicare paperwork to find the correct information or ask someone (family or friend) to help him/her with this information.</p>	<p>If the beneficiary is able to provide the correct information, release per the instructions above.</p> <p>If the beneficiary is unable to provide the correct information, THE CONTRACTOR MAY NOT release any entitlement or claim information or answer any questions pertaining to the beneficiary.</p> <p>Advise the beneficiary that the information is protected under the Privacy Act and it is for the beneficiary’s protection that we will not release the information.</p>	<p>45 CFR Subtitle A 5b.5(b)(v)</p> <p>Medicare General Information, Eligibility and Entitlement, Chapter 6, “Disclosure of Information”</p>
Parent of a minor child	<p>A request for information from a minor child’s record by the child’s parent is an access request that must be honored, as</p>	<p>Verify the identity of the minor child by asking for his/her:</p> <ul style="list-style-type: none"> <li>• Full name,</li> </ul>	<p>Release any entitlement and claim information and answer any questions pertaining to the minor child’s Medicare coverage, except</p>	<p>Medicare General Information, Eligibility, and Entitlement Manual, Chapter 6, “Disclosure of Information,” §10.B</p>

<b>If The Contact Is:</b>	<b>And:</b>	<b>The Contractor Must:</b>	<b>Then Contractor Can:</b>	<b>Reference</b>
	long as it is clear that the parent is acting on the child's behalf.	<ul style="list-style-type: none"> <li>• Date of birth,</li> <li>• HIC number,</li> <li>• One additional piece of information such as:               <ul style="list-style-type: none"> <li>◦ SSN,</li> <li>◦ Address,</li> <li>◦ Phone number,</li> <li>◦ Effective date(s),</li> <li>◦ Whether he/she has Part A and/or Part B coverage.</li> </ul> </li> </ul> <p>Verify that the caller's name matches the parent's name listed in contractor files.</p>	information related to diagnosis.	
SSA-Appointed Representative Payee Or	To answer any questions via the telephone, the contractor must have	Verify that the caller's name matches the representative payee or legal guardian's name	Release any entitlement and claim information and answer any questions pertaining to the	Medicare General Information, Eligibility and Entitlement Manual, Chapter 6, "Disclosure of

<b>If The Contact Is:</b>	<b>And:</b>	<b>The Contractor Must:</b>	<b>Then Contractor Can:</b>	<b>Reference</b>
<p>A legal guardian of any individual who has been declared incompetent by the court</p>	<p>proof of the arrangement for services on file or the representative's name must appear on the system (e.g., Master Beneficiary Record (MBR), Supplemental Security Income Record (SSR), Health Insurance Master Record (HIMR) or Inquiry Response Numident Identification screen (QRID))</p>	<p>in contractor files.</p> <p>Have the representative payee or legal guardian provide the beneficiary's:</p> <ul style="list-style-type: none"> <li>• Full name,</li> <li>• Date of birth,</li> <li>• HIC number,</li> <li>• One additional piece of information such as: <ul style="list-style-type: none"> <li>◦ SSN,</li> <li>◦ Address,</li> <li>◦ Phone number,</li> <li>◦ Effective date(s),</li> <li>◦ Whether he or she has Part A and/or Part B coverage.</li> </ul> </li> </ul>	<p>beneficiary's Medicare coverage, except information related to diagnosis.</p>	<p>Information," §10.K</p> <p>SSA training module -</p> <p>Title II Claims Representative Basic Training Course</p> <p>(CR-02) "Disclosure/ Confidentiality/ Privacy Act/ Freedom of Information"</p>

<b>If The Contact Is:</b>	<b>And:</b>	<b>The Contractor Must:</b>	<b>Then Contractor Can:</b>	<b>Reference</b>
<p>Legal representative as defined by the State</p>	<p>Initially, these types of requests must come in as written requests in order to verify the relationship.</p> <p>To answer any questions via the telephone, the contractor must have proof of the arrangement for services on file or the representatives name must appear on the system (e.g., Master Beneficiary Record (MBR), Supplemental Security Income Record (SSR) or Inquiry Response Numident Identification screen (QRID)).</p> <p>The representative's name must match the name of the representative that is on file.</p>	<p>Verify the identify of the beneficiary by asking for his/her:</p> <ul style="list-style-type: none"> <li>• Full name,</li> <li>• Date of birth,</li> <li>• HIC number,</li> <li>• One additional piece of information such as: <ul style="list-style-type: none"> <li>◦ SSN,</li> <li>◦ Address,</li> <li>◦ Phone number,</li> <li>◦ Effective date(s),</li> <li>◦ Whether he or she has Part A and/or Part B coverage.</li> </ul> </li> </ul> <p>Verify that the caller's name matches the representative's name</p>	<p>Release information to legal representatives (such as an attorney) pertaining to the matter for which they have been appointed as representative. The contractor may assume the legal representative can receive any entitlement and claim information, except information related to diagnosis, on behalf of the beneficiary unless it is evident by the documentation that they represent the beneficiary for limited services (i.e., financial representative only.)</p>	<p>SSA training module - Title II Claims Representative Basic Training Course</p> <p>(CR-02) "Disclosure/Confidentiality/"</p> <p>"Privacy Act/ Freedom of Information"</p>

If The Contact Is:	And:	The Contractor Must:	Then Contractor Can:	Reference
		in contractor files.		
<p>A beneficiary's spouse, relative, friend, or advocacy group (<b>excluding</b> State Health Insurance Assistance Program (SHIP) employees and volunteers)</p>	<p>The beneficiary gives verbal consent for the contractor to speak with the contact.</p> <p>(The beneficiary does not have to remain on the line during the conversation, or even be at the same place as the contact - the contractor may obtain the beneficiary's consent to speak with the contact via another line or three way calling.)</p>	<p>Verify the identity of the beneficiary by asking the beneficiary for his/her:</p> <ul style="list-style-type: none"> <li>• Full name,</li> <li>• Date of birth,</li> <li>• HIC number,</li> <li>• One additional piece of information such as: <ul style="list-style-type: none"> <li>◦ SSN,</li> <li>◦ Address,</li> <li>◦ Phone number,</li> <li>◦ Effective date(s);</li> <li>◦ Whether he/she has Part A and/or Part B coverage.</li> </ul> </li> </ul> <p>A verbal consent is</p>	<p>Release any entitlement and claim information and answer any questions pertaining to the beneficiary's Medicare coverage, except information related to diagnosis.</p>	<p><a href="#">§20.2</a> above</p>

If The Contact Is:	And:	The Contractor Must:	Then Contractor Can:	Reference
		<p>good for 14 days. Advise the beneficiary and the contact that if the beneficiary wants the contact to receive information for more than 14 days, the beneficiary should send in a written authorization.</p>		
<p>A beneficiary's spouse, relative, friend, or advocacy group (excluding State Health Insurance Assistance Program (SHIP) employees and volunteers)</p>	<p>The beneficiary is not available to verbally consent for the contractor to speak with the caller and there is no written consent on file.</p>	<p>Advise the caller that the contractor may not give out any information without the beneficiary's consent.</p> <p>The caller may call back at a later time with the beneficiary present to give consent.</p> <p>-Or-</p> <p>The beneficiary could provide written consent authorizing caller to obtain information about his or her record.</p>	<p>THE CONTRACTOR MAY NOT release any claim information or answer any questions pertaining to the beneficiary.</p> <p>Advise the contact that the information is protected under the Privacy Act and it is for the beneficiary's protection that we will not release the information.</p>	<p><a href="#">§20.2</a> above</p> <p>Medicare General Information, Eligibility and Entitlement, Chapter 6, "Disclosure of Information," §40</p>
<p>A beneficiary's spouse, relative, friend, or</p>	<p>The contractor has written consent on file</p>	<p>The caller must provide the beneficiary's:</p>	<p>Only discuss information authorized by the written</p>	<p><a href="#">§20.2</a> above</p>



If The Contact Is:	And:	The Contractor Must:	Then Contractor Can:	Reference
advocacy group <b>(excluding</b> State Health Insurance Assistance Program (SHIP) employees and volunteers)	that allows it to give beneficiary-specific information to the caller.  See Notes at end of chart for information regarding written consent/authorization.	<ul style="list-style-type: none"> <li>• Full name,</li> <li>• Date of birth,</li> <li>• HIC number,</li> <li>• One additional piece of information such as:               <ul style="list-style-type: none"> <li>◦ SSN,</li> <li>◦ Address,</li> <li>◦ Phone number,</li> <li>◦ Effective date(s),</li> <li>◦ Whether he/she has Part A and/or Part B coverage.</li> </ul> </li> </ul> <p>Ensure that the caller is the authorized individual, and within the authorized time period (if specified).</p>	consent. The contractor may not discuss information related to diagnosis.	
A beneficiary's spouse,	Previous written	In order to access the	Unless contractor receives	<a href="#">§20.2</a> above

<b>If The Contact Is:</b>	<b>And:</b>	<b>The Contractor Must:</b>	<b>Then Contractor Can:</b>	<b>Reference</b>
<p>relative, friend, or advocacy group (excluding State Health Insurance Assistance Program (SHIP) employees and volunteers)</p>	<p>consent has expired</p>	<p>beneficiary's record, the caller must provide the beneficiary's:</p> <ul style="list-style-type: none"> <li>• Full name,</li> <li>• Date of birth,</li> <li>• HIC number,</li> <li>• One additional piece of information such as: <ul style="list-style-type: none"> <li>◦ SSN,</li> <li>◦ Address,</li> <li>◦ Phone number,</li> <li>◦ Effective date(s),</li> <li>◦ Whether he/she has Part A and/or Part B coverage.</li> </ul> </li> </ul> <p>Advise the caller that the written consent has expired.</p>	<p>a verbal consent, IT MAY NOT release any claim information or answer any questions pertaining to the beneficiary.</p> <p>Advise the caller that the information is protected under the Privacy Act and it is for the beneficiary's protection that we will not release the information.</p> <p>However, if the caller has a question about a specific claim, see the instructions regarding release of information on a specific claim.</p>	

If The Contact Is:	And:	The Contractor Must:	Then Contractor Can:	Reference
		Obtain the beneficiary's verbal consent and/or develop for a new written consent.		
<p>A beneficiary's spouse, relative, friend, or advocacy group is requesting information on a specific claim</p> <p>(No MSN)</p>	<p>The beneficiary is not available to verbally consent for the contractor to speak with the caller and there is no written consent on file, however the caller has the beneficiary's</p> <ul style="list-style-type: none"> <li>• Full name,</li> <li>• Date of birth,</li> <li>• HIC number,</li> <li>• Information on a specific claim (e.g., date of service, physician name, procedure).</li> </ul>	Suggest that the caller have the beneficiary forward written consent/authorization to the Call Center if he/she anticipates any need for future telephone contacts	<p>Release information only</p> <p>On whether or not the claim has been received or processed, and</p> <p>The date the beneficiary can expect to receive the MSN.</p>	<a href="#">§20.2</a> above
A beneficiary's spouse, relative, friend, or advocacy group is	The beneficiary is not available to verbally consent/authorize the	Suggest that the caller have the beneficiary forward written	Only release information for the service(s) that appear on the MSN.	<a href="#">§20.2</a> above

<b>If The Contact Is:</b>	<b>And:</b>	<b>The Contractor Must:</b>	<b>Then Contractor Can:</b>	<b>Reference</b>
<p>requesting information on a specific claim</p> <p>(Has MSN)</p>	<p>contractor to speak with the caller and there is no written consent/authorization on file, however the caller has the beneficiary's:</p> <ul style="list-style-type: none"> <li>• Full name;</li> <li>• Date of birth;</li> <li>• HIC number; and</li> <li>• Copy of the MSN.</li> </ul>	<p>consent/authorization to the Call Center if he/she anticipates any need for future telephone contacts.</p>		
<p>A beneficiary's spouse, relative, friend, or advocacy group (excluding State Health Insurance Assistance Program (SHIP) employees and volunteers)</p>	<p>The caller states that the beneficiary is deceased. The contractor DOES NOT have proof of death (i.e., date of death shown on Common Working File (CWF) or copy of death certificate).</p>	<p>In order to access the beneficiary's record, the contact must provide the beneficiary's:</p> <ul style="list-style-type: none"> <li>• Full name,</li> <li>• Date of birth,</li> <li>• HIC number,</li> <li>• One additional piece of information such as:</li> </ul>	<p>THE CONTRACTOR MAY NOT release any claim information or answer any questions pertaining to the beneficiary.</p> <p>Advise the contact that the information is protected under the Privacy Act and it is for the beneficiary's protection that we will not release the information.</p> <p>However, if the caller has a question about a specific</p>	<p>Medicare General Information, Eligibility and Entitlement, Chapter 6, "Disclosure of Information," §70</p>

If The Contact Is:	And:	The Contractor Must:	Then Contractor Can:	Reference
		<ul style="list-style-type: none"> <li>o SSN,</li> <li>o Address,</li> <li>o Phone number,</li> <li>o Effective date(s),</li> <li>o Whether he/she has Part A and/or Part B coverage.</li> </ul> <p>Advise the contact to notify SSA at 1-800-772-1213 that beneficiary is deceased.</p>	claim, see the instructions regarding release of information on a specific claim.	
A beneficiary's spouse, relative, friend, or advocacy group ( <b>excluding</b> State Health Insurance Assistance Program (SHIP) employees and volunteers)	The beneficiary is deceased and the contractor has proof that the beneficiary is deceased (e.g., date of death shown on Common Working File (CWF), MBR or copy of death certificate).	<p>In order to access the beneficiary's record, the contact must provide the beneficiary's:</p> <ul style="list-style-type: none"> <li>• Full name,</li> <li>• Date of birth,</li> <li>• HIC number,</li> <li>• One additional</li> </ul>	<p>When a beneficiary is deceased, (and we have proof) they are no longer protected under the Privacy Act; therefore any information may be released as long as it is not harmful to the family or to the estate.</p> <p><b>(NOTE:</b> The HIPAA privacy regulation will extend privacy protections</p>	Medicare General Information, Eligibility and Entitlement, Chapter 6, "Disclosure of Information," §70

<b>If The Contact Is:</b>	<b>And:</b>	<b>The Contractor Must:</b>	<b>Then Contractor Can:</b>	<b>Reference</b>
		<p>piece of information such as:</p> <ul style="list-style-type: none"> <li>o SSN,</li> <li>o Address,</li> <li>o Phone number,</li> <li>o Effective date(s),</li> <li>o Whether he/she has Part A and/or Part B coverage.</li> </ul>	<p>to the deceased. The effective date for implementation of the privacy regulation is April 2003.)</p>	
<p>A CMS employee</p>	<p>The CMS employee provides the following information in order to identify the beneficiary in question.</p> <ul style="list-style-type: none"> <li>• Full name</li> <li>• Date of birth</li> <li>• HIC number</li> <li>• One additional piece of</li> </ul>	<p>There are three ways that a CSR may verify that he/she is speaking with a CMS employee.</p> <ol style="list-style-type: none"> <li>1. Both parties on the call look at the CWF or MBR record (or other beneficiary record to which they both have access). The CSR or CMS employee can name</li> </ol>	<p>If the CSR is reasonably certain that he/she is speaking to a CMS employee, the CSR may release any claim information and answer any questions pertaining to the beneficiary's Medicare coverage.</p>	<p>45 CFR Subtitle A 5b.5 (v)</p> <p>Medicare General Information, Eligibility and Entitlement, Chapter 6, "Disclosure of Information," §50</p>

If The Contact Is:	And:	The Contractor Must:	Then Contractor Can:	Reference
	<p>information such as:</p> <ul style="list-style-type: none"> <li>o SSN,</li> <li>o Address,</li> <li>o Phone number,</li> <li>o Effective date(s),</li> <li>o Whether he/she has Part A and/or Part B coverage.</li> </ul>	<p>a field on the CWF or MBR and ask that the other party identify what is in that particular field.</p> <p><b>OR</b></p> <p>2. The CSR may ask for the CMS employee's phone number and call him/her back, making sure that the area code and exchange are correct for the CO or RO location;</p> <p><b>NOTE:</b> Caller ID or similar service may be used to verify the area code and exchange in lieu of a callback.</p> <p><b>OR</b></p> <p>The CSR may take the name and number of the agency employee, the name and number</p>		

<b>If The Contact Is:</b>	<b>And:</b>	<b>The Contractor Must:</b>	<b>Then Contractor Can:</b>	<b>Reference</b>
		of his/her supervisor, the date and reason for the inquiry, and post this information to the “NOTES” screen.		



If The Contact Is:	And:	The Contractor Must:	Then Contractor Can:	Reference
<p>An employee of another Federal agency (e.g., SSA, RRB, VA, DoD) who needs the information to perform their duties</p>	<p>The employee of the other agency provides the following information in order to identify the beneficiary in question:</p> <ul style="list-style-type: none"> <li>• Full name,</li> <li>• Date of birth,</li> <li>• HIC number,</li> <li>• One additional piece of information such as: <ul style="list-style-type: none"> <li>◦ SSN,</li> <li>◦ Address,</li> <li>◦ Phone number,</li> <li>◦ Effective date(s), whether he/she has Part A and/or Part B coverage.</li> </ul> </li> </ul> <p>Ensure that the reason</p>	<p>There are three ways that a CSR may verify that he/she is speaking with an employee of another agency.</p> <ol style="list-style-type: none"> <li>1. Both parties on the call look at the MBR record (or other beneficiary record to which they both have access). The CSR can name a field on the MBR and ask that the other agency's employee identify what is in that particular field.</li> </ol> <p><b>OR</b></p> <ol style="list-style-type: none"> <li>2. The CSR may ask for the employee's phone number and call him/her back, making sure that the area code and exchange matches a listed phone number for that</li> </ol>	<p>If the CSR is reasonably certain that he/she is speaking to the other agency's employee, the CSR may release any claim information and answer any questions related to the administration of that agency's program.</p>	<p>Medicare General Information, Eligibility and Entitlement, Chapter 6, "Disclosure of Information"</p>

If The Contact Is:	And:	The Contractor Must:	Then Contractor Can:	Reference
	for the inquiry is related to the administration of that agency's program.	agency;  <b>NOTE:</b> Caller ID or similar service may be used to verify the area code and exchange in lieu of a callback.  <b>OR</b>  The CSR may take the name and number of the agency employee, the name and number of his/her supervisor, the date and reason for the inquiry, and post this information to the "NOTES" screen.		
State Agencies administering Medicaid		Inform the caller that State agencies must get this information through the channels formerly referred to as BEST/CASF.	Advise the caller that instructions on the process can be found at <a href="http://www.cms.hhs.gov/medicaid/smd90600.htm">http://www.cms.hhs.gov/medicaid/smd90600.htm</a>	Medicare General Information, Eligibility and Entitlement, Chapter 6, "Disclosure of Information," §140.1  <a href="http://www.cms.hhs.gov/medicaid/smd90600.htm">http://www.cms.hhs.gov/medicaid/smd90600.htm</a>

<b>If The Contact Is:</b>	<b>And:</b>	<b>The Contractor Must:</b>	<b>Then Contractor Can:</b>	<b>Reference</b>
Complementary health insurance (Medigap, complementary crossover, supplemental)	The beneficiary has signed an agreement with the complementary health insurer granting that company the authorization to receive Medicare claim information.	<p>Verify the complementary health insurer is identified on the beneficiary's file.</p> <p>Verify the identity of the beneficiary in question by asking for his/her:</p> <ul style="list-style-type: none"> <li>• Full name;</li> <li>• Date of birth;</li> <li>• HIC number; and</li> <li>• One additional piece of information such as: <ul style="list-style-type: none"> <li>◦ SSN,</li> <li>◦ Address,</li> <li>◦ Phone number, effective date(s),</li> <li>◦ Whether he/she has Part A and/or Part B</li> </ul> </li> </ul>	Answer any question pertaining to the beneficiary's claims that should have crossed over to the complementary insurer.	<p>Medicare General Information, Eligibility and Entitlement, Chapter 6, "Disclosure of Information," §140.1</p> <p><a href="http://www.cms.hhs.gov/medicaid/smd90600.htm">http://www.cms.hhs.gov/medicaid/smd90600.htm</a></p>

If The Contact Is:	And:	The Contractor Must:	Then Contractor Can:	Reference
		coverage.		
Medicare Contractor (Fiscal Intermediary/Carrier/ DMERC/RHHI)	<p>The Medicare Contractor being contacted processed the claim in question.</p> <p>Verify the identity of the beneficiary in question by asking for his/her:</p> <ul style="list-style-type: none"> <li>• Full name;</li> <li>• Date of birth;</li> <li>• HIC number; and</li> <li>• One additional piece of information such as:               <ul style="list-style-type: none"> <li>◦ SSN,</li> <li>◦ Address,</li> <li>◦ Phone number,</li> <li>◦ Effective date(s), whether he/she has Part A</li> </ul> </li> </ul>	<p>There are three ways that a CSR may verify that he/she is speaking with an employee of another agency.</p> <ol style="list-style-type: none"> <li>1. Both parties on the call look at the MBR record (or other beneficiary record to which they both have access). The CSR can name a field on MBR and ask that the other agency's employee identify what is in that particular field.</li> </ol> <p><b>OR</b></p> <ol style="list-style-type: none"> <li>2. The CSR may ask for the employee's phone number and call him/her back, making sure that the area code and exchange matches a listed phone</li> </ol>	<p>If the CSR is reasonably certain that he/she is speaking to the other contractor's employee, the CSR may release any claim information and answer any questions pertaining to the beneficiary's claims that were processed by the Medicare Contractor being contacted.</p>	<p>Medicare General Information, Eligibility and Entitlement, Chapter 6, "Disclosure of Information," §140.1</p> <p><a href="http://www.cms.hhs.gov/medicaid/smd90600.htm">http://www.cms.hhs.gov/medicaid/smd90600.htm</a></p>

If The Contact Is:	And:	The Contractor Must:	Then Contractor Can:	Reference
	<p>has Part A and/or Part B coverage.</p>	<p>number for that agency;</p> <p><b>NOTE:</b> Caller ID or similar service may be used to verify the area code and exchange in lieu of a callback.</p> <p><b>OR</b></p> <p>3. The CSR may take the name and number of the agency employee, the name and number of his/her supervisor, the date and reason for the inquiry, and post this information to the “NOTES” screen.</p>		
<p>Other Health Insurer (MSP involved)</p>	<p>The beneficiary has signed an agreement with the health insurer granting that company the right to coordinate benefits with Medicare.</p>	<p>Verify the identity of the beneficiary in question by asking for his/her:</p> <ul style="list-style-type: none"> <li>• Full name;</li> <li>• Date of birth;</li> </ul>	<p>The contractor may answer any questions pertaining to the beneficiary’s file that are necessary to coordinate benefits.</p>	<p>Medicare General Information, Eligibility and Entitlement, Chapter 6, “Disclosure of Information,” §140.1</p> <p><a href="http://www.cms.hhs.gov/medicaid/smd90600.htm">http://www.cms.hhs.gov/medicaid/smd90600.htm</a></p>

If The Contact Is:	And:	The Contractor Must:	Then Contractor Can:	Reference
		<ul style="list-style-type: none"> <li>• HIC number; and</li> <li>• One additional piece of information such as:               <ul style="list-style-type: none"> <li>◦ SSN,</li> <li>◦ Address,</li> <li>◦ Phone number,</li> <li>◦ Effective date(s),</li> <li>◦ Whether he/she has Part A and/or Part B coverage.</li> </ul> </li> </ul> <p>Refer the caller to the Coordination of Benefits (COB) Contractor for all MSP inquiries (<b>except claims-related questions which must be addressed by the carrier, intermediary, or DMERC</b>)</p>		

If The Contact Is:	And:	The Contractor Must:	Then Contractor Can:	Reference
		<p>including:</p> <ul style="list-style-type: none"> <li>• The reporting of potential MSP situations</li> <li>• Changes in a beneficiary's insurance coverage</li> <li>• Changes in employment,</li> <li>• All other general MSP questions.</li> <li>• Questions in regards to completing the Initial Enrollment Questionnaire.</li> </ul> <p>COB Contractor Number 1-800-999-1118</p> <p>The COB contractor Web site may be accessed at:</p>		

If The Contact Is:	And:	The Contractor Must:	Then Contractor Can:	Reference
		<p data-bbox="869 267 1178 337"><a href="http://cms.hhs.gov/medicare/cob/">http://cms.hhs.gov/medicare/cob/</a>.</p> <p data-bbox="869 440 1010 472">TTY/TDD</p> <p data-bbox="869 508 1083 540">1-800-318-8782</p> <p data-bbox="869 643 1142 712">CSRs are available 8 a.m. to</p> <p data-bbox="869 748 1157 781">8 p.m. (Eastern Time)</p>		
<p data-bbox="184 820 485 1036">An institutional provider, physician, supplier, or other provider (received on the beneficiary inquiry line)</p>			<p data-bbox="1203 820 1524 889">Refer the provider to the provider inquiry line.</p> <p data-bbox="1203 925 1545 1252">If the contractor’s call center is blended (CSRs answer both beneficiary and provider inquiries simultaneously), the contractor may answer the provider’s inquiry according to the provider line guidelines.</p> <p data-bbox="1203 1287 1539 1421">The contractor may speak with that provider only about his/her own claims. The contractor may not</p>	<p data-bbox="1570 820 1900 1036">Medicare General Information, Eligibility and Entitlement, Chapter 6, “Disclosure of Information,” §50 and §60</p>



<b>If The Contact Is:</b>	<b>And:</b>	<b>The Contractor Must:</b>	<b>Then Contractor Can:</b>	<b>Reference</b>
			discuss other provider's claims.	

## General Notes and Definitions:

Access	Releasing information in a Medicare record directly to the beneficiary to whom it pertains. A natural or adoptive parent of a minor child or legal guardian can also have access when acting on behalf of the individual. A minor child may access his/her own record. Any person may have access to information (except information related to diagnosis) maintained in his/her own record after identifying his/herself.
Disclosure	Releasing information in a Medicare record to anyone other than the subject individual, legal guardian or parent of minor. The individual to whom the information pertains must consent to, or authorize, (either verbally or in writing) the disclosure of his/her personal information to the third party
Representative Payee	This is a person or organization appointed by the Social Security Administration (SSA) when it is determined that the beneficiary is unable (due to mental or physical incapability) to handle, manage or direct someone else to manage his/her own benefits, and it is determined to be in the best interest of the beneficiary to appoint a payee. The beneficiary does not have to be declared legally incompetent in order to use or have a representative payee, however if a beneficiary is judged legally incompetent, they must have a payee. The representative payee may make any request or give any notice on behalf of the beneficiary. He/she may give or draw out evidence of information, get information, and receive any notice in connection with a pending claim or asserted rights. The payee has the responsibility to handle all matters related to Social Security and Medicare on behalf of the beneficiary.
Legal Representative	A “LEGAL REPRESENTATIVE” is appointed by the beneficiary to handle specific areas of concern on his/her behalf. The legal representative may only receive information related to the reason he/she was appointed (i.e., health care decisions, financial matters, etc.). The beneficiary does not have to be unable to handle his/her affairs.
Designated Representative other than “Legal Representative”	<p>See <a href="#">§20.2</a> for a discussion of how to deal with a party that proposes to represent the beneficiary but has not been legally designated by the beneficiary as a representative.</p> <p>Certain individuals are entitled to Medicare but not entitled to Social Security benefits and are directly billed for the Medicare premium payments. If SSA determines that an individual is not capable of handling his/her premium payments, or at the individual’s request, SSA will appoint a premium payer. A premium payer is similar to a representative payee and can be given information related to Medicare claims.</p>

## Notes for Desk Reference Guide

The State Health Insurance Assistance Program (SHIP) employees and volunteers are not addressed in these guidelines. The contractor disclosure instructions for the SHIP employees and volunteers will be addressed as a separate issue. Contractors continue current practice until such instructions are published.

An individual who makes a request by telephone must verify his or her identity by providing identifying particulars, which parallel the record to which notification or access is being sought. If the CSR determines that the particulars provided by telephone are insufficient, the requestor will be required to submit the request in writing or in person. Telephone requests will not be accepted where an individual is requesting notification of, or access to, sensitive records such as medical records.

Always remember that access and disclosure involve looking at a Medicare record and giving out information. If contractors do not have to look at a record (for example, in explaining a letter), access and disclosure rules are not involved. General (that is, non beneficiary-specific) information may be discussed at any time with any caller.

Medicare Customer Service Center (MCSC) employees must follow the MCSC rules governing disclosure, which requires CSRs to obtain at least four items of information to identify the beneficiary for claims information and six items when accessing the MBR or EDB. For consistency among contractors, we recommend that three of those items are the beneficiary's name, HIC number, and date of birth.

On all Medicare Customer Service Center (MCSC) calls dealing with Managed Care issues other than enrollment/disenrollment issues and dates, CSRs refer the contact to the Managed Care organization. Contractors may not release any Managed Care claims information.

**NOTE:** Representative payees are not authorized to enroll or disenroll beneficiaries in Managed Care organizations, unless the representative payee has that authority under State law.

A written consent/authorization must:

- Be signed by the beneficiary and dated by the beneficiary;
- Specify the individual, organization unit, class of individuals or organizational units to which the information may be disclosed;
- Specify the records, information, or types of information that may be disclosed; and
- Indicate whether the consent is a one-time, a limited time, or an ongoing release.

For non-English speaking beneficiaries, the contractor must obtain the beneficiary's identifying information and verbal consent (via the AT&T language line or similar service, or other interpreter) prior to speaking with the friend, relative, etc.

Blended call centers (those that answer both beneficiary and provider calls at the same place) may choose to answer provider calls on the beneficiary line if they have the ability to track the calls appropriately. Otherwise, they should refer the contact to the appropriate provider inquiry number.

When there is a systems problem that causes a claim to be rejected or denied, it is the contractor's responsibility to accept the information from the provider in order to make corrections that will allow the claim to be processed. It is at the discretion of the contractor as to whether certain types of calls may be referred to the provider representatives or whether to utilize the beneficiary representative to resolve the issue in the most cost effective and efficient manner.

If the Automated Voice Response (ARU) or Interactive Voice Response (IVR) system obtains the beneficiary's name, HIC number and DOB, and one additional piece of information (such as SSN, address, phone number, effective date(s), whether they have Part A and/or Part B coverage) prior to the CSR answering, and this is evident to the CSR, it is not necessary to obtain that information again. The CSR should ask to whom they are speaking just to ascertain if it is the beneficiary or someone acting on the beneficiary's behalf.

The contractor can discuss diagnosis denials such as medical necessity, MSP, and routine diagnosis services in order to explain the reason the claim was denied. The contractor assists the caller if the diagnosis is in dispute.

#### **EXAMPLE 1**

The patient's claim denied for a routine physical exam (program exclusion). The CSR explains the reason the claim was denied was because of the routine diagnosis submitted on the claim. The patient explains that he/she was seeing the doctor for back pain. The CSR needs to advise the caller to contact the physician to discuss the reported diagnosis.

#### **EXAMPLE 2**

After receiving an auto/liability questionnaire, the beneficiary calls to report a service noted was not related to an accident/injury. The CSR should check the claims history to verify the presence of an open MSP auto/liability segment with an unrelated diagnosis. If an open MSP segment and an unrelated diagnosis are present on the claim, the CSR should follow established procedure for overriding the edit and adjusting the claim. This may include contacting the provider office first to confirm whether an erroneous unrelated diagnosis was reported. If an unrelated diagnosis was erroneously reported, the CSR may initiate an adjustment after receiving confirmation of the incorrect reporting from the provider office. For situations not specifically addressed here, the CSR should use his/her discretion, taking care to protect the beneficiary's privacy and confidentiality.

Refer situations in which the CSR is unsure of whether or not to release information to his/her supervisor or to the organization's privacy official.

Frequently Asked Questions on this topic may be found at <http://www.cms.hhs.gov/callcenters/qanda.asp>.

# Medicare Contractor Beneficiary and Provider Communications Manual

## Chapter 3 - Provider Customer Services

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### **10 - Introduction**

**(Rev. 1, 10-01-03)**

This chapter contains general instructions and requirements for Medicare carriers, including DMERCs and intermediaries for processing correspondence. Normally, the term "contractor" is used in this manual to mean any or all of these. If an instruction should apply to only one type of contractor, this will be specified.

## **20 - Provider Services**

*(Rev. 3, 12-09-03)*

### **A2-2959, B2-5105**

The Centers for Medicare & Medicaid Services' (CMS) goal is to continuously improve the Medicare customer satisfaction through the delivery of high quality and cost-effective customer service. Every member of the customer service team should be committed to providing the highest level of service to our partner, the Medicare provider. This commitment should be reflected in the manner in which each provider inquiry is handled. The following guidelines are designed to help ensure that the CMS high standards of service are met.

### **20.1 - Written Inquiries**

*(Rev. 3, 12-09-03)*

#### **A2-2959, B2-5105.A**

#### **20.1.1 - Requirements for Handling Written Inquiries**

*(Rev. 3, 12-09-03)*

##### **A2-2959.A, B2-5105.A.1**

- **Date Stamping:** Contractors must stamp all written inquiries with the date of receipt in the corporate mailroom and control them until final answers are sent.
- **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 contractors 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).

Contractors must 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 the most efficient for the conditions. If contractors 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 provider 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: provider's name and address, telephone number, provider number, date of contact, internal inquiry control number, subject, summary of discussion, status action required (if any) and the name of the customer service representative who handled the inquiry. Upon request, send the provider 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 discretion when identifying which written inquiries (i.e., provider correspondence that represents 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 the requestor cannot be reached by phone, contractors do not leave a message for the provider to return the call. A written response should be developed within 45 calendar days from the incoming inquiry if the matter cannot be resolved by phone.

- **Typewritten Responses:** All responses must be typewritten 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 provider.
- **Contact Information:** Include a contact's name and telephone number in the response.
- **Appeal Requests:** Forward all valid appeals requests to the appeals unit for handling.
- **CMS Alpha Representation:** Include the official CMS alpha representation on all responses.
- **Reproduction:** Keep responses in a format from which reproduction is possible.



## **20.1.2 - Requirements for Responding to Written Inquiries**

*(Rev. 3, 12-09-03)*

### **A2-2959.A.2, B2-5105.A.2, B2-5105.A.3**

Contractors must establish and implement a written plan to strengthen the quality of written responses. The plan should include an internal review process and activities to ensure that the quality of communications is continuously improving. These responses should be reviewed and appraised based on the following requirements for written inquiries:

- **Accuracy** - Content is correct with regard to Medicare policy and contractor data. Overall, the information broadened the writer's understanding of the issues that prompted the inquiry.
- **Responsiveness** - The response addresses the writer's major concerns and states an appropriate action to be taken.
- **Clarity** - Letters have good grammatical construction, sentences are of varying lengths (as a general rule, keep the average length of sentences to no more than 12-15 words), and paragraphs generally contain no more than five sentences. All written inquiries are to be processed using a font size of 12 points and a font style of Universal or Times New Roman or another similar style for ease of reading by the provider.
- **Timeliness** - Substantive action is taken and an interim or a 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 the delay. All responses, including computer-generated letters and form letters, should be user-friendly and understandable by the reader.

If the contractor is responsible for handling both Part A and Part B claims, inquiries requiring response from both of these areas share the same timeframe for response (i.e., the 45-day period starts on the same day for both responses).

Contractor personnel must 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 a contractor's conditions. If the contractor responds separately, each response must refer to the fact that the other area of inquiry will be responded to separately.

Every contractor must have the flexibility to respond to provider written inquiries by phone within 45 calendar days. They should develop a report of contact for tracking purposes. It should include:

- Provider's name and address,
- Telephone number;
- Provider number;
- Date of contact;
- Internal inquiry control number;
- Subject;
- Summary of discussion;
- Status, action required (if any); and
- The name of the customer service representative who handled the inquiry.

Upon request, the contractor sends the provider a copy of the report of contact that results from the telephone response. The contractor retains the report of contact in the same manner and time frame as it does for written responses.

The contractor uses its discretion to identify which written inquiries (e.g., provider correspondence that represent simple questions) it can answer by phone. It uses the correspondence, which includes the requestor's telephone number or it obtains a requestor's telephone number from internal records if it can more appropriately respond to the inquiry by telephone. If the contractor cannot reach the requester by phone, it does not leave a message for the requester to return the call. It prepares a written response within 45 calendar days from the incoming inquiry if it cannot resolve the matter by phone.

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

## **A - Written Inquiries Files**

- Some contractors house files at a remote location during the year due to costs and space constraints. Those contractors must notify CMS within six 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. In the event an onsite CPE review is conducted, contractors are required to allow CMS access to all written inquiries stored off site within 1 day of notification to the contractor.
- All written inquiries, whether maintained on site or off site, must be clearly identified and filed in a manner that will allow 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.

Effective FY 2003, all contractors will be expected to:

- Involve clinicians as needed in developing responses to coverage/coding inquiries from providers.
- Use clinicians in scoring the accuracy of responses to coverage/coding inquiries in their quality appraisal program

## **B - E-mail Inquiries**

Any E-mail inquiry received can be responded to by E-mail. Since E-mail represents official correspondence with the public, it is paramount that contractors use sound E-mail practices and proper etiquette when communicating electronically. Responses that are personal in nature (contain financial information, HIC#, etc.) cannot be answered by E-mail. Contractors must ensure that all E-mail responses utilize the same guidelines that pertain to written inquiries (i.e., timeliness, accuracy, clarity, tone, comprehension, etc.).

## **20.2 - Telephone Inquiries**

*(Rev. 3, 12-09-03)*

**A2-2959.C, B2-5105.C**

The guidelines established below apply to all calls to telephone numbers the contractor established as general provider inquiry numbers. The standards do not apply to those inquiries handled by other units within the contractor (i.e. appeals, fraud, MSP). To ensure all inquiries are handled as expeditiously as possible, inbound provider inquiry numbers (and the lines) must be separate from

beneficiary inquiry numbers. Providers should not use numbers established for inquiries from beneficiaries. (For MSP Situations, see Medicare Secondary Payer (MSP) Manual, Chapter 4, §§10, 80, 110; and Chapter 5, §10.)

## **A - Availability of Telephone Service**

Contractors must:

1. **Hours of Operation:** Make live telephone service available to callers continuously during normal business hours--including break and lunch periods. The minimal “normal business hours” for live telephone services are 9:00 a.m. until 3:30 p.m. for all time zones of the geographical area serviced, Monday through Friday. Where contractors provide national coverage or where contractors serve areas outside of the continental United States, CMS will entertain a request for a waiver related to standard hours of operation.
2. **IVR Hours of Operation:** To the extent possible, the IVR shall be available to providers from 6:00 a.m. through 10:00 p.m. in their local prevailing time, Monday through Friday, and from 6:00 a.m. until 6:00 p.m. on weekends. Allowances may be made for normal claims processing system and mainframe availability, as well as normal IVR and system maintenance. Contractors should identify what services can be provided to providers during the processing system unavailable time.

**NOTE:** Interactive Voice Response Units (IVR) should be programmed to provide callers with an after-hours message indicating normal business hours. (It is not necessary to duplicate this message if the caller is informed of the normal business hours via the telephone system prior to being delivered to the IVRs)

3. **Delay Message:** Although the provider should have the ability to speak with a CSR during operating hours, if callers encounter a temporary delay before a CSR is available, a recorded message will inform them of the delay. The message will also request that the provider have certain information readily available before speaking with the agent. During peak volume periods, the message shall indicate the preferred time to call.
4. At the beginning of each fiscal year, contractors will send CMS their list of call center holiday closures for the entire fiscal year. This information should be sent to: [ServiceReports@cms.hhs.gov](mailto:ServiceReports@cms.hhs.gov). On Federal holidays, in lieu of answering telephone inquiries, contractors may choose to perform other appropriate call center work (e.g., provide CSR training).
5. **Call Center Staffing:** 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 the workday is maintained in accordance with call center standards. Telephone service must not be interrupted in order to conduct CSR training.

6. CSR Identification to Callers: CSRs must identify themselves when answering a call, however the use of both first and last names in the greeting will be 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. The CSRs should also follow local procedures for escalating calls to supervisors or managers in situations where warranted.
7. 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.

With automated tools being available for improving customer service while simultaneously managing cost, emphasis must be placed on developing and implementing self-service capabilities through the utilization of IVR. The contractor should strive to use the IVRs based upon lessons learned and best practices throughout CMS and its partners. All contractors are required to utilize an IVR that meets the following guidelines:

- Busy Signals: Call center customer premise equipment should not be configured/programmed to return “soft busies.” Contractor call centers shall only provide “hard” busy signals to the FTS network. At no time, shall any software, gate, vector, application, IVR, and/or ACD/PBX accept the call by providing answer back supervision to the FTS network and then providing a busy signal to the caller and/or dropping the call. The contractor should optimize their inbound toll-free circuits to ensure the proper ratio of circuits to existing FTEs.
- IVR Content: The IVR should offer at least the following information:
  1. Contractor hours of operations for inbound Medicare provider CSR service announced to callers after the hours of CSR availability and during peak times when a caller may be waiting on hold.
  2. General Medicare program information.
  3. Specific information regarding claims in process and claims completed.
  4. A statement if additional evidence is needed to have a claim processed.
  5. Information about appeal rights and actions required of a provider to exercise these rights.

- IVR Call Flow: Call centers must submit to CMS a call flow document that outlines their IVR scripts and call flow, clearly showing all provider inquiry transactions that they are performing through the IVR. Contractors must also indicate how they are authenticating the call when claim 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 (RO) and the central office (CO) at ServiceReports@cms.hhs.gov. If the contractor changes the IVR script or call flow, they must submit a revised document to these parties within 2 WEEKS OF IMPLEMENTING THE CHANGES.
- IVR Operating Guide: The contractors must have a readily understood IVR operating guide to distribute to providers upon request.

### **B - Toll-Free Telephone Service Costs**

The CMS will use the General Service Administration's Federal Telephone Service (FTS) 2001 contract for all inbound toll-free service. Any new toll-free numbers and the associated network circuits used to carry these calls will be acquired via the FTS 2001 network. The costs associated with the installation and monthly fees for this toll-free service will be paid centrally by CMS and should not be considered by contractors in their budget requests. However, Medicare contractors will still be responsible for all other internal telecommunications costs and devices such as agent consoles, handsets, internal wiring and equipment (ACD, IVR, PBX, etc.) and any local or outbound telephone services and line charges. Since these costs are not specifically identified in any cost reports, contractors must maintain records for all costs associated with providing telephone service to providers (e.g., costs for headsets) and provide this information upon request by RO or CO.

Contractors must print on their notices and Web sites any toll-free Medicare provider customer service number that the CMS provides and pays for. Contractors display this toll-free number prominently so the reader will know whom to contact regarding the notice.

### **C - Customer Service Representative (CSR) Standard Desktop**

The CMS is transitioning to the Medicare Customer Service Center Next Generation Desktop (MCSC NGD) FOR Medicare contractors. Listed below are the minimum personal computer (PC) requirements for the MCSC NGD for CSRs. Contractors are reminded that they 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:	64MB (more recommended for running multiple applications simultaneously with the NGD)
Operating System:	One of the following 4 options: <ul style="list-style-type: none"> <li>• Windows 98 SE</li> <li>• Windows ME</li> <li>• Windows NT Workstation 4.0 with Service Pak 6a</li> <li>• Windows 2000</li> </ul>
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 desktop systems are adequate, the following suggested configuration 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:

- Next Generation Desktop (using Internet Explorer)
- Microsoft Word
- Microsoft Outlook (or other e-mail/calendar package)
- Adobe Acrobat Reader, Folio, or other document viewing software

#### Personal Computer Software:

- Web browser (Internet Explorer 5.5 Service Pack 2)
- 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. The CMS will provide additional information on rollout 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 Provider Telephone Inquiries Activity Code 33001.

#### **D - Inquiry Staff Qualifications**

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

- Good keyboard computer skills;
- Good telephone communications skills;
- Sensitivity for special concerns of the Medicare providers;
- Flexibility to handle different situations that may arise;
- Knowledge of Medicare claims processing and review procedures;
- Prior experience in positions where the above skills are used, e.g., claims representative or telephone operator, is desired, but not required;
- 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

technical instructions on Medicare eligibility, coverage benefits, claims processing, Medicare systems and administration, customer service skills and telephone techniques, and the use of a computer terminal. Contractors must have a training evaluation process in place to certify that the trainee is ready to independently handle questions;

- During FY 2003, CMS will be developing testing and issuing standardized training processes and materials for provider telephone CSRs. Upon receipt of these materials, contractors are required to implement these standardized CSR training materials, including job aids for all CSRs on duty and those hired in the future. Since the development of these materials will be done by CMS, it is not expected that there will be any costs to the contractors to use these training materials. Contractors may supplement the standard materials with their own materials as long as there is no contradiction of policy or procedures;
- Send training representatives to 2-4 national train-the-trainer conferences provided by CMS. Contractors should be prepared to send at least one customer service/provider education representative to these training sessions to represent areas of provider education/customer service, payment, claims processing, billing, and medical review. Contractors should expect training sessions to run from 2-4 days. This representative will be responsible for training additional contractor customer service staff. These staff members should also be prepared to develop training programs for Medicare providers and suppliers on the various initiatives; and

Call Center User Group (CCUG) Call: Call centers are required to participate in the monthly CCUG calls. The CCUG is held the third Wednesday of each month at 2:00 p.m. Eastern time. 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 call center manager or a designated representative must participate at a minimum.

### **E - Customer Service Assessments and Management System (CSAMS)**

The CSAMS is an interactive Web-based software tool used by CMS to collect and display Call Center Telephone Performance data. Contractors use the following guidelines for the appropriate CSAMS reporting:

- Monthly Reports: Each call center site must enter required telephone customer service data elements into CSAMS between the 1<sup>st</sup> and 10<sup>th</sup> of each month for the prior month. To correct or change data after the 10<sup>th</sup> of the month, users must inform central office via CSAMS at [csams@cms.hhs.gov](mailto:csams@cms.hhs.gov). All specified information must be captured and reported to CMS on a monthly basis via the CSAMS. This information may be captured manually, if necessary, to calculate each required field.

- Call Center Definition for CSAMS: All contractors must ensure that monthly CSAMS data are being reported by individual call center and that the data are not being consolidated. The CMS wants telephone data grouped at the lowest level 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/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.
- The CSRs Sign-in Policy: Establish and follow a standard CSR sign-in policy in order for CMS to ensure data collected for telephone performance measurement is consistent from contractor to contractor. This policy will include the following:
  1. The CSRs available to answer telephone inquiries will sign-in to the telephone system to begin data collection.
  2. The CSRs should sign-off the telephone system for breaks, lunches, 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 be utilized in lieu of CSRs signing off the system.)
  3. The CSRs should sign-off the telephone system at the end of their workday.
  4. Call Handling Reporting Requirements for CSAMS:
    - Contractors must track and report “Total Sign-in Time” (TSIT). Total sign-in time is the amount of time that CSRs were available to answer telephone inquiries. This time includes that CSRs were plugged-in, logged-in, handling calls, making outgoing calls, in the after call work state or in an available state.
    - Contractors must track and report “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).
    - Contractors must track and report “Number of Workdays.” Number of workdays is the number of calendar days for the month that the call center is open and processing telephone inquiries. For reporting purposes, a call center is considered open for the entire day even though the call center may have been closed or not able to process telephone inquiries for a portion of the day.

- Contractors must track “Call Acknowledgement Rate.” Call acknowledgement rate is the time it takes a system to acknowledge a call before an agent, IVR, or automated call distributor (ACD) prompt is reached. This measure may not be required to be reported but must be substantiated when requested.
- Contractors must track and report “Service Level Indicator.” For callers choosing to talk with a CSR, calls shall be answered within a specified time of their delivery to the queuing system. This rate should be reported to CMS monthly.
- Contractors must track and report “Initial Call Resolution.” A call is considered resolved during the initial contact if it does not require a return call by the CSR.
- Contractors must track and report “Number of Attempts.” Report the monthly total FTS toll-free calls offered to the provider call center during the month, defined as the number of calls that reach the call center’s telephone system, which can be split up according to trunk lines in instances where a call center is taking calls for Part A, B and other non-CMS calls. 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, <http://customercenter.worldcom.com>.
- Contractors must track and report “Call Abandonment Rate.” Call abandonment rate is the percentage of provider calls that abandon their call from the ACD queue up to and including 60 seconds.
- Contractors must track and report “Average Speed of Answer.” Average speed of answer is the amount of time that all calls waited in queue before being connected to a CSR. This time begins when the caller enters the queue (it includes ringing, delay recorder(s), and music).
- Contractors must track and report “Average Talk Time.” Average talk time is any time the caller is placed on hold by the CSR.
- Contractors must track and report “Productivity.” Productivity is the average number of calls handled per CSR.
- Contractors must track and report “After Call Work.” After call work (ACW) is the time that the CSR needs to complete all administrative work associated with call activity after the customer disconnects.
- Contractors must track and report “Call back Report.” Call back is the number of calls not resolved at first contact. Those calls should be reported as follows:

- **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.
- **Callbacks closed within 5 workdays:** This number is based on calls received for the calendar month and represents the number of inquiries closed within 5 workdays even if a callback is closed within the first 5 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 7 calendar days rather than 5 workdays.
- **IVR Handle Rate:** Contractors should report the IVR handle rate. This is the number of calls delivered to the IVR where providers received the information they required from the automated system.

## **F - Quality Call Monitoring Process**

Contractors must monitor, measure, and report the quality of service continuously by employing CMS' quality call monitoring (QCM) process. Copies of the official scorecard and chart may be obtained at the telephone customer service Web site at <http://www.cms.hhs.gov/callcenters/qcm.asp>. Contractors use only the official version of the scorecard posted at the Web site.

1. **QCM Sampling Method:** Monitor CSRs throughout the month using a sampling routine. The sampling routine must ensure that CSRs are monitored at the beginning, middle, and end of the month (ensuring that assessments are distributed throughout the week and during morning and afternoon hours). Monitor the calls in any combination of the following ways: live remote, live side-by-side (shadow), or taped. For taped calls CMS requires contractors to maintain such tapes for an on-going 90-days 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. Where possible, rotate auditors regularly among the CSRs.
2. **Calibration Calls:** Participate in national and regional calibration sessions in 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 website. National sessions are held on the first Wednesday of February, May, August, and November at 1:30 Eastern time. Contractor call centers with more than one quality assurance analyst should conduct regular calibration sessions.
3. **Scorecard:** Record all monitored calls on the standard scorecard, using the QCM chart as a guideline. Train every CSR and auditor on the scorecard and chart and ensure that each person has a copy of the chart available for reference.

4. Feedback to CSR: Complete the scorecard in its entirety and give feedback to the CSR in a timely fashion, coaching and assisting the CSR to improve in areas detected during monitoring. Feedback on monitored calls shall be given to within two business days for live monitored calls and within seven business days for recorded calls.

## **G - QCM Reporting Requirements for CSAMS**

Contractors are encouraged to heavily monitor CSR trainees that have just completed classroom instruction before they begin to handle calls without assistance of a “mentor.” Scores for these trainees may be excluded from CSAMS reporting for a period up to one month following the end of formal classroom training.

- QCM-Number of CSRs available for monitoring: Contractors must track and report the number of CSRs (not FTEs) that take calls on a regular basis, both full-time and part-time. This number is obtained from the QCM Database.
- QCM-Number of completed scorecards: Contractors must track and report the number of completed scorecards for the month. This number is obtained from the QCM Database.
- QCM-Customer Skills Assessment: Contractors must track and report 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: Contractors must track and report 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: Contractors must track and report the percentage of calls that scored as pass. This number is obtained from the QCM Database.

## **H - Calls Regarding Claims**

When a telephone representative receives an inquiry from a provider about a claim, first, verify the provider’s name, identification number. Any information regarding the claim, including why the claim was reduced or denied, may then be discussed with the caller.

## **I - Calls Regarding Fraud and Abuse**

If a caller indicates an item or service was not received, or that a beneficiary or provider is involved in some potential fraudulent activity, screen the complaint for billing errors or abuse before sending it to the Benefit Integrity Unit. After screening the claim, if the CSR suspects abuse, the Medical Review Unit would handle the complaint. If the CSR suspects fraud, the complaint is forwarded

to the Benefit Integrity Unit and the CSR informs the caller that the Benefit Integrity Unit will contact him/her about the complaint. The CSR asks the caller to provide the Benefit Integrity Unit with any documentation he or she may have that substantiates the allegation. The CSR assures caller that the matter will be investigated.

### **J - Equipment Requirements**

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

- Online access to a computer terminal for each telephone representative 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;
- An outgoing line for callbacks; and
- A supervisor's console for monitoring telephone representatives' accuracy, responsiveness, clarity, and tone.

Any contractor call center upgrades or initiatives for purchases or developmental costs of 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 RO for review.

The RO shall forward all recommendations for approval to CO for a final decision

### **K - Publicizing Provider Toll-Free Lines**

Effective with the publication of these instructions, contractors will not be responsible for publishing their provider inbound 800 numbers in local telephone directories. The CMS will publish provider inbound 800 numbers in the appropriate directories. No other listings are to be published by the contractor.

However, contractors must publicize the toll-free service to the providers they serve in other normal business ways. An announcement about the availability of the service should be prominently displayed and maintained on contractor's Medicare Web site. Toll-free numbers should also be displayed on all provider education materials. Finally, the toll-free numbers should be publicized at all scheduled provider conferences, meetings and workshops.



## **20.3 - Processes for Line Changes, Troubleshooting, and Disaster Recovery**

*(Rev. 3, 12-09-03)*

**A2-2959.D, B2-5105.D**

### **A - Ordering More Lines, Changing Configurations, or Disconnecting Lines**

The ongoing management of the entire provider toll free system requires a process for making changes, which may be initiated by either contractor or CMS. All change requests associated with the FTS 2001 network (e.g., adding or removing channels or Tis, office moves, routing changes), must be processed through SAIC, the Provider Telecommunications Technical Support Contractor.

The CMS-initiated changes (i.e., adding lines, removing lines, reconfiguring trunk groups) will be based upon an analysis of CSAMS data and traffic reports.

In requesting changes to the phone environment, the contractor should follow the process outlined below:

Contractors will provide an analysis of their current telephone environment including a detailed traffic report specific to the service being requested that shows the need for changes to their phone system (i.e., additional lines, trunk group reconfiguration). This information should be gathered at the contractor site through the contractor's switch reporting as well as through WorldCom Customer Center (previously Interact).

- Based on technical merit and availability of funds, CO will review the recommendation and make a determination.

In cases where the request is approved, CO will forward approved requests to the designated agency representative (DAR) for order issuance.

### **B - Troubleshooting**

To ensure that provider toll-free service is available and clear, CMM established the Provider Incident Reporting & Response System (PIRRS). The PIRRS establishes a standard, incident response and resolution system for Medicare contractors who are troubleshooting problems and processing required changes for the toll-free provider lines.

The CMM has assembled a multi-functional team, consisting of both MCI telecommunications support and CMM Technical Support Contractor (TSC) personnel; to quickly and effectively resolve reported problems. To report and monitor a problem, contractors follow these steps.

#### Step 1

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

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

Toll-Free Network Service Problem - Contractor reports the problem to MCI by calling 1-888-387-7821.

#### Step 2

Involve CMM's Technical Support Contractor (TSC), if needed, to answer technical questions or to facilitate discussions with the GSA FTS provider service.

#### Step 3

File an incident report with the TSC for major interruptions of service. The TSC will notify CMM staff. Major interruption of service is defined as any incident with a trouble ticket opened for more than 24 hours or a total loss of service.

#### Step 4

Utilize WorldCom Customer Service to review documentation, track trouble tickets status, or close a trouble ticket online.

#### Step 5

File a monthly report with CMM about interruption of service - including both those of MCI and in-house origins and send a copy to the contractor's CMS Regional Office.

### **C - Disaster Recovery**

When a call center is faced with a situation that results in a major disruption of service, the call center must take the necessary action to ensure that callers are made aware of the situation.

This service is intended to supplement the contractor's existing disaster recovery or contingency plans. Whenever possible, the call center is responsible for activating its own emergency messages or re-routing calls. However, when this is not possible and providers are unable to reach the call center switch, the call center must contact the Beneficiary Network Services Center (BNS) and request that they initiate a pre-scripted disaster recovery message based in the FTS 2001 network. Once the problem is resolved, the call center must also contact the BNS to de-activate the FTS 2001 network disaster messages.

For provider call centers, contractors contact the BNS should only for the disaster situations. It will manage only these types of requests. The CMS designed the single point of contact to streamline the process for shared call centers and avoid making two calls in an emergency situation. The BNS contacts and updates the provider TSC when a provider call center disaster situation occurs. For all other FTS 2001 support requests, provider call centers should follow their normal procedures.

**30 – Disclosure Desk Reference for Call Centers – Provider Portion**

*(Rev. 3, 12-09-03)*

<b>IF THE CONTACT IS:</b>	<b>AND:</b>	<b>YOU MUST:</b>	<b>THEN YOU CAN:</b>	<b>REFERENCE</b>
22. A Provider/Physician  Part A or B	Provider/physician inquires about claims information on a pre-claim basis		No claims information may be released on a pre-claim basis without the beneficiary’s authorization.	100-1, Ch. 6, §80  100-9, Ch. 3, §20.2
23. A Provider/Physician  Part A or B	Provider/physician inquires about claims information on a post-claim basis.	Validate the provider/physician’s name and identification number.  Verify the beneficiary’s: <ul style="list-style-type: none"> <li>● Date of Service</li> <li>● Last name and first initial</li> <li>● HIC number</li> </ul>	<b>Assigned Claims</b>  Participating and Non-Participating: Discuss any information on that provider/physician’s claim or any other related claim from that provider/physician for that beneficiary.  <b>Non-Assigned Claims</b>  Non-Participating:	100-1, Ch. 6, §80  100-9, Ch. 3, §20.2

		<p>Items must match exactly.</p>	<p>Discuss any information regarding only the claim in question, including why it was reduced or denied.</p> <p>General Note:</p> <p>You may speak with the provider/physician about his/her own claims. You may also disclose information about another provider/physician, as long as both providers/physicians have a relationship with the beneficiary, and the purpose of the disclosure is to facilitate the payment of the provider/physician that receives the information.</p>	
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<b>IF THE CONTACT IS:</b>	<b>AND:</b>	<b>YOU MUST:</b>	<b>THEN YOU CAN:</b>	<b>REFERENCE</b>
<p>24. A Provider/physician</p> <p>Part A</p>	<p>Provider/physician inquires about beneficiary eligibility information, which would be available via EDI.</p> <p>This information may only be used in order to submit an accurate claim.</p>	<p>Validate the provider/physician's name and identification number.</p> <p>Verify the beneficiary's:</p> <ul style="list-style-type: none"> <li>● Last name &amp; first initial</li> <li>● Date of birth</li> <li>● HIC number</li> <li>● Gender</li> </ul> <p>Items must match exactly.</p>	<p>Release the following eligibility information on a pre-claim or post-claim basis:</p> <ul style="list-style-type: none"> <li>– Date of death</li> <li>– Lifetime reserve days remaining</li> <li>– Lifetime psychiatric days remaining (if the requesting caller has a psychiatric identification number)</li> <li>– Cross reference HICN</li> <li>– Current and prior A and B entitlements</li> <li>– Spell of illness: hospital full and coinsurance days remaining, SNF full</li> </ul>	<p>100-1, Ch. 6, §40 &amp; 60.1</p>

			<p>days and coinsurance days remaining, Part A cash deductible remaining to be met, date of earliest billing action for indicated spell of illness</p> <ul style="list-style-type: none"><li>– Blood deductible (combined Part A and B) remaining to be met for applicable year entered by provider</li><li>– Part B trailer year (applicable year based on date entered by provider)</li><li>– Part B cash deductible</li><li>– Physical/speech and occupational therapy amount</li><li>– Hospice data (applicable periods based on the date entered by the provider and the next most recent period)</li><li>– ESRD indicator</li></ul>	
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			<ul style="list-style-type: none"><li>– Rep payee indicator</li><li>– MSP indicator</li><li>– HMO information: identification code, option code, start &amp; termination date</li><li>– Pap smear screening: risk indicator, professional and technical date</li><li>– Mammography screening: risk indicator, professional and technical date</li><li>– Colorectal screening: procedure code, professional and technical date</li><li>– Pelvic screening: risk indicator and professional date</li><li>– Pneumococcal pneumonia vaccine (PPV) date</li><li>– Influenza virus vaccine date</li></ul>	
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			<ul style="list-style-type: none"><li>– Hepatitis B vaccine date</li><li>– Home health start and end dates and servicing agency's name.</li></ul>	
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<b>IF THE CONTACT IS:</b>	<b>AND:</b>	<b>YOU MUST:</b>	<b>THEN YOU CAN:</b>	<b>REFERENCE</b>
<p>25. A Provider/Physician</p> <p>Part B</p>	<p>Provider inquires about beneficiary eligibility information, which would be available via EDI.</p> <p>This information may only be used in order to submit an accurate claim.</p>	<p>Validate the provider's name and provider number.</p> <p>Verify the beneficiary's:</p> <ul style="list-style-type: none"> <li>● Last name and first initial</li> <li>● Date of birth</li> <li>● HIC number</li> <li>● Gender</li> </ul> <p>Items must match exactly.</p>	<p>Release the following eligibility information on a pre-claim or post-claim basis:</p> <ul style="list-style-type: none"> <li>– Part A and B entitlement and termination dates</li> <li>– Deductible met (yes or no) for current and prior years</li> <li>– HMO information: "cost" or "risk" plan, effective and termination dates</li> <li>– MSP activity (yes or no)</li> <li>– Home health start and end dates and servicing agency's name.</li> </ul>	<p>100-1, Ch. 6, §40 &amp; 60.1</p>

			-- Physical/speech and occupational therapy amount	
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<b>IF THE CONTACT IS:</b>	<b>AND:</b>	<b>YOU MUST:</b>	<b>THEN YOU CAN:</b>	<b>REFERENCE</b>
26. Supplier  DMERC	Supplier inquires about claims information on a pre-claim basis.		No claims related information may be released on a pre-claim basis without the beneficiary's authorization.	100-1, Ch. 6, §80  100-9, Ch. 3, §20.2
27. Supplier  DMERC	Supplier inquires about claims information on a post-claim basis.	<p>Validate the supplier's name and NSC identification number</p> <p>Verify the beneficiary's:</p> <ul style="list-style-type: none"> <li>● Date of service</li> <li>● Last name and first initial</li> <li>● HIC number</li> </ul> <p>Items must match exactly.</p>	<p><b>Assigned Claims</b></p> <p>Participating and Non-Participating: Discuss any information on that supplier's claim or any other related claim from that supplier for that beneficiary.</p> <p><b>Non-Assigned Claims</b></p> <p>Participating and Non-Participating: Discuss any information regarding only the claim in question, including</p>	100-1, Ch. 6, §80  100-9, Ch. 3, §20.2

			<p>why it was reduced or denied.</p> <p>General Note:</p> <p>You may speak with the supplier about his/her own claims. You may also disclose information about another supplier, as long as both suppliers have a relationship with the beneficiary, and the purpose of the disclosure is to facilitate the payment of the supplier that receives the information.</p>	
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<b>IF THE CONTACT IS:</b>	<b>AND:</b>	<b>YOU MUST:</b>	<b>THEN YOU CAN:</b>	<b>REFERENCE</b>
<p>28. Supplier</p> <p>DMERC</p>	<p>Supplier inquires about a Certificate of Medical Necessity (CMN)</p> <p>NO claim has been submitted.</p>		<p>You may not release answers to the question sets on the CMN on file without the beneficiary's authorization.</p>	
<p>29. Supplier</p> <p>DMERC</p>	<p>Supplier inquires about a Certificate of Medical Necessity (CMN)</p> <p>Supplier receives a claim denial due to the CMN.</p> <p>This information may only be used in order to submit an accurate claim.</p>	<p>Validate the supplier's name and NSC identification number.</p> <p>Verify the beneficiary's:</p> <ul style="list-style-type: none"> <li>● Date of service</li> <li>● Last name and first initial</li> <li>● HIC number</li> <li>● HCPCs code or name of item</li> </ul>	<p>You may confirm whether or not the answers to the question sets on the CMN on file matches what the supplier has in his/her records.</p>	

		Items must match exactly.		
30. Supplier  DMERC	Supplier inquires about beneficiary eligibility information, which would be available via EDI.  This information may only be used in order to submit an accurate claim.	Validate the supplier's name and NSC identification number.  Verify the beneficiary's: <ul style="list-style-type: none"> <li>● Last name and first initial</li> <li>● Date of birth</li> <li>● HIC number</li> <li>● Gender</li> </ul> Items must match exactly.	Release the following eligibility information on a pre-claim or post-claim basis: <ul style="list-style-type: none"> <li>– Part A and B entitlement and termination dates</li> <li>– Deductible met (yes or no) for current and prior years</li> <li>– HMO information: “cost” or “risk” plan, effective and termination dates</li> <li>– MSP activity (yes or no)</li> <li>– Home health start and end dates and servicing agency 's name.</li> <li>-- Physical/speech and occupational therapy</li> </ul>	100-1, Ch. 6, §40 & 60.1

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<b>IF THE CONTACT IS:</b>	<b>AND:</b>	<b>YOU MUST:</b>	<b>THEN YOU CAN:</b>	<b>REFERENCE</b>
31. Ambulance Supplier	Supplier inquires about claims information on a pre-claim basis.		No claims related information may be released on a pre-claim basis without the beneficiary's authorization.	100-1, Ch. 6, §80  100-9, Ch. 3, §20.2
32. Ambulance Supplier	Supplier inquires about claims information on a post-claim basis.	Validate the supplier's name and identification number  Verify the beneficiary's: <ul style="list-style-type: none"> <li>● Date of service</li> <li>● Last name and first initial</li> <li>● HIC number</li> </ul> Items must match exactly.	<b>Assigned Claims</b>  Participating and Non-Participating: Discuss any information on that supplier's claim or any other related claim from that supplier for that beneficiary.  <b>Non-Assigned Claims</b>  Participating and Non-Participating: Discuss any information regarding only the claim in question, including	100-1, Ch. 6, §80  100-9, Ch. 3, §20.2

			<p>why it was reduced or denied.</p> <p>General Note:</p> <p>You may speak with the supplier about his/her own claims. You may also disclose information about another supplier, as long as both suppliers have a relationship with the beneficiary, and the purpose of the disclosure is to facilitate the payment of the supplier that receives the information.</p>	
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<b>IF THE CONTACT IS:</b>	<b>AND:</b>	<b>YOU MUST:</b>	<b>THEN YOU CAN:</b>	<b>REFERENCE</b>
33. Ambulance Supplier	<p>Supplier inquires about beneficiary eligibility information, which would be available via EDI.</p> <p>This information may only be used in order to submit an accurate claim.</p>	<p>Validate the supplier's name and identification number.</p> <p>Verify the beneficiary's:</p> <ul style="list-style-type: none"> <li>● Last name and first initial</li> <li>● Date of birth</li> <li>● HIC number</li> <li>● Gender</li> </ul> <p>Items must match exactly.</p>	<p>Release the following eligibility information on a pre-claim or post-claim basis:</p> <ul style="list-style-type: none"> <li>– Part A and B entitlement and termination dates</li> <li>– Deductible met (yes or no) for current and prior years</li> <li>– HMO information: "cost" or "risk" plan, effective and termination dates</li> <li>– MSP activity (yes or no)</li> <li>– Home health start and end dates and servicing agency's name.</li> </ul>	100-1, Ch. 6, §40 & 60.1

			-- Physical/speech and occupational therapy limit	
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<b>IF THE CONTACT IS:</b>	<b>AND:</b>	<b>YOU MUST:</b>	<b>THEN YOU CAN:</b>	<b>REFERENCE</b>
34. Billing Service/ Clearinghouse	Billing Service/ Clearinghouse inquires about claims information on a pre-claim basis.		No claims related information may be released on a pre-claim basis without the beneficiary's authorization.	
35. Billing Service/ Clearinghouse	Billing Service/ Clearinghouse inquires about claims information on a post-claim basis.	<p>Validate the employing provider/physician/ supplier's name and identification number.</p> <p>Verify beneficiary's:</p> <ul style="list-style-type: none"> <li>● Date of service</li> <li>● Last name and first initial</li> <li>● HIC number</li> </ul> <p>Items must match exactly.</p>	You may speak with the billing service/clearinghouse about the employing provider/physician/ supplier's claims.	

<p>36. Billing Service/ Clearinghouse</p>	<p>Billing Service/ Clearinghouse inquires about beneficiary eligibility information, which would be available via EDI.</p> <p>This information may only be used in order to submit an accurate claim.</p>	<p>Validate the employing provider/physician/suppl ier’s name and identification number.</p> <p>Verify the beneficiary’s:</p> <ul style="list-style-type: none"> <li>● Last name and first initial</li> <li>● Date of birth</li> <li>● HIC number</li> <li>● Gender</li> </ul> <p>Items must match exactly.</p>	<p>Release the following eligibility information on a pre-claim or post- claim basis:</p> <ul style="list-style-type: none"> <li>– Part A and B entitlement and termination dates</li> <li>– Deductible met (yes or no) for current and prior years</li> <li>– HMO information: “cost” or “risk” plan, effective and termination dates</li> <li>– MSP activity (yes or no)</li> <li>– Home health start and end dates and servicing agency’s name.</li> <li>-- Physical/speech and occupational therapy limit</li> </ul>	
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## General Notes and Definitions

**ASSIGNMENT** When a provider agrees to accept Medicare approved charges as payment in full and the beneficiary agrees to have Medicare's share of the cost of service paid directly to the provider.

**BILLING SERVICE** Collects provider/physician/supplier claim information and bills the appropriate insurance companies, including Medicare. It may provide claims billing service only, or provide full financial accounting

**CLEARINGHOUSE** Transfers or moves EDI transactions for a provider/physician/supplier and translates the data into the format required by a health care trading partner, such as a payer. A clearinghouse accepts multiple types of claims and generally other EDI transactions and sends them to various payers, including Medicare. They also accept EDI transactions from payers for routing to and/or reformatting for providers/physicians/suppliers. They perform general and payer-specific edits on claims, and usually handle all of the transactions for a given provider/physician/supplier. Clearinghouses frequently reformat data for various payers and manage acknowledgements and remittance advice. Clearinghouses ordinarily submit initial claims and may qualify as a billing service.

**DATE OF SERVICE** The date on which the beneficiary received health services from a provider, physician or supplier.

and/or other services. Billing services may view beneficiary or provider data to perform their obligations to the provider/physician/supplier, and if the provider/physician/supplier designates them for that access. To qualify as a billing service, the entity must submit initial claims on the provider/physician/supplier's behalf.

**DISCLOSURE** Releasing information in a Medicare record to anyone other than the subject individual, legal guardian or parent of

minor. The individual to whom the information pertains must authorize (either verbally or in writing) the disclosure of his/her personal information to the third party.

**NONASSIGNMENT** When a provider has not agreed to accept Medicare approved charges as payment in full and the claim potentially is payable directly to the Medicare beneficiary.

**NONPARTICIPATING** A physician who has not signed a participation agreement and is not obligated to accept assignment on PHYSICIAN Medicare claims; may accept assignment of Medicare claims on a case-by-case basis.

**PARTICIPATING** A physician who has signed a participation agreement to accept assignment on all claims submitted to PHYSICIAN Medicare.

**PHYSICIAN** Doctor of medicine, doctor of osteopathy (including osteopathic practitioner), doctor of dental surgery or dental medicine (within the limitations in Pub. 100-1, Chapter 5, subsection §70.2 ), doctor of podiatric medicine (within the limitations in Pub. 100-1, Chapter 5, subsection §70.3), or doctor of optometry (within the limitations of Pub. 100-1, Chapter 5, subsection §70.5), and, with respect to certain specified treatment, a doctor of chiropractic legally authorized to practice by a State in which he/she performs this function.

**NOTE:** The term physician does not include such practitioners as a Christian Science practitioner or naturopath.

**POST-CLAIM** After a provider, physician or supplier services a beneficiary and a claim has been submitted for that beneficiary.



**PRE-CLAIM** Before the provider, physician or supplier services a beneficiary and before a claim has been submitted for that beneficiary.

**PROVIDER** Section 1866(e) of the Social Security Act defines the term "provider of services" (or provider) as:

(1) A clinic, rehabilitation agency, or public health agency if, in the case of a clinic or rehabilitation agency, such clinic or agency meets the requirements of section 1861(p)(4)(A) (or meets the requirements of such section through the operation of section 1861(g)), or if, in the case of a public health agency, such agency meets the requirements of section 1861(p)(4)(B) (or meets the requirements of such section through the operation of section 1861(g)), but only with respect to the furnishing of outpatient physical therapy services (as therein defined) or (through the operation of section 1861(g)) with respect to the furnishing of outpatient occupational therapy services; and

(2) A community mental health center (as defined in section 1861(ff)(3)(B)), but only with respect to the furnishing of partial hospitalization services (as described in section 1861(ff)(1)). Definitions of providers, physicians, practitioners, and suppliers, and a description of the requirements that each must meet in order for their services to be considered covered are described in the following sections.

**RELATIONSHIP** When a provider/physician/supplier has rendered, or is rendering, health services to a beneficiary.

**REPRESENTATIVE** This is a person or organization appointed by the Social Security Administration when it is determined

**PAYEE** that the beneficiary is unable (due to mental or physical incapability) to handle, manage or direct someone

else to manage his/her own benefits, and it is determined to be in the best interest of the beneficiary to appoint a payee. The beneficiary does not have to be declared legally incompetent in order to use a representative payee. However, if a beneficiary is judged legally incompetent, they must have a payee. The representative payee may make any request or give any notice on behalf of the beneficiary. He/she may give or draw out evidence of information, get information, and receive any notice in connection with a pending claim or asserted rights. The payee has the responsibility to handle all matters related to Social Security and Medicare on behalf of the beneficiary.

**SUPPLIER** An entity that is qualified to furnish health services covered by Medicare, other than providers, and practitioners, physicians,

The following suppliers must meet the conditions in order to receive Medicare payment: ambulatory surgical centers (ASCs), independent physical therapists, mammography facilities, DMEPOS suppliers, independent occupational therapists, clinical laboratories, portable X-ray suppliers, dialysis facilities, rural health clinics, and Federally-qualified health centers.

A DME supplier is an entity that furnishes DME and has a number assigned by the National Supplier Clearinghouse.

### **GENERAL NOTES:**

Blended call centers (those that answer both beneficiary and provider calls at the same place) may choose to answer provider calls regarding eligibility inquiries and claims issues on the beneficiary line if they have the ability to track the calls appropriately. Otherwise, they should refer the contact to the appropriate provider inquiry number.

An individual who makes a request by telephone must verify his/her identity by providing identifying particulars, which parallel the record to which notification or access is being sought. If the CSR determines that the particulars provided by telephone are insufficient, the requestor will be required to submit the request in writing or in person. Telephone requests will not be accepted where an individual is requesting notification of, or access to, sensitive records such as medical records.

Always remember that access and disclosure involve looking at a Medicare record and giving out information. If you do not have to look at a record (for example, in explaining a letter), access and disclosure rules are not involved. General (that is, non beneficiary-specific) information may be discussed at any time with any caller.

Medicare Customer Service Center (MCSC) employees must follow the MCSC rules governing disclosure, which require CSRs to obtain at least four items of information to identify the beneficiary for claims information and six items when accessing the MBR or EDB. For consistency among contractors, we recommend that three of those items are the beneficiary's name, HIC number, and date of birth.

On all Medicare Customer Service Center (MCSC) calls dealing with Managed Care issues other than enrollment/disenrollment issues and dates, refer the contact to the Managed Care organization. You may not release any Managed Care claims information. **NOTE:** Representative payees are not authorized to enroll or disenroll beneficiaries in Managed Care Organizations, unless the representative payee has that authority under State law.

The written authorization must:

- Include the beneficiary's name, and HIC;
- Specify the individual, organizational unit, class of individuals or organizational units who may make the disclosure;
- Specify the individual, organizational unit, class of individuals or organizational units to which the information may be disclosed;
- Specify the records, information, or types of information that may be disclosed;
- A description of the purpose of the requested use or disclosure (if the beneficiary does not want to provide a statement of the purpose, he/she can describe the use as “at the request of the individual”);
- Indicate whether the authorization is for a one-time disclosure, or give an expiration date or event that relates to the individual or the purpose of the use or disclosure (e.g., for the duration of the beneficiary's enrollment in the health plan);
- Be signed and dated by the beneficiary or his/her authorized representative. If signed by the representative, a description of the representative's authority to act for the individual must also be provided; and

- A statement describing the individual's right to revoke the authorization along with a description of the process to revoke the authorization;
- A statement describing the inability to condition treatment, payment, enrollment or eligibility for benefits on whether or not the beneficiary signs the authorization;
- A statement informing the beneficiary that information disclosed pursuant to the authorization may be redisclosed by the recipient and may no longer be protected.

For non-English speaking beneficiaries, you must obtain the beneficiary's identifying information and verbal consent (via the AT&T language line or similar service, or other interpreter) prior to speaking with the friend, relative, etc.

If the Automated Voice Response (ARU) or Interactive Voice Response (IVR) system obtains the beneficiary's name, HIC number and DOB and one additional piece of information (such as SSN, address, phone number, effective date(s), whether they have Part A and/or Part B coverage) prior to the CSR answering, and this is evident to the CSR, it is not necessary to obtain that information again. The CSR should ask to whom they are speaking just to ascertain if it is the beneficiary or someone acting on the beneficiary's behalf.

If the ARU or IVR system is not currently programmed to obtain all of the disclosure elements, and it is necessary for the CSR to answer the call, the CSR should obtain the required data elements before disclosing any identifiable information.

These instructions do not change any requirements for contractors regarding the use of ARU/IVR systems. You are not authorized to reprogram the ARU or IVR at this time.

For situations not specifically addressed here, the CSR should use his/her discretion, taking care to protect the beneficiary's privacy and confidentiality. Refer situations in which the CSR is unsure of whether or not to release information to his/her supervisor or to the organization's privacy official

# Medicare Contractor Beneficiary and Provider Communications Manual

## Chapter 4 - Provider Communications

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## **10 - Introduction**

**(Rev. 1, 10-01-03)**

This chapter contains general instructions and requirements for Medicare carriers, including DMERCs, and fiscal intermediaries (FIs) regarding provider communications, education, and training. Normally, the term “contractor” is used in this manual to mean any or all of these. If an instruction should apply to only one type of contractor, this will be specified.

## ***20 – FI Provider Communications – Provider Education and Training***

***(Rev.3, 12-09-03)***

***A2-2965***

*This section and its related subsections apply only to FIs.*

*Sections 1816 (a) and 1842 (a)(3) of the Social Security Act (the Act) require that contractors serve as a channel of communication for information to and from providers. The fundamental goal of the CMS’ Provider Communications (PCOM) program (formerly Provider Education and Training, PET) is to give those who provide service to beneficiaries the information they need to understand the Medicare program so that, in the end, they manage Medicare related matters appropriately and bill correctly.*

*PCOM uses mass media, such as print, Internet, satellite networks, and other technologies, face-to-face instruction, and presentations in classrooms and other settings, to meet the needs of Medicare providers for timely, accurate, and understandable Medicare information.*

*PCOM is directed at educating providers and their staffs about fundamental Medicare programs and policies, new Medicare initiatives, and significant changes to the Medicare program. These efforts are aimed at reducing the number of provider inquiries and claim submission errors. Unlike Local Provider Education and Training (LPET), PCOM, for the most part, is not targeted to individual providers or limited and confined problems or errors. PCOM is instead designed to be broader in nature so as to meet the basic informational needs of Medicare providers, plus have a unique focus upon training and consulting for new Medicare providers as well. The scope of PCOM is to identify and address issues that are of concern to the broad provider audience.*

## ***20.1 - Provider Communications – Program Elements***

***(Rev. 3, 12-09-03)***

### ***A2-2965.A***

*The FI is required to implement the basic requirements for PCOM stated herein. The intermediary is also required to meet budget and performance requirements (BPRs) for this program issued each fiscal year that provide additional guidance on the program.*

*The FI reports costs and workload data for the PCOM program according to the prescribed CAFM activity codes.*

### ***20.1.1 - Provider Service Plan (PSP)***

***(Rev. 3, 12-09-03)***

*The FI is required to prepare and submit a PSP annually. The PSP must address the FI's overall plans for implementing the provider communications program in the forthcoming fiscal year. The PSP outlines the strategies, projected activities, efforts, and approaches that will be used during the year to support provider communications. The PSP must address and support all the activities stated herein as well as all required activities stated in the yearly BPRs for this program.*

*The Plan must include how the following elements of the PCOM program, described hereafter, will be met, and note, when appropriate, how many events, occurrences or other happenings are planned or anticipated for these elements (e.g., the number of workshops, seminars, speeches, frequency of bulletins, number distributed, number of partnerships with external entities, number of times listserv(s) used, etc.):*

- Provider Inquiry Analysis,*
- Provider Data Analysis,*
- Seminars/Workshops/Educational Events,*
- Provider Communications Advisory Group,*
- Bulletins/Newsletters,*
- New Technologies/Electronic Media, and*
- Promoting Beneficiary Use of Preventive Benefits Through Provider Education Activities.*

*A draft or preliminary PSP should be sent at the time the FI submits its annual budget request to its Regional Office (RO) PSP coordinator or contact for review. A final PSP*



*should be sent by October 31, to the FI's RO PSP coordinator and to CMS Central Office (CO). Plans sent to CO should be addressed to:*

*Centers for Medicare & Medicaid Services  
Center for Medicare Management  
Division of Contractor Provider Communications  
Mail Stop C4-10-07  
7500 Security Boulevard  
Baltimore, Maryland 21244-1850.*

*The FI provides the name, phone number, and mailing address of its PSP coordinator with its PSP.*

### ***20.1.2 - Provider Inquiry Analysis***

***(Rev. 3, 12-09-03)***

*The FI must maintain a provider inquiry analysis program that will produce a monthly list of the most frequently asked questions (FAQs) and areas of concern/confusion for providers. The FI uses an organized, consistent, systematic and reproducible process to generate the most frequently asked questions. The FI describes this process in the PSP. Outreach and educational efforts must be developed and implemented to address the needs of providers as identified by this program.*

### ***20.1.3 - Provider Data Analysis***

***(Rev. 3, 12-09-03)***

*FI's must maintain a provider data analysis program that will produce a monthly list of the most frequent, collective claims submission errors from all providers. Claims submission errors result in rejected, denied, or incorrectly paid claims. Outreach and educational efforts must be developed and implemented to address the needs of providers as identified by this program.*

### ***20.1.4 - Provider Communications Advisory Group***

***(Rev. 3, 12-09-03)***

*FI's must support and maintain a PCOM Advisory Group (formerly referred to as the PET Advisory Group). This group should generally convene quarterly, but at a minimum, meet three times per year, and will provide advice and recommendations to the FI on provider communications matters.*

#### ***A - Purpose of PCOM Advisory Groups***

*The primary function of the PCOM Advisory Group is to assist the FI in the creation, implementation, and review of provider education strategies and efforts. The PCOM Advisory Group provides input and feedback on training topics, provider education*

*materials, and dates and locations of provider education workshops and events. The group also identifies salient provider education issues, and recommends effective means of information dissemination to all appropriate providers and their staff. The PCOM Advisory Group should be used as a provider education consultant resource, and not as an approval or sanctioning authority.*

*While it remains allowable for the FI to use PCOM Advisory Groups to provide updates and facilitate discussion on current issues, the focus of the group meetings should remain centered on the development and implementation of effective provider communication materials and strategies.*

### ***B - Composition of PCOM Advisory Group***

*The FI should strive to maintain professional and geographic diversity within its PCOM advisory groups. The FI should attempt to include representatives of various provider specialties serviced including state and local trade and professional associations, practicing providers or staff members they deem appropriate, and representatives of billing organizations. Providers from different geographic areas, as well as from urban and rural locales, should be represented in any PCOM Advisory Group. The FI should consider inviting representatives of Quality Improvement Organizations (QIOs) from its area to participate in PCOM Advisory Group meetings.*

*The FI should consider having more than one PCOM Advisory Group when the breadth of its geographic service area, or range of the providers serviced, diminishes the practicality and effectiveness of having a single PCOM Advisory Group. For further guidance on this issue, the FI should contact its regional office PCOM or provider education and training (PET) Coordinator.*

### ***C - The FI Role***

*The FI should maintain the PCOM Advisory Group. While group members should be solicited for agenda topics, it is not permissible for Medicare FIs to allow outside organizations to operate the PCOM Advisory Group. After soliciting suggestions from the provider community, the FI should select the appropriate individuals and organizations to be included in the group. The main point of contact for all PCOM Advisory Group communication should be within the FI's PCOM, PET, or similar department. At a minimum, the FI is responsible for recruiting potential members, setting-up and arranging all meetings, handling meeting logistics, producing and distributing an agenda, completing and distributing minutes, and keeping adequate records of the advisory group's proceedings.*

*Medicare FIs having more than one kind of Medicare contract (e.g., intermediary, Part B carrier, DMERC, rural home health intermediary, etc.) are required to have separate PCOM advisory groups for each kind of Medicare contract. It is also impermissible for FIs having geographic proximity or overlap with one another to share a PCOM Advisory Group. Each FI must have its own separate group. FIs shall not reimburse or charge a fee to group members for membership or for costs associated with serving*

*on a PCOM Advisory Group. FIs are required to notify their CMS regional office PET or PCOM coordinator of the schedule and location of PCOM Advisory Group meetings.*

*The FI is expected to consider the suggestions and recommendations of the PCOM Advisory Group, and implement or enact them if it deems them reasonable, practicable, and within its provider communications program requirements and budget constraints. After consideration, must explain to the group reasons for not implementing or adopting any group suggestions or recommendations.*

#### ***D - Meeting Specifics***

*An FI may hold PCOM Advisory Groups in-person or via teleconferencing. The CMS recommends that the FI holds at least one meeting per calendar year with group members in-person. Teleconferencing should be made available to Advisory Group members who cannot be present for any meeting. The FI should also have a specific area on its Web site that allows providers to access information about the PCOM Advisory Group (minutes from meetings, list of organizations or entities comprising the PCOM Advisory Group, an e-mail address for a contact point and for further information on the PCOM Advisory Group, etc.). This area of the FI's Web site should be operational by March 31, 2003. The FI notifies its PCOM Advisory Group members that information about their participation on the Advisory Group may be on the Web site. The FI consults with its CMS regional office PET or PCOM coordinator if a member has objections, and on ways to mitigate them.*

*Meeting agendas, which include discussion topics garnered from solicitation of group members, should be distributed to all members of the group and the CMS regional office PET or PCOM coordinator at least 2 business days prior to any meeting. After each meeting, minutes should be disseminated within 7 business days to all group members and others who request them.*

#### ***E - Relationship to Other FI Advisory Groups***

*PCOM advisory groups operate independently from other existing FI advisory committees. While a PCOM Advisory Group may, at its discretion, share information with other advisory groups, the PCOM Advisory Group does not need the approval, authorization or input from any other entity for its advice, recommendations, or issuances. While an individual PCOM Advisory Group member can be a member of another FI advisory committee, the majority of PCOM Advisory Group members should not be current members of any other FI advisory group.*

*For more information or specific guidance on any of the above issues, the FI contacts its regional office PET or PCOM coordinator.*

### **20.1.5 - Bulletins/Newsletters**

**(Rev. 3, 12-09-03)**

*Print and distribute regular provider bulletins/newsletters, at least quarterly, which contain program and billing information. When feasible and cost-effective, stop sending regular bulletins to providers with no billing activity in the previous 12 months. Newly created bulletins/newsletters must be posted on the FI's Web site. All printed bulletins/newsletters must have either a header or footer in boldface type within the first three pages that states the following: "**This Bulletin Should Be Shared With All Health Care Practitioners and Managerial Members of the Provider Staff. Bulletins Are Available at No Cost from Our Web Site [Insert FI Web Site Address].**"*

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

### **20.1.6 - Seminars/Workshops/Teleconferences**

**(Rev. 3, 12-09-03)**

*The FI holds seminars, workshops, classes, or other face-to-face meetings, to educate and train providers about the Medicare program and billing issues. Whenever feasible, activities should be coordinated with other regional Medicare FIs, including quality improvement organizations (QIOs), other carriers and intermediaries, State Health Insurance Assistance Programs (SHIPs), and End Stage Renal Disease (ESRD) networks as well as interested groups, organizations, and CMS partners in its service area. Develop, and implement whenever practicable, effectiveness measures for each education and training activity. This includes, but is not limited to, customer satisfaction survey instruments, pre- and post-testing at workshops and seminars, and other feedback mechanisms.*

*Whenever feasible, hold teleconferences to address and resolve inquiries from providers as a method to reach a broad audience. If facilities permit, the FI should host Medicare Learning Network (MLN) satellite broadcasts for providers in its service area.*

### **20.1.7 - New Technologies/Electronic Media**

**(Rev. 3, 12-09-03)**

*FI's must use new technologies and electronic media as an efficient, timely and cost-effective means of disseminating Medicare provider information to the audiences they serve.*

### ***A - Provider Education Web Site***

*Maintain a Web site that is dedicated to furnishing providers with timely, accessible, and understandable Medicare program information. To reduce costs, Web sites should fit into existing infrastructure and use existing resource technologies whenever possible.*

*This Web site must comply with "Contractor Website Standards and Guidelines" posted at <http://cms.hhs.gov/about/web/contractors.asp> and must be compatible with multiple browsers. Periodically the FI reviews the "Web site Standards and Guidelines" to determine its continued compliance. During the first three months of each calendar year, the FI sends a signed and dated statement to its RO PCOM or PET Coordinator attesting to whether its Web site continues to comply with these guidelines and whether it is compatible with multiple browsers. The person in the FI's organization who has authority over the Web site should sign the attestation statement.*

*The FI's Provider Outreach Web site must contain the following:*

- All newly created provider bulletins/newsletters;*
- A schedule of upcoming events (e.g., seminars, workshops, fairs.);*
- Ability to register for seminars and other events via the Web site;*
- Search engine functionality;*
- Features that permit providers to download and save copies of bulletins, training materials, schedules of upcoming events, and other items;*
- A "What's New" or similarly titled section that contains newsworthy and important information that is of an immediate or time sensitive nature to Medicare providers;*
- E-mail based support/help/customer service;*
- A listing of FAQs/areas of concern updated quarterly as evidenced through the FI's inquiry analysis program; and*
- Information for providers on how to submit claims electronically.*

*The FI's Provider Outreach Web site must link to:*

- The Medicare program Web site at: <http://cms.hhs.gov/>;*
- The MLN at: <http://cms.hhs.gov/medlearn>;*
- The site for downloading CMS publications at <http://cms.hhs.gov/publications/>;*

- *The site for downloading CMS manuals and transmittals at <http://cms.hhs.gov/manuals/transmittals/>; and*
- *Other CMS Medicare FIs, partners, QIOs, and other sites that may be useful to providers.*

### **1 - Directed Web Site/Bulletin Article**

*FIs often receive instructions from CMS to print a provider education article or other information in their provider bulletin or newsletter and also place it on their Web site. Unless specifically directed otherwise, the FI locates the article or information from CMS on the “What’s New” or similarly titled section of the its provider education Web site. Unless specifically directed otherwise, the article or information should be put on the FI’s Web site as soon as possible after receipt, and should remain on the Web site for 2 months, or until the bulletin or newsletter in which it is appearing is put on the FI’s Web site, whichever is later.*

### **2 - Use of Current Procedural Terminology**

*Web sites must adhere to requirements stated in the Medicare Claims Processing Manual, Chapter 23, Subsection 20.7, regarding the use of current procedural terminology (CPT) codes and descriptions. During the first 3 months of each calendar year, the FI determines whether its Web site complies with requirements stated in this chapter and subsection of the Medicare Claims Processing Manual. A signed and dated attestation statement must be sent to the FI’s RO PSP or PET Coordinator. The person in the FI’s organization who has authority over the Web site should sign the attestation statement.*

### **B - Electronic Mailing List/Listserv**

*Maintain at least one electronic mailing list, or listserv, to notify registrants via e-mail of important, time-sensitive Medicare program information, upcoming provider communications events, and other announcements necessitating immediate attention. At a minimum, the FI uses its electronic mailing lists to notify registrants of the availability of bulletins/newsletters or other important information on the FI’s Web site. Providers should be able to join the FI’s electronic mailing lists via the FI’s provider education Web site. Subscribers to the FI’s electronic mailing lists should also be able to initiate de-listing themselves via the Web site. The FI posts notices on its Web sites and in bulletins/newsletters that encourage subscription to the electronic mailing lists. The FI’s electronic mailing lists should be capable of accommodating all of its providers. It is recommended that the FI’s electronic mailing list(s) be constructed for only one-way communication, i.e., from the FI to subscribers. The FI is encouraged to offer multiple electronic mailing lists to accommodate the various providers served.*

*The FI is required to protect its electronic mailing list(s) addresses from unauthorized access or inappropriate usage. The FI’s electronic mailing lists, or any portions or information contained therein, should not be shared, sold or in any way transferred to*

*any other organization or entity. In special or unique circumstances where such a transference or sharing of listserv information to another organization or entity is deemed to be in the best interests of CMS or the Medicare program, the FI must first obtain express written permission of its CMS regional office PCOM or PSP Coordinator.*

*The FI maintains record of its electronic mailing list usage. These records should include when the electronic mailing list(s) were used, text of the messages sent, the number of subscribers transmitted to per usage, and the author of the message. Records should be kept for one year from the date of usage.*

### **20.1.8 - Training of Providers in Electronic Claims Submission**

**(Rev. 3, 12-09-03)**

*Conduct training for provider staff in electronic claims submission. This may include, but is not limited to, activities listed in Productivity Investments; use of Medicare billing and PC-Print software; use of available Medicare Electronic Data Interchange (EDI) transactions; use of new or updated Medicare software released during the year; and use of newly introduced EDI standards and/or functions or changes to existing standards or functions.*

**NOTE:** *There are multiple sources of provider training requirements associated with EDI functions. The PCOM function covers providers in group settings rather than contact with individuals. PCOM covers newsletters, classes or outreach to groups of providers and their staff on Medicare coverage, billing and benefits of EDI. PCOM does not include instruction related to connectivity for individual providers or the resolution of connectivity problems.*

### **20.1.9 - Provider Education and Beneficiary Use of Preventive Benefits**

**(Rev. 3, 12-09-03)**

*Through the provider education activities, promote beneficiary use of preventive benefits as specified in the Balanced Budget Act of 1997, the Balanced Budget and Reconciliation Act of 1999, and the Benefits Improvement and Protection Act of 2000. These benefits include screening mammography and screening for colorectal, cervical, and prostate cancer.*

### **20.1.10 - Internal Development of Provider Issues**

**(Rev. 3, 12-09-03)**

*Hold periodic meetings with staff in appropriate areas of the organization (including personnel responsible for medical review, EDI/systems, appeals, and program integrity) to ensure that inquiries and issues made known by providers to these other areas in the organization are communicated and shared with provider education staff.*



*Mechanisms to resolve these issues should be discussed. Minutes of the meetings should be kept and filed.*

### ***20.1.11 - Training of Provider Education Staff***

***(Rev. 3, 12-09-03)***

*Implement a developmental plan for training new provider education personnel, and periodically assessing the training needs of existing provider education staff. The plan, which must be written and available to the FI's provider education staff, should include schedules, course or instruction vehicle descriptions, and satisfaction criteria. Training materials such as workbooks, manuals, and policy guidelines should always be readily available to the provider education staff.*

## ***20.2 - Provider Communications – Program Administration***

***(Rev. 3, 12-09-03)***

***A2-2965.B***

### ***20.2.1 - PSP Quarterly Activity Report***

***(Rev. 3, 12-09-03)***

***A2-2965.B.1***

*The FI is required to develop and submit PSP Quarterly Activity Reports (QAR) that summarizes and recounts the provider education and training activities for the previous quarter year. The FI uses its annual PSP, the Budget and Performance Requirements, and the provider communications program requirements herein to help formulate its QAR.*

*Reports must be submitted 30 days after the end of every quarter in the fiscal year. The deadlines for submitting the quarterly reports are as follows:*

*First quarter – January 31*

*Second quarter – April 30*

*Third quarter – July 31*

*Fourth quarter – October 31*

*The FI sends its QAR reports, either in hardcopy or electronically, to its RO PCOM or PSP coordinator, and to the CMS CO Provider Communications Regional Consortium staff under which the FI falls. (The e-mail address of the CO Consortium Liaison can be obtained from the FI's RO PSP coordinator.) Request an acknowledgement from*



*the CMS recipient for any electronically submitted report. Hardcopy QAR reports sent to CO should be addressed to:*

*Centers for Medicare & Medicaid Services  
Center for Medicare Management  
Division of Contractor Provider Communications  
Mail Stop C4-10-07  
7500 Security Boulevard  
Baltimore, Maryland 21244-1850.*

*The FI provides the name, phone number, and mailing address of the PSP coordinator for its organization on its QAR reports.*

### ***A - Format and Content of QAR***

*Report on provider communications activities using the following headings:*

- 1. Inquiry and Data Analysis*
- 2. Pcom Advisory Group/ Participation in Recommended Educational Activities/Forums*
- 3. Bulletins/Newsletters*
- 4. Seminars/Workshops/Teleconferences*
- 5. New Technologies/Electronic Media*
- 6. Internal Staff Development/Plan To Strengthen the Quality of Written Communication*
- 7. Other Activities*

*Use the following in formatting the QAR reports:*

### ***B - Cover Page***

*The cover page should contain the following information:*

- FI Name/Type*
- FI Number*
- Reporting period (1st, 2nd, 3rd, or 4th quarter)*
- PSP Coordinators' Name/Phone Number/E-mail address*
- Date Submitted*

- *Geographic Service Area (State)/Regional Office Affiliation*

***Provider Communication Activities 1 – 7***

***Activity 1: Inquiry and Data Analysis***

***Specific Format Requirement:***

*Word Table or Spreadsheet*

*Spreadsheet Headings*

- *Top Ten Inquiries and Claim Submission Errors (table heading)*
- *I (Inquiry)/CSE (Claim Submission Error)*
- *Provider Specialty (optional field)*
- *Number received*
- *Action/Resolution*

***Example***

***TOP TEN INQUIRIES AND CLAIMS SUBMISSION ERRORS (CSE)***

<b><i>TOP Ten Inquiries and CSE's</i></b>	<b><i>I /CSE</i></b>	<b><i>Provider Specialty</i></b>	<b><i>Number Received</i></b>	<b><i>Action taken/Resolution (if applicable)</i></b>

***Instructions for Completing Each Field:***

***1. Top Ten Inquiries and Claim Submission Errors***

*List the top 10 provider inquiries or frequently asked questions and the top 10 claim submission errors. This should include the top ten inquiries, and the top 10 ten claim submission errors, for a total of twenty entries in this column.*

***2. Inquiry/Claim Submission Errors***

*Identify the entry as either an inquiry (I), or a claim submission error (CSE).*

3. *Provider Specialty*

*List the provider specialty, if known. This is an optional field.*

4. *Number of inquiries or claim submission errors*

*Record the number for inquiries or claim submission errors received during the reporting period.*

5. *Action taken /Resolution*

*Indicate the provider communications or other action taken or soon to be taken. Indicate any resolution to the issue, if applicable.*

***Activity 2: Provider Communications Advisory Group/Participation In Recommended Educational Activities/Forums***

***Specific Format Requirement:***

*Word Table or Spreadsheet*

*Spreadsheet Headings:*

- *PCOM Advisory Group/Related Activities (table heading)*
- *Activity*
- *Frequency*
- *Date*
- *Attachments*
- *Comments*

***Example***

***PCOM ADVISORY GROUP/RELATED ACTIVITIES***

<b><i>Activity</i></b>	<b><i>Frequency</i></b>	<b><i>Date</i></b>	<b><i>Attachments (Yes/No)</i></b>	<b><i>COMMENTS</i></b>

<i>Activity</i>	<i>Frequency</i>	<i>Date</i>	<i>Attachments (Yes/No)</i>	<i>COMMENTS</i>

***Instructions for Completing Each Field:***

*1. Identification of Activity*

*Indicate the type of activity including those that resulted from recommendations of the advisory group (i.e., PCOM Advisory Group, Workshop, Seminar, Speech, other)*

*2. Frequency*

*Frequency means how often the event was held, (e.g., continuously, weekly, monthly, quarterly, annually)*

*3. Date*

*Indicate the specific date on which the activity occurred.*

*4. Attachments (Yes or No)*

*Indicate whether or not the attachment(s) (i.e., agenda, membership listing, minutes, action items, etc.) associated with the event/meeting, are included in the report.*

*5. Comments*

*List any appropriate comments related to a subcategory.*

***Activity 3: Issue Regular Bulletins/Newsletters***

***Specific Format Requirement:***

*Word Table or Spreadsheet*

*Spreadsheet Headings:*

- Bulletins/Newsletters (table heading)*
- Date Mailed*
- Number of Hard Copies Mailed*

- *Major Topics Covered*

**Example**

***BULLETINS/NEWSLETTERS***

<i>Bulletin/ Newsletter</i>	<i>Date Mailed</i>	<i>Number of Hard Copies Mailed</i>	<i>Major Topics Covered</i>

***Instructions for Completing Each Field:***

*1. Bulletin/Newsletter*

*Give the name of the bulletin/newsletter*

*2. Date Mailed*

*Give the date the newsletter/bulletin was mailed.*

*3. Number of Hard Copies Mailed*

*Indicate the number of paper copies mailed.*

*4. Major Topic Areas Covered*

*List 3-4 major topic areas covered.*

***Activity 4: Seminars/Workshops/Teleconferences***

***Specific Format Requirement:***

*Word Document or Spreadsheet*

*Spreadsheet Headings:*

- *Seminars/Workshops/Teleconferences (table heading)*
- *Date*
- *Location*
- *Event Type*

- *Topic*
- *Target Audience*
- *Number of Participants*
- *Materials Distributed*

**Example**

**SEMINARS/WORKSHOPS/TELECONFERENCES**

<i>Date</i>	<i>Location</i>	<i>Event Type</i>	<i>Topic</i>	<i>Target Audience</i>	<i>Number of Participants</i>	<i>Materials Distributed</i>

**Instructions for Completing Each Field:**

1. *Date*

*Indicate the date of the activity.*

2. *Location*

*Indicate the location of the activity.*

3. *Event Type*

*Indicate the type of event based on the codes below:*

*S=Seminar*

*C=Convention (or annual meeting)*

*W=Workshop*

*P=Presentation*

*E=Educational Forum*

*O=Other*

4. *Topic*

*Indicate the topic(s) of the training*

5. *Target Audience*

*Indicate the audience(s) based on the codes below:*

*P=Physician*

*PB=Other Part B provider*

*H=Hospital*

*A=Ancillary*

*PA=Other Part `A provider*

*D=DME*

*S=Supplier*

*PR=General provider*

*PM=Practice/Office Manager and staff*

*BM=Billing Manager and staff*

*O=Other*

*6. Number of Participants*

*Indicate the number of participants in the event.*

*7. Materials Distributed*

*Indicate the material(s) distributed (i.e., Fact Sheet, Manual, video, CD-ROM, etc.).*

***Activity 5: New Technologies/Electronic Media***

***Internet Web Site:***

*Indicate fully: Provider Web Site Address: \_\_\_\_\_*

***Specific Format Requirement:***

*Word document and two Tables/Narrative*

**Example 1**

**TABLE 5A – WEB SITE BASIC REQUIREMENTS**

<b>CRITERIA</b>	<b>YES</b>	<b>NO</b>
<i>Web site</i>		
<i>Newly created bulletins/newsletters</i>		
<i>Schedule of upcoming events</i>		
<i>Automated registration</i>		
<i>Area designated for Medicare Learning Network</i>		
<i>Quarterly listing of Frequently Asked Questions</i>		
<i>Search engine functionality</i>		
<i>E-mail based support</i>		
<i>CPT Code information</i>		
<i>Ability to link to other sites</i>		
<i>Information for providers for electronic claims submission</i>		

**Instructions for Completing Each Field:**

1. *Yes*

*Check “Yes” if the criterion has been met.*

2. *No*

*Check “No” if the criterion has not been met.*

**Example 2**

**TABLE 5B - ELECTRONIC MEDIA USAGE**

<b>COMPONENT</b>		
------------------	--	--



<b><i>COMPONENT</i></b>		
<b><i>Bulletin/Newsletter</i></b>	<b><i>Date Bltn./Nwsltr. Posted to Web</i></b>	
<b><i>Issue number/identification</i></b>		
<b><i>CMS Furnished Article/Information</i></b>	<b><i>Date Artcl./Info. Posted to Web</i></b>	
<b><i>Article Title/Description of Information</i></b>		
<b><i>Listserv (Electronic Mailing List) Usage</i></b>	<b><i>Date Used</i></b>	<b><i>Subject</i></b>
<b><i>Listserv name/description</i></b>		

***Table Components:***

*Electronic Media Usage (table heading)*

*Bulletin/Newsletter*

*Date Bltn./Nwsltr. Posted to Web*

*CMS Furnished Article/Information*

*Date Artcl./Info. Posted to Web*

*Listserv (Electronic Mailing List) Usage*

*Date Used*

*Subject*

**Instructions for Completing Each Field:**

1. *Bulletin/Newsletter*

*Identify the issue (edition month, season or number) of the bulletin or newsletter.*

2. *Date Bltn./Nwsltr. Posted to Web*

*Indicate the date the bulletin/newsletter was first posted and available on the Web site*

3. *CMS Furnished Article/Information*

*Identify specific CMS furnished provider targeted article or information for posting to the Web site*

4. *Date Artcl./Info. Posted to Web*

*Indicate the date the CMS furnished article or information was posted on the Web site*

5. *Listserv (Electronic Mailing List) Usage*

*Identify the name or designation of the listserv(s) (electronic mailing lists)*

6. *Date Used*

*Indicate the date(s) the listserv(s) were used*

7. *Subject*

*Identify the subject(s) of each listserv transmission*

**Activity 6: Internal Development of Provider Issues**

**Specific Format Requirement:**

*Word document or Spreadsheet/Narrative*

**Example**

**INTERNAL DEVELOPMENT of PROVIDER ISSUES**

<b>Internal Component</b>	<b>Frequency of Meetings</b>	<b>Date(s)</b>	<b>Comments</b>
<b>Medical Review</b>			

<i>Internal Component</i>	<i>Frequency of Meetings</i>	<i>Date(s)</i>	<i>Comments</i>
<i>Fraud</i>			
<i>Customer Service</i>			
<i>DME</i>			
<i>Reimbursement</i>			
<i>Provider Records/Enrollment</i>			
<i>Provider Relations</i>			
<i>Communications</i>			
<i>Other</i>			

***Spreadsheet Headings:***

- *Internal Development of Provider Issues (table heading)*
- *Internal Component*
- *Frequency of Meetings*
- *Date(s)*
- *Comments*

***Instructions for Completing Each Field:***

*1. Frequency of Meetings*

*Indicate the frequency with which provider education staff meets with each of the individual areas to learn of issues or questions communicated by providers. Use NA (not applicable) if the organizational component is not appropriate to the organization*

*2. Dates*

*Indicate the date of the meeting(s).*

*3. Comments*

*Indicate the provider issues discussed or other information considered relevant.*

## ***Activity 7: Other Activities***

### ***Specific Format Requirement:***

*Narrative*

### ***Instructions:***

*Use this section to discuss any additional highlights for the quarter. Feel free to mention any areas of significance not previously noted. This should also include the following:*

- 1. Any noteworthy activities, efforts, enhancements, or changes to the provider/supplier education program including the provider Web site that should be brought to CMS' attention;*
- 2. Any activities or issues coordinated with the DMERC during the quarter;*
- 3. Mechanisms used to actively solicit feedback related to the Medicare program;*
- 4. Provider/supplier education activities or efforts used to promote utilization of preventive benefits; and*
- 5. Mechanisms developed and/or implemented to measure the effectiveness of the educational and training activities. This may include customer satisfaction survey instruments, findings from administering these surveys, and results from pre and post-testing at workshops and seminars.*

## ***20.2.2 - Charging Fees to Providers for Medicare Education and Training Activities***

***(Rev.3, 12-09-03)***

### ***A2-2945.B.2***

*The FI may assess fees or charges for provider education activities in accordance with the guidelines stated herein. Provider education and training activities are separated into two cost categories:*

- 1. No charge; and*
- 2. Fair and reasonable cost.*

*The cost of conducting these activities, or any fees assessed, must conform to the requirements provided below. These cost categorizations distinguish provider education efforts considered to be statutorily mandated (provided at no-charge to providers), and those considered to be enhanced or supplemental.*

### ***A - No Charge -- Statutorily Required Training***

- *Activities and training materials designed to educate providers in Medicare enrollment, coverage, reimbursement, and billing requirements. The number of sessions and the scope of this training should be based on recommendations from business partners including, but not limited to, the Provider Communications (PCOM) Advisory Committee, and fit within program management resources.*
- *Training and materials on statutorily mandated or significant Medicare program changes, (e.g., hospital outpatient prospective payment system, home health, inpatient rehabilitation, SNF PPS and consolidated billing, and ambulance). The CMS will provide advance notice on this training (including any needed follow-up training) and the availability of additional funding.*
- *Participation in conferences sponsored by other Medicare FIs and government agencies that are based upon recommendations from the PET Advisory Committee.*

### ***B - Fair and Reasonable Cost--Discretionary Activities***

- *Individualized training requested by a provider. This may include the cost of travel, materials, accommodations, staff preparation, follow-up activities, and a fee for expenses to attend the event and make the presentation.*
- *Training videos, audiotapes, specialized brochures, pamphlets, and manuals developed by FIs (except for materials included in no-charge-statutorily required training).*
- *Presentations and training at non-Medicare FI sponsored conferences, trade shows, conventions, annual meetings, etc. If the FI receives a request from a group such as a national, regional or state association or medical industry body to make a presentation at an event, the FI can charge the association or group a fee for travel expenses to attend the event. This fee may include the cost for materials, meeting rooms (if the FI is required to incur that cost), accommodations, travel, staff preparation, handouts, follow-up activities, and other incidentals. The travel fee must be fair and reasonable, and based on the cost incurred for providing the service or activity. The FI must confer with its regional office PCOM or PET coordinator about the costs associated with providing the training to ensure that the costs are reasonable.*

***NOTE:*** *The FI may accept nominal speakers fees, or recognition gifts such as pens engraved with the host logo, coffee mugs, plaques, flowers, etc. However, the FI is not permitted to accept and use substantive gifts or donations associated with participation in education and training activities absent specific authority.*

- *Reference manuals, guides, workbooks, and other resource materials developed by the FI designed to supplement or provide easy reference to formal Medicare provider manuals and instructions.*

*Revenues collected from these discretionary activities must be used only to cover the cost of these activities and may not be used to supplement other Medicare FI activities.*

### ***C. Facilities, Food and Beverages, and Provider Communications***

*Holding provider education and training events for both statutorily required and discretionary activities at alternate locations (other than at the FI's own offices or buildings) may often reduce provider time and travel costs associated with attending these events. When such an opportunity exists, the FI may recover the costs incurred for meeting rooms, auditoriums and other facilities and equipment through a fee to participants. This fee or charge should be fair and reasonable and within the means of likely participants.*

*It is also recognized that many contractual agreements with hotels or other meeting site locations stipulate that food and beverages be purchased as a condition of furnishing a meeting or training room. In addition, light refreshments and food may be desirable to facilitate the training and/or for the convenience of the trainees or participants. If light refreshments and food are provided, a fee that covers this cost and is charged to participants must be fair and reasonable, and based on the costs incurred by the FI. Providing food and beverages that exceed these guidelines are prohibited.*

*Keep records per event of the costs incurred and all fees charged to, and collected from, registrants. The total of fees or charges for any event should not exceed by more than 10 per cent the actual costs incurred for the event. If it does, the FI should refund the entire excess amount collected to all the registrants who paid a fee for that event. For example, participants are charged a \$50 registration fee for an event that costs \$10,000 (e.g., light refreshments, meeting facility, and equipment rental), 250 individuals pay to attend and \$12,500 is collected. Since the amount collected exceeded more than 10 per cent of the costs (\$1,000), the entire excess amount collected (\$2,500) is disbursed back to all paying registrants.*

### ***D - Refunds/Credits***

*In order to secure sites needed for future provider training events, the FI may have to make commitments under which it will incur contractual expenses for training accommodations and services. Full or partial refunds/credits to providers who register for an event, and cancel before the event, or do not attend the event, should be made within the context of these contractual arrangements. If training is scheduled and the FI cancels the event, a full refund must be made to registrants. If there are questions concerning the implementation of this policy in a given case, the FI contacts its RO PCOM coordinator.*

### ***E - Bulletins/Newsletters***

*Unless otherwise established, the FI must furnish free of charge one paper copy of the regular bulletin/newsletter which contains program and billing information to providers. If providers are interested in obtaining additional paper copies on a regular basis, the FI is permitted to charge a fee for this. The fee for this subscription should be "fair and reasonable" and based on the cost of producing and mailing the publication. A separate charge may also be assessed to any provider who periodically requests additional single paper copies.*

### ***F - Mixed Training Events***

*In situations where provider education and training activities involve both statutorily required training and discretionary training, the FI must allocate the proportional costs between the activities. That is, the proportional share of the cost of a function allocated to statutorily required training is equal to the percentage of time related to this training. For example, if it costs \$1,000 to arrange and conduct a mixed training session, with 25 percent of the session related to statutorily required training, then the proportional cost allocation for the training would be  $.25 \times \$1,000 = \$250$  for statutorily required training and  $.75 \times \$1,000 = \$750$  for discretionary training activities.*

### ***G - Recording of Training Events***

*Entities not employed by CMS, or under contractual arrangement with the FI, are not permitted to videotape or otherwise record training events for profit-making purposes.*

## ***20.2.3 - Provider Information and Education Materials and Resource Directory***

***(Rev. 3, 12-09-03)***

### ***A2-2965.B.3***

#### ***A - Dating of Materials***

*Provider education and training materials produced (pamphlets, brochures, work books, reference manuals, CDs, etc.) must bear the month and year they were produced or re-issued.*

#### ***B - Provider Information and Education Materials Resource Directory***

*The Provider Information and Education Resource Directory is comprised of provider education materials developed by Medicare contractors. The materials, which include brochures, manuals, work and reference books, fact sheets, videos, audio tapes, CDs, etc., are used to convey Medicare program, policy and billing information to professional health care providers and others associated with the health services about industry. The purpose of the Directory is to facilitate the sharing of provider*

*information and education tools among Medicare FIs, and would, therefore, help reduce the cost of development of these materials.*

*Unless previously submitted, the FI sends one copy of any provider information and education material of note developed or used within the last 2 years to the address below. This material should be suitable to be used or copied in whole or in part by other Medicare FIs.*

***NOTE:*** *All materials developed by Medicare FIs using CMS funding as the principal source for its development are considered the property of CMS, and must be made available to CMS upon request.*

*Submit materials that address subjects primarily on a national, rather than a regional or local basis. The FI does not send materials containing information predominately tailored to local or regional audiences that have little national application such as unique letters, event notices, or complete provider bulletins or newsletters. Individual bulletin or newsletter articles focusing on subjects of nationwide interest can be sent. The FI includes the name, address, telephone number and e-mail address of a contact person for each piece.*

*Send these materials to:*

*Centers for Medicare & Medicaid Services  
Division of Provider Information Planning and Development  
Mail Stop C4-11-27  
7500 Security Boulevard,  
Baltimore, MD 21244-1850  
Attn: Resource Directory*

*The FI sends one copy of all appropriate provider education and information materials (excluding bulletins/newsletters) developed in the future, to the address above. Also, send any significantly revised or updated versions of material previously submitted.*

*If the FI reproduces or uses material, in whole or in part, originally developed by another Medicare FI, that FI should be acknowledged either within the material, or on its cover, case, or container. In the case of printed text material, this acknowledgement should appear on the inside back page or cover.*

### ***30 – Carrier (Including DMERCs) Provider/Supplier Communications – Provider/Supplier Education and Training***

***(Rev. 3, 12-09-03)***

***B2-5107***

*This section and its related subsections apply only to carriers (including DMERCs).*



*Sections 1816(a) and 1842(a)(3) of the Social Security Act (the Act) require that contractors serve as a channel of communication for information to and from providers/suppliers. The fundamental goal of the CMS' Provider/Supplier Communications (PCOM) program (formerly Provider Education and Training, PET) is to give those who provide service to beneficiaries the information they need to understand the Medicare program so that, in the end, they manage Medicare related matters appropriately and bill correctly.*

*PCOM uses mass media, such as print, Internet, satellite networks, and other technologies, face-to-face instruction, and presentations in classrooms and other settings, to meet the needs of Medicare providers/suppliers for timely, accurate, and understandable Medicare information.*

*PCOM is directed at educating provider/supplier and their staffs about fundamental Medicare programs and policies, new Medicare initiatives, and significant changes to the Medicare program. These efforts are aimed at reducing the number of provider/supplier inquiries and claim submission errors. Unlike Local Provider Education and Training (LPET), PCOM, for the most part, is not targeted to individual providers/suppliers or limited and confined problems or errors. PCOM is instead designed to be broader in nature so as to meet the basic informational needs of Medicare providers/suppliers, plus have a unique focus upon training and consulting for new Medicare providers/suppliers as well. The scope of PCOM is to identify and address issues that are of concern to the broad provider/supplier audience.*

### **30.1 - Provider/Supplier Communications - Program Elements**

**(Rev. 3, 12-09-03)**

*The carrier is required to implement the basic requirements for PCOM stated herein. The carrier is also required to meet budget and performance requirements (BPRs) for this program issued each fiscal year that provide additional guidance on the program.*

*The carrier reports the costs and workload data for the PCOM program according to the prescribed CAFM activity codes.*

#### **30.1.1 - Provider/Supplier Service Plan (PSP)**

**(Rev. 3, 12-09-03)**

*The carrier is required to prepare and submit a PSP annually. The PSP must address the carrier's overall plans for implementing the provider/supplier communications program in the forthcoming fiscal year. The PSP outlines the strategies, projected activities, efforts, and approaches that will be used during the year to support provider/supplier communications. The PSP must address and support all the activities stated herein as well as all required activities stated in the yearly BPRs for this program.*

*The Plan must include how the following elements of the PCOM program, described hereafter, will be met, and note, when appropriate, how many events, occurrences or other happenings are planned or anticipated for these elements (e.g., the number of workshops, seminars, speeches, frequency of bulletins, number distributed, number of partnerships with external entities, number of times listserv(s) used, etc.):*

- Provider/Supplier Inquiry Analysis,*
- Provider/Supplier Data Analysis,*
- Seminars/Workshops/Educational Events,*
- Provider/Supplier Communications Advisory Group,*
- Bulletins/Newsletters,*
- New Technologies/Electronic Media, and*
- Promoting Beneficiary Use of Preventive Benefits Through Provider/Supplier Education Activities.*

*A draft or preliminary PSP should be sent at the time the carrier submit its annual budget request to the regional office (RO) PSP coordinator or contact for review is submitted. A final PSP should be sent by October 31, to the RO PSP coordinator and to CMS Central Office (CO). Plans sent to CO should be addressed to:*

*Centers for Medicare & Medicaid Services  
Center for Medicare Management  
Division of Contractor Provider Communications  
Mail stop C4-10-07  
7500 Security Boulevard  
Baltimore, Maryland 21244*

*The carrier provides the name, phone number, and mailing address of the PSP coordinator with the PSP.*

### ***30.1.2 -. Provider/Supplier Inquiry Analysis***

***(Rev. 3, 12-09-03)***

*The carrier must maintain a provider/supplier inquiry analysis program that will produce a monthly list of the most frequently asked questions (FAQs) and areas of concern/confusion for providers/suppliers. The carrier uses an organized, consistent, systematic, and reproducible process to generate most frequently asked questions. The carrier describes this process in the PSP. Outreach and educational efforts must be developed and implemented to address the needs of providers/suppliers as identified by this program.*

### **30.1.3 - Provider/Supplier Data Analysis**

**(Rev. 3, 12-09-03)**

*The carrier must maintain a provider/supplier data analysis program that will produce a monthly list of the most frequent, collective claims submission errors from all providers/suppliers. Claims submission errors result in rejected, denied, or incorrectly paid claims. Outreach and educational efforts must be developed and implemented to address the needs of providers/suppliers as identified by this program.*

### **30.1.4 - Provider/Supplier Communications Advisory Group**

**(Rev. 3, 12-09-03)**

*The carrier must support and maintain a PCOM Advisory Group (formerly referred to as the PET Advisory Group). This group should generally convene quarterly, but at a minimum, meet three times per year, and will provide advice and recommendations to the carrier on provider/supplier communications matters.*

#### **A. Purpose of PCOM Advisory Groups**

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

*While it remains allowable for the carrier to use PCOM Advisory Groups to provide updates and facilitate discussion on current issues, the focus of the group meetings should remain centered on the development and implementation of effective provider/supplier communication materials and strategies.*

#### **B. Composition of PCOM Advisory Group**

*The carrier should strive to maintain professional and geographic diversity within the PCOM advisory groups. The carrier should attempt to include representatives of various provider/supplier specialties serviced including state and local trade and professional associations, practicing provider/supplier or staff members deemed appropriate, and representatives of billing organizations. Providers/suppliers from different geographic areas, as well as from urban and rural locales, should be represented in any PCOM Advisory Group. The carrier should consider inviting representatives of Quality Improvement Organizations (QIOs) from its area to participate in PCOM Advisory Group meetings.*

*The carrier should consider having more than one PCOM Advisory Group when the breadth of the geographic service area, or range of the providers/suppliers serviced by the carrier diminishes the practicality and effectiveness of having a single PCOM Advisory Group. For further guidance on this issue, the carrier should contact its regional office PCOM or provider education and training (PET) Coordinator.*

### **C. Carrier Role**

*The carrier should maintain the PCOM Advisory Group. While group members should be solicited for agenda topics, it is not permissible for Medicare carriers to allow outside organizations to operate the PCOM Advisory Group. After soliciting suggestions from the provider/supplier community, the carriers should select the appropriate individuals and organizations to be included in the group. The main point of contact for all PCOM Advisory Group communication should be within the carrier's PCOM, PET or similar department. At a minimum, the carrier is responsible for recruiting potential members, setting-up and arranging all meetings, handling meeting logistics, producing and distributing an agenda, completing and distributing minutes, and keeping adequate records of the advisory group's proceedings.*

*A Medicare carrier having more than one kind of Medicare contract (e.g., intermediary, Part B carrier, DMERC, rural home health intermediary, etc.) is required to have separate PCOM advisory groups for each kind of Medicare contract. It is also impermissible for the carrier having geographic proximity or overlap with one another to share a PCOM Advisory Group. Each carrier must have its own separate group. The carrier shall not reimburse or charge a fee to group members for membership or for costs associated with serving on a PCOM Advisory Group. The carrier is required to notify its CMS regional office PET or PCOM coordinator of the schedule and location of PCOM Advisory Group meetings.*

*The carrier is expected to consider the suggestions and recommendations of the PCOM Advisory Group, and implement or enact them if the carrier deems them reasonable, practicable, and within the provider/supplier communications program requirements and budget constraints. After consideration, a carrier must explain to the group the reasons for not implementing or adopting any group suggestions or recommendations.*

### **D. Meeting Specifics**

*The carrier may hold PCOM Advisory Groups in-person or via teleconferencing. The CMS recommends that the carrier holds at least one meeting per calendar year with group members in-person. Teleconferencing should be made available to Advisory Group members who cannot be present for any meeting. The carrier should also have a specific area on its Web site that allows providers/suppliers to access information about the PCOM Advisory Group (minutes from meetings, list of organizations or entities comprising the PCOM Advisory Group, an e-mail address for a contact point and for further information on the PCOM Advisory Group, etc.). This area of the carrier's Web site should be operational by March 31, 2003. The carrier notifies the PCOM Advisory Group members that information about its participation on the*

*Advisory Group may be on the Web site. The carrier consults with the CMS regional office PET or PCOM coordinator if a member has objections, and on ways to mitigate them.*

*Meeting agendas, which include discussion topics garnered from solicitation of group members, should be distributed to all members of the group and the CMS regional office PET or PCOM coordinator at least 2 business days prior to any meeting. After each meeting, minutes should be disseminated within 7 business days to all group members and others who request them.*

### ***E. Relationship to Other Carrier Advisory Groups***

*PCOM advisory groups operate independently from other existing carrier advisory committees. While a PCOM Advisory Group may, at its discretion, share information with other advisory groups, the PCOM Advisory Group does not need the approval, authorization or input from any other entity for its advice, recommendations, or issuances. While an individual PCOM Advisory Group member can be a member of another carrier advisory committee, the majority of PCOM Advisory Group members should not be current members of any other carrier advisory group.*

*For more information or specific guidance on any of the above issues, the carrier contacts its regional office PET or PCOM coordinator.*

### ***30.1.5 - Bulletins/Newsletters***

***(Rev. 3, 12-09-03)***

*The carrier prints and distributes regular provider/supplier bulletins/newsletters, at least quarterly, which contain program and billing information. When feasible and cost-effective, the carrier stops sending regular bulletins to providers/suppliers with no billing activity in the previous 12 months. Newly created bulletins/newsletters must be posted on the carrier's Web site. All printed bulletins/newsletters must have either a header or footer in boldface type within the first three pages that states the following: **"This Bulletin Should Be Shared With All Health Care Practitioners and Managerial Members of the Provider/Supplier Staff. Bulletins Are Available at No Cost from Our Web Site [Insert Carrier Web Site Address]"***

*The carrier encourages providers/suppliers to obtain electronic copies of bulletins/newsletters and other notices through the Web site. If providers/suppliers are interested in obtaining additional paper copies on a regular basis, the carrier is permitted to charge a fee for this. The subscription fee should be "fair and reasonable" and based on the cost of producing and mailing the publication. A charge may also be assessed to any provider/supplier who requests additional single paper copies.*

### **30.1.6 - Seminars/Workshops/Teleconferences**

**(Rev. 3, 12-09-03)**

*The carrier holds seminars, workshops, classes, or other face-to-face meetings, to educate and train providers/suppliers about the Medicare program and billing issues. Whenever feasible, activities should be coordinated with other regional Medicare carriers, including quality improvement organizations (QIOs), other carriers, and intermediaries, State Health Insurance Assistance Programs (SHIPs), and End Stage Renal Disease (ESRD) networks as well as interested groups, organizations, and CMS partners in the service area. The carrier develops, and implements whenever practicable, effectiveness measures for each education and training activity. This includes, but is not limited to, customer satisfaction survey instruments, pre- and post-testing at workshops and seminars, and other feedback mechanisms.*

*Whenever feasible, hold teleconferences to address and resolve inquiries from providers/suppliers as a method to reach a broad audience. If facilities permit, carriers should host Medicare Learning Network (MLN) satellite broadcasts for providers/suppliers in the service area.*

### **30.1.7 - New Technologies/Electronic Media**

**(Rev. 3, 12-09-03)**

*The carriers must use new technologies and electronic media as an efficient, timely, and cost-effective means of disseminating Medicare provider/supplier information to the audiences they serve.*

#### ***A - Provider/Supplier Education Web Site***

*The carrier maintains a Web site that is dedicated to furnishing providers/suppliers with timely, accessible, and understandable Medicare program information. To reduce costs, Web sites should fit into existing infrastructure and use existing resource technologies whenever possible.*

*This Web site must comply with “Contractor Web Site Standards and Guidelines” posted at <http://www.cms.hhs.gov/about/web/contractors.asp> and must be compatible with multiple browsers. The carrier periodically reviews the “Web Site Standards and Guidelines” to determine continued compliance. During the first 3 months of each calendar year, the carrier sends a signed and dated statement to the RO PCOM or PET Coordinator attesting to whether the carrier’s Web site continues to comply with these guidelines and whether it is compatible with multiple browsers. The person in the carrier’s organization who has authority over the Web site should sign the attestation statement.*

*The Carrier’s Provider/Supplier Outreach Web site must contain the following:*

- *All newly created provider/supplier bulletins/newsletters;*

- *A schedule of upcoming events (e.g., seminars, workshops, fairs);*
- *Ability to register for seminars and other events via the Web site;*
- *Search engine functionality;*
- *Features that permit providers/suppliers to download and save copies of bulletins, training materials, schedules of upcoming events, and other items;*
- *A “What’s New” or similarly titled section that contains newsworthy and important information that is of an immediate or time sensitive nature to Medicare providers/suppliers;*
- *E-mail based support/help/customer service;*
- *A listing of FAQs/areas of concern updated quarterly as evidenced through the carrier’s inquiry analysis program; and*
- *Information for providers/suppliers on how to submit claims electronically.*

*The Carrier’s Provider/Supplier Outreach Web site must link to:*

- *The Medicare program Web site at: <http://cms.hhs.gov>;*
- *The MLN at: <http://cms.hhs.gov/medlearn>;*
- *The site for downloading CMS publications at <http://cms.hhs.gov/publications/>;*
- *The site for downloading CMS manuals and transmittals at <http://cms.hhs.gov/manuals/transmittals/>; and*
- *Other CMS Medicare carriers, partners, QIOs, and other sites that may be useful to providers/suppliers.*

### ***1 - Directed Web Site/Bulletin Article***

*The carrier often receives instructions from CMS to print a provider/supplier education article or other information in its provider/supplier bulletin or newsletter and also place it on their Web site. Unless specifically directed otherwise, the carrier locates the article or information from CMS on the “What’s New” or similarly titled section of the provider/supplier education Web site. Unless specifically directed otherwise, the article or information should be put on the carrier Web site as soon as possible after receipt, and should remain on the Web site for 2 months, or until the bulletin or newsletter in which it is appearing is put on the Web site, whichever is later.*



## **2 - Use of Current Procedural Terminology**

*Web sites must adhere to requirements stated in the Medicare Claims Processing Manual, Chapter 23, Subsection 20.7, regarding the use of current procedural terminology (CPT) codes and descriptions. During the first 3 months of each calendar year, the carrier determines whether the carrier's Web site complies with requirements stated in this chapter and subsection of the Medicare Claims Processing Manual. A signed and dated attestation statement must be sent to the carrier's RO PCOM or PET Coordinator. The person in the carrier's organization who has authority over the Web site should sign the attestation statement.*

### **B - Electronic Mailing List/Listserv**

*The carrier maintains at least one electronic mailing list, or listserv, to notify registrants via e-mail of important, time-sensitive Medicare program information, upcoming provider/supplier communications events, and other announcements necessitating immediate attention. At a minimum, the carrier uses electronic mailing lists to notify registrants of the availability of bulletins/newsletters or other important information on the carrier's Web site. Providers/suppliers should be able to join the carrier's electronic mailing lists via the carrier's provider/supplier education Web site. Subscribers to the carrier's electronic mailing lists should also be able to initiate de-listing themselves via the Web site. The carrier posts notices on its Web site and in bulletins/newsletters that encourage subscription to the electronic mailing lists. The carrier's electronic mailing lists should be capable of accommodating all of its providers/suppliers. It is recommended that the carrier's electronic mailing list(s) be constructed for only one-way communication, i.e., from the carrier to subscribers. The carrier is encouraged to offer multiple electronic mailing lists to accommodate the various providers/suppliers served.*

*The carrier is required to protect its electronic mailing list(s) addresses from unauthorized access or inappropriate usage. The carrier's electronic mailing lists, or any portions or information contained therein, should not be shared, sold or in any way transferred to any other organization or entity. In special or unique circumstances where such a transference or sharing of listserv information to another organization or entity is deemed to be in the best interests of CMS or the Medicare program, the carriers must first obtain express written permission of the CMS regional office PCOM or PSP Coordinator.*

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



### **30.1.8 - Training of Providers/Supplier in Electronic Claims Submission**

**(Rev. 3, 12-09-03)**

*The carrier conducts training for provider/supplier staff in electronic claims submission. This may include, but is not limited to, activities listed in Productivity Investments; use of Medicare billing and PC-Print software; use of available Medicare Electronic Data Interchange (EDI) transactions; use of new or updated Medicare software released during the year; and use of newly introduced EDI standards and/or functions or changes to existing standards or functions.*

**NOTE:** *There are multiple sources of provider/supplier training requirements associated with EDI functions. The PCOM function covers providers/suppliers in group settings rather than contact with individuals. PCOM covers newsletters, classes, or outreach to groups of providers/suppliers and their staff on Medicare coverage, billing and benefits of EDI. PCOM does not include instruction related to connectivity for individual providers/suppliers or the resolution of connectivity problems.*

### **30.1.9 - Provider/Supplier Education and Beneficiary Use of Preventive Benefits**

**(Rev. 3, 12-09-03)**

*Through provider/supplier education activities, the carrier must promote beneficiary use of preventive benefits as specified in the Balanced Budget Act of 1997, the Balanced Budget and Reconciliation Act of 1999, and the Benefits Improvement and Protection Act of 2000. These benefits include screening mammography and screening for colorectal, cervical, and prostate cancer.*

### **30.1.10 - Provider/Supplier Education and Home Health Benefit**

**(Rev. 3, 12-09-03)**

*Where appropriate and feasible, incorporate information in the provider/supplier communications activities that delineates the physician's role in the creation, certification and re-certification of the plan of care for home health, and the beneficiary need for partial hospitalization.*

### **30.1.11 - Internal Development of Provider/Supplier Issues**

**(Rev. 3, 12-09-03)**

*The carrier holds periodic meetings with staff in appropriate areas of the carrier organization (including personnel responsible for medical review, EDI/systems, appeals, and program integrity) to ensure that inquiries and issues made known by providers/suppliers to these other areas in the carrier organization are communicated and shared with provider/supplier education staff. Mechanisms to resolve these issues should be discussed. Minutes of the meetings should be kept and filed.*

### **30.1.12 - Training of Provider/Supplier Education Staff**

**(Rev. 3, 12-09-03)**

*The carrier implements a developmental plan for training new provider/supplier education personnel, and periodically assessing the training needs of existing provider/supplier education staff. The plan, which must be written and available to the provider/supplier education staff, should include schedules, course or instruction vehicle descriptions, and satisfaction criteria. Training materials such as workbooks, manuals, and policy guidelines should always be readily available to the provider/supplier education staff.*

### **30.2 - Provider/Supplier Communications - Program Administration**

**(Rev. 3, 12-09-03)**

#### **30.2.1. - PSP Quarterly Activity Report**

**(Rev. 3, 12-09-03)**

*The carriers is required to develop and submit PSP Quarterly Activity Reports (QAR) that summarize and recount the provider/supplier education and training activities for the previous quarter year. The carrier uses the carrier annual PSP, the Budget and Performance Requirements, and the provider/supplier communications program requirements herein to help formulate the QAR.*

*Reports must be submitted 30 days after the end of every quarter in the fiscal year. The deadlines for submitting the quarterly reports are as follows:*

*First quarter – January 31*

*Second quarter – April 30*

*Third quarter – July 31*

*Fourth quarter – October 31*

*The carrier sends QAR reports, either in hardcopy or electronically, to its RO PSP or PCOM coordinator, and to the CMS CO Provider Communications Regional Consortium staff under which the carrier falls. (The e-mail address of the CO Consortium Liaison can be obtained from the carrier's RO PSP coordinator.) The carrier requests an acknowledgement from the CMS recipient for any electronically submitted report. Hardcopy QAR reports sent to CO should be addressed to:*

*Centers for Medicare & Medicaid Services*

*Center for Medicare Management*

*Division of Contractor Provider Communications*

*Mail Stop C4-10-07*

*7500 Security Boulevard  
Baltimore, Maryland 21244-1850*

*The carrier provides the name, phone number, and mailing address of the PSP coordinator for the carrier organization on its QAR reports.*

### ***A - Format and Content of QAR***

*Report on the provider/supplier communications activities using the following headings:*

- 1. Inquiry and data analysis*
- 2. PCOM advisory group/participation in recommended educational activities/forums*
- 3. Bulletins/newsletters*
- 4. Seminars/workshops/teleconferences*
- 5. New technologies/electronic media*
- 6. Internal staff development/plan to strengthen the quality of written communication*
- 7. Home health benefit*
- 8. Other activities*

*The carrier uses the following in formatting QAR reports:*

### ***B - Cover Page***

*The cover page should contain the following information:*

- Carrier Name/Type*
- Carrier Number*
- Reporting period (1st, 2nd, 3rd, or 4th quarter)*
- PSP Coordinators' Name/Phone Number/E-mail address*
- Date Submitted*
- Geographic Service Area (State)/Regional Office Affiliation*

## ***Provider/Supplier Communication Activities 1 - 8***

### ***Activity 1: Inquiry and Data Analysis***

#### ***Specific Format Requirement:***

*Word Table or Spreadsheet*

*Spreadsheet Headings:*

- *Top Ten Inquiries and Claim Submission Errors (table heading)*
- *I (Inquiry)/CSE (Claim Submission Error)*
- *Provider Specialty (optional field)*
- *Number received*
- *Action/Resolution*

#### ***Example***

##### ***TOP TEN INQUIRIES AND CLAIMS SUBMISSION ERRORS (CSE)***

<b><i>TOP Ten Inquiries and CSE's</i></b>	<b><i>I/ CSE</i></b>	<b><i>Provider Specialty</i></b>	<b><i>Number Received</i></b>	<b><i>Action taken/Resolution (if applicable)</i></b>

#### ***Instructions for Completing Each Field:***

1. *Top Ten Inquiries and Claim Submission Errors*

*List the top 10 provider/supplier inquiries or frequently asked questions and the top 10 claim submission errors. This should include the top ten inquiries, and the top 10 ten claim submission errors, for a total of twenty entries in this column.*

2. *Inquiry/Claim Submission Errors*

*Identify the entry as either an inquiry (I), or a claim submission error (CSE).*

3. *Provider Specialty*

*List the provider specialty, if known. This is an optional field.*

4. *Number of inquiries or claim submission errors*

*Record number of inquiries or claim submission errors received during the reporting period.*

5. *Action taken /Resolution*

*Indicate the provider/supplier communications or other action taken, or soon to be taken. Indicate any resolution to the issue, if applicable.*

***Activity 2: Provider/Supplier Communications Advisory Group/Participation in Recommended Educational Activities/Forums***

***Specific Format Requirement:***

*Word Table or Spreadsheet*

*Spreadsheet Headings:*

- *PCOM Advisory Group/Related Activities (table heading)*
- *Activity*
- *Frequency*
- *Date*
- *Attachments*
- *Comments*

**Example**

**PCOM ADVISORY GROUP/RELATED ACTIVITIES**

<b>Activity</b>	<b>Frequency</b>	<b>Date</b>	<b>Attachments (Yes/No)</b>	<b>Comments</b>

**Instructions for Completing Each Field:**

**1. Identification of Activity**

*Indicate the type of activity including those that resulted from recommendations of the advisory group (i.e., PCOM Advisory Group, Workshop, Seminar, Speech, other)*

**2. Frequency**

*Frequency means how often the event was held, (e.g., continuously, weekly, monthly, quarterly, annually).*

**3. Date**

*Indicate the specific date on which the activity occurred.*

**4. Attachments (Yes or No)**

*Indicate whether or not the attachment(s) (i.e., agenda, membership listing, minutes, action items, etc.) associated with the event/meeting, are included in the report.*

**5. Comments**

*List any appropriate comments related to a subcategory.*

**Activity 3: Issue Regular Bulletins/Newsletters**

**Specific Format Requirement:**

*Word Table or Spreadsheet*

*Spreadsheet Headings:*

- *Bulletins/Newsletters (table heading)*
- *Date Mailed*
- *Number of Hard Copies Mailed*
- *Major Topics Covered*

***Example***

***BULLETINS/NEWSLETTERS***

<b><i>Bulletin/ Newsletter</i></b>	<b><i>Date Mailed</i></b>	<b><i>Number of Hard Copies Mailed</i></b>	<b><i>Major Topics Covered</i></b>

***Instructions for Completing Each Field:***

1. *Bulletin/Newsletter*

*Give the name of the bulletin/newsletter*

2. *Date Mailed*

*Give the date the newsletter/bulletin was mailed.*

3. *Number of Hard Copies Mailed*

*Indicate the number of paper copies mailed.*

4. *Major Topic Areas Covered*

*List 3-4 major topic areas covered.*

***Activity 4: Seminars/Workshops/Teleconferences***

***Specific Format Requirement:***

*Word Document or Spreadsheet*

*Spreadsheet Headings:*

- *Seminars/Workshops/Teleconferences (table heading)*
- *Date*
- *Location*
- *Event Type*
- *Topic*
- *Target Audience*
- *Number of Participants*
- *Materials Distributed*

**Example**

**SEMINARS/WORKSHOPS/TELECONFERENCES**

<i>Date</i>	<i>Location</i>	<i>Event Type</i>	<i>Topic</i>	<i>Target Audience</i>	<i>Number of Participants</i>	<i>Materials Distributed</i>

**Instructions for Completing Each Field:**

**1. Date**

*Indicate the date of the activity.*

**2. Location**

*Indicate the location of the activity.*

**3. Event Type**

*Indicate the type of event based on the codes below:*

*S=Seminar*

*C=Convention (or annual meeting)*

*W=Workshop*

*P=Presentation*



*E=Educational Forum*

*O=Other*

*4. Topic*

*Indicate the topic(s) of the training.*

*5. Target Audience*

*Indicate the audience(s) based on the codes below:*

*P=Physician*

*PB=Other Part B provider*

*H=Hospital*

*A=Ancillary*

*PA=Other Part A provider*

*D=DME*

*S=Supplier*

*PR=General provider*

*PM=Practice/Office Manager and staff*

*BM=Billing Manager and staff*

*O=Other*

*6. Number of Participants*

*Indicate the number of participants in the event.*

*7. Materials Distributed*

*Indicate the material(s) distributed (i.e., Fact Sheet, Manual, video, CD-ROM, etc.).*

**Activity 5: New Technologies/Electronic Media**

**Internet Web site**

Indicate fully: Provider/Supplier Web site Address: \_\_\_\_\_

**Specific Format Requirement:**

Word document and two Tables/Narrative

**Example 1**

**TABLE 5A – WEB SITE BASIC REQUIREMENTS**

<b>CRITERIA</b>	<b>YES</b>	<b>NO</b>
<b>Web site</b>		
<b>Newly created bulletins/newsletters</b>		
<b>Schedule of upcoming events</b>		
<b>Automated registration</b>		
<b>Area designated for Medicare Learning Network</b>		
<b>Quarterly listing of Frequently Asked Questions</b>		
<b>Search engine functionality</b>		
<b>E-mail based support</b>		
<b>CPT Code information</b>		
<b>Ability to link to other sites</b>		
<b>Information for providers/suppliers for electronic claims submission</b>		

**Instructions for Completing Each Field:**

**1. Yes**

Check “Yes” if the criterion has been met.

2. No

Check "No" if the criterion has not been met.

**Example 2**

**TABLE 5B - ELECTRONIC MEDIA USAGE**

<b>COMPONENT</b>		
<b>Bulletin/Newsletter</b>	<b>Date Bltn./Nwsltr. Posted to Web</b>	
<b>Issue number/identification</b>		
<b>CMS Furnished Article/Information</b>	<b>Date Artcl./Info. Posted to Web</b>	
<b>Article Title/Description of Information</b>		
<b>Listserv (Electronic Mailing List) Usage</b>	<b>Date Used</b>	<b>Subject</b>
<b>Listserv name/description</b>		

**Table Components:**

*Electronic Media Usage (table heading)*

*Bulletin/Newsletter*

*Date Bltn./Nwsltr. Posted to Web*

*CMS Furnished Article/Information*

*Date Artcl/Info. Posted to Web*

*Listserv (Electronic Mailing List) Usage*

*Date Used*

*Subject*

***Instructions for Completing Each Field:***

*1. Bulletin/Newsletter*

*Identify the issue (edition month, season or number) of the bulletin or newsletter.*

*2. Date Bltn./Nwsltr. Posted to Web*

*Indicate the date the bulletin/newsletter was first posted and available on the Web site*

*3. CMS Furnished Article/Information*

*Identify specific CMS furnished provider targeted article or information for posting to the carrier Web site*

*4. Date Artcl./Info. Posted to Web*

*Indicate the date the CMS furnished article or information was posted on the carrier Web site*

*5. Listserv (Electronic Mailing List) Usage*

*Identify the name or designation of the listserv(s) (electronic mailing lists)*

*6. Date Used*

*Indicate the date(s) listserv(s) was/were used*

*7. Subject*

*Identify the subject(s) of each listserv transmission*

## ***Activity 6: Internal Development of Provider/Supplier Issues***

### ***Specific Format Requirement:***

*Word Document or Spreadsheet/Narrative*

### ***Example***

#### ***INTERNAL DEVELOPMENT of PROVIDER/SUPPLIER ISSUES***

<b><i>Internal Component</i></b>	<b><i>Frequency of Meetings</i></b>	<b><i>Date(s)</i></b>	<b><i>Comments</i></b>
<b><i>Medical Review</i></b>			
<b><i>Fraud</i></b>			
<b><i>Customer Service</i></b>			
<b><i>DME</i></b>			
<b><i>Reimbursement</i></b>			
<b><i>Provider Records/Enrollment</i></b>			
<b><i>Provider/Supplier Relations</i></b>			
<b><i>Communications</i></b>			
<b><i>Other</i></b>			

### ***Spreadsheet Headings***

- *Internal Development of Provider/Supplier Issues (table heading)*
- *Internal Component*
- *Frequency of Meetings*
- *Date(s)*
- *Comments*

***Instructions for Completing Each Field:***

*1. Frequency of Meetings*

*Indicate the frequency with which provider/supplier education staff meets with each of the individual areas to learn of issues or questions communicated by providers/suppliers. Use NA (not applicable) if the organizational component is not appropriate to the carrier organization.*

*2. Date(s)*

*Indicate the date of the meeting(s).*

*3. Comments*

*Indicate the provider/supplier issues discussed or other information carriers feel is relevant.*

***Activity 7: Home Health Benefit***

***Specific Format Requirement:***

*Narrative*

***Instructions:***

*Provide a summary of any provider/supplier educational activities and efforts in this area.*

***Activity 8: Other Activities***

***Specific Format Requirement:***

*Narrative*

***Instructions:***

*Use this section to discuss any additional highlights for the quarter. Feel free to mention any areas of significance not previously noted. This should also include the following:*

- 1. Any noteworthy activities, efforts, enhancements or changes to the provider/supplier education program including the provider Web site that should be brought to CMS' attention;*
- 2. Any activities or issues carriers have coordinated with the DMERC during the quarter;*
- 3. Mechanisms used to actively solicit feedback related to the Medicare program;*

4. *Provider/supplier education activities or efforts used to promote utilization of preventive benefits; and*
5. *Mechanisms developed and/or implemented to measure the effectiveness of educational and training activities. This may include customer satisfaction survey instruments, findings from administering these surveys, and results from pre and post-testing at workshops and seminars.*

### **30.2.2. - Charging Fees to Providers/Suppliers for Medicare Education and Training Activities**

*(Rev.3, 12-09-03)*

*The carrier may assess fees or charges for provider/supplier education activities in accordance with the guidelines stated herein. Provider/supplier education and training activities are separated into two cost categories: (1) **no charge** and (2) **fair and reasonable cost**. The cost of conducting these activities, or any fees assessed, must conform to the requirements provided below. These cost categorizations distinguish provider/supplier education efforts considered to be statutorily mandated (provided at no-charge to providers and suppliers), and those considered to be enhanced or supplemental.*

#### **A - No Charge -- Statutorily Required Training**

- *Activities and training materials designed to educate providers and suppliers in Medicare enrollment, coverage, reimbursement and billing requirements. The number of sessions and the scope of this training should be based on recommendations from business partners including, but not limited to, the Provider/Supplier Communications (PCOM) Advisory Committee, and fit within program management resources.*
- *Training and materials on statutorily mandated or significant Medicare program changes, (e.g., hospital outpatient prospective payment system, home health, inpatient rehabilitation, SNF PPS and consolidated billing, and ambulance). CMS will give advance notice on this training (including any needed follow-up training) and the availability of additional funding.*
- *Participation in conferences sponsored by other Medicare carriers and government agencies that are based upon recommendations from the PET Advisory Committee.*

#### **B - Fair and Reasonable Cost--Discretionary Activities**

- *Individualized training requested by a provider/supplier. This may include the cost of travel, materials, accommodations, staff preparation, follow-up activities, and a fee for expenses to attend the event and make the presentation.*

- *Training videos, audiotapes, specialized brochures, pamphlets, and manuals developed by carriers (except for materials included in no-charge-statutorily required training).*
- *Presentations and training at non-Medicare carrier sponsored conferences, trade shows, conventions, annual meetings, etc. If carriers receive a request from a group such as a national, regional or state association or medical industry body to make a presentation at an event, carriers can charge the association or group a fee for travel expenses to attend the event. This fee may include the cost for materials, meeting rooms (if carriers are required to incur that cost), accommodations, travel, staff preparation, handouts, follow up activities, and other incidentals. The travel fee must be fair and reasonable, and based on the cost carriers incurred for providing the service or activity. The carrier must confer with the regional office PCOM or PET coordinator about the costs associated with providing the training to ensure that the costs are reasonable.*

**NOTE:** *The carrier may accept nominal speakers fees, or recognition gifts such as pens engraved with the host logo, coffee mugs, plaques, flowers, etc. However, the carrier is not permitted to accept and use substantive gifts or donations associated with participation in education and training activities absent specific authority.*

*Reference manuals, guides, workbooks, and other resource materials developed by the carrier designed to supplement or provide easy reference to formal Medicare provider/supplier manuals and instructions.*

*Revenues collected from these discretionary activities must be used only to cover the cost of these activities and may not be used to supplement other Medicare carrier activities.*

### ***C - Facilities, Food and Beverages, and Provider/Supplier Communications***

*Holding provider/supplier education and training events for both statutorily required and discretionary activities at alternate locations (other than at the carrier's own offices or buildings) may often reduce provider/supplier time and travel costs associated with attending these events. When such an opportunity exists, carriers may recover the costs incurred for meeting rooms, auditoriums and other facilities and equipment through a fee to participants. This fee or charge should be fair and reasonable and within the means of likely participants.*

*It is also recognized that many contractual agreements with hotels or other meeting site locations stipulate that food and beverages be purchased as a condition of furnishing a meeting or training room. In addition, light refreshments and food may be desirable to facilitate the training and/or for the convenience of the trainees or participants. If light refreshments and food are provided, a fee that covers this cost and is charged to*



*participants must be fair and reasonable, and based on the costs incurred by the carriers. Providing food and beverages that exceed these guidelines are prohibited.*

*Keep records per event of the costs incurred and all fees charged to, and collected from, registrants. The total of fees or charges for any event should not exceed by more than 10 per cent the actual costs incurred for the event. If it does, the carrier should refund the entire excess amount collected to all the registrants who paid a fee for that event. For example, charge participants a \$50 registration fee for an event that cost the carrier \$10,000 (e.g., light refreshments, meeting facility, and equipment rental), 250 individuals pay to attend and the carrier collects \$12,500. Since the amount collected exceeded more than 10 per cent of the costs (\$1,000), the entire excess amount collected (\$2,500) is disbursed back to all paying registrants.*

#### ***D - Refunds/Credits***

*In order to secure sites needed for future provider/supplier training events, the carrier may have to make commitments under which it will incur contractual expenses for training accommodations and services. Full or partial refunds/credits to providers/suppliers who register for an event, and cancel before the event, or do not attend the event, should be made within the context of these contractual arrangements. If training is scheduled and the carrier cancels the event, a full refund must be made to registrants. If there are questions concerning the implementation of this policy in a given case, the carrier contacts the RO PCOM coordinator.*

#### ***E - Bulletins/Newsletters***

*Unless otherwise established, the carrier must furnish free of charge one paper copy of the regular bulletin/newsletter which contains program and billing information to providers/suppliers. If providers/suppliers are interested in obtaining additional paper copies on a regular basis, the carrier is permitted to charge a fee for this. The fee for this subscription should be "fair and reasonable" and based on the cost of producing and mailing the publication. A separate charge may also be assessed to any provider/supplier who periodically requests additional single paper copies.*

#### ***F - Mixed Training Events***

*In situations where provider/supplier education and training activities involve both statutorily required training and discretionary training, the carrier must allocate the proportional costs between the activities. That is, the proportional share of the cost of a function allocated to statutorily required training is equal to the percentage of time related to this training. For example, if it costs \$1,000 to arrange and conduct a mixed training session, with 25 percent of the session related to statutorily required training, then the proportional cost allocation for the training would be  $.25 \times \$1,000 = \$250$  for statutorily required training and  $.75 \times \$1,000 = \$750$  for discretionary training activities.*

## ***G - Recording of Training Events***

*Entities not employed by CMS, or under contractual arrangement are not permitted to videotape or otherwise record training events for profit-making purposes.*

### ***30.2.3 - Provide/Supplier Information and Education Materials and Resource Directory***

***(Rev. 3, 12-09-03)***

#### ***A - Dating of Materials***

*Provider/supplier education and training materials produced (pamphlets, brochures, work books, reference manuals, CDs, etc.) must bear the month and year they were produced or re-issued.*

#### ***B - Provider/Supplier Information and Education Materials Resource Directory***

*The Provider/Supplier Information and Education Resource Directory is comprised of provider and supplier education materials developed by Medicare contractors. The materials, which include brochures, manuals, work and reference books, fact sheets, videos, audio tapes, CDs, etc., are used to convey Medicare program, policy and billing information to professional health care providers/suppliers and others associated with the health services about industry. The purpose of the Directory is to facilitate the sharing of provider/supplier information and education tools among Medicare carriers, and would, therefore, help reduce the cost of development of these materials.*

*Unless previously submitted, send one copy of any provider/supplier information and education material of note that have been developed or used within the last 2 years to the address below. This material should be suitable to be used or copied in whole or in part by other Medicare carriers.*

***NOTE:*** *All materials developed by Medicare carriers using CMS funding as the principal source for its development are considered the property of CMS, and must be made available to CMS upon request.*

*Submit materials that address subjects primarily on a national, rather than a regional or local basis. The carrier does not send materials containing information predominately tailored to local or regional audiences that have little national application such as unique letters, event notices, or complete provider/supplier bulletins or newsletters. Individual bulletin or newsletter articles focusing on subjects of nationwide interest can be sent. The carrier includes the name, address, telephone number, and e-mail address of a contact person for each piece.*

*These materials are sent to:*

*Centers for Medicare & Medicaid Services*

*Division of Provider Information Planning and Development,  
Mail Stop C4-11-27  
Attn: Resource Directory  
7500 Security Boulevard  
Baltimore, MD 21244-1850*

*The carrier sends one copy of all appropriate provider/supplier education and information materials (excluding bulletins/newsletters) developed in the future, to the address above. Also, the carrier sends any significantly revised or updated versions of material previously submitted.*

*If carriers reproduce or use material, in whole or in part, originally developed by another Medicare carrier, that carrier should be acknowledged either within the material, or on its cover, case or container. In the case of printed text material, this acknowledgement should appear on the inside back page or cover.*

# Medicare Contractor Beneficiary and Provider Communications Manual

## Chapter 5 Correct Coding Initiative

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### **10 - Introduction**

**(Rev. 1, 10-01-03)**

This chapter contains general instructions and requirements for Medicare carriers, including DMERCs and intermediaries for processing correspondence. Normally, the

term “contractor” is used in this manual to mean any or all of these. If an instruction should apply to only one type of contractor, this will be specified.

## **20 - Correct Coding Initiative**

*(Rev. 3, 12-09-03)*

### **B3-4630**

#### **20.1 - Effective Date/Scope**

*(Rev. 3, 12-09-03)*

##### **B3-4630.A**

The effective date for the implementation of the Correct Coding Initiative (CCI) edits within the contractor’s claims processing system is for **dates of service** on or after January 1, 1996. This applies only to the specific CCI edit combinations and **not** the associated policies. Where CMS has previously instructed the contractor to install specific edits, these edits should continue. The contractor claims processing system should not be altered to reflect the underlying policies of the CCI.

#### **20.2 - MSN Messages**

*(Rev. 3, 12-09-03)*

##### **B3-4630.B**

The following message should be displayed on the beneficiary’s MSN for assigned claims for CCI editing on the same claim:

MSN - “Payment is included in another service received on the same day.”  
(MSN message 16.8)

Display the following message on the beneficiary’s MSN for assigned claims for CCI editing on different claims:

MSN - “This allowance has been reduced by the amount previously paid for a related procedure.” (MSN message 16.9)

The following message should be displayed on the beneficiary’s MSN for unassigned claims for CCI editing on the same claim:

MSN - “Payment is included in another service received on the same day.”  
(MSN message 16.8) “Your doctor did not accept assignment for this service. Under Federal law, your doctor cannot charge more than \$\_\_\_\_\_. If you have already paid more than this amount, you are entitled to a refund from the provider.”

(NOTE: This message should print on all unassigned service lines for which the billed amount exceeds the Medicare limiting charge. The contractor does not print when the amount the limiting charge is exceeded is less than any threshold established by CMS.) - CO45 with adjustment amount in excess of the limiting charge; PR42 with the amount that is the difference between the allowed amount and the limiting charge for which the beneficiary is liable; if excess payment made by the beneficiary. Also, the contractor reports MA77 or MA78 as applicable for the provider to refund the excess to the beneficiary (MSN message 30.3).

The following message should be displayed on the beneficiary's MSN for unassigned claims for CCI editing on different claims:

MSN - This allowance has been reduced by the amount previously paid for a related procedure (MSN message 16.9).

### **20.3 - Remittance Notice Messages**

*(Rev. 3, 12-09-03)*

#### **B3-4630.C**

When MSN message 16.8 applies, contractors use claim adjustment reason code B15 ("Payment adjusted because this procedure/service is not paid separately.") at the service level on the provider remittance advice. Also, contractors use remark code M80 ("Not covered when performed during the same session/date as a previously processed service for the patient").

### **20.4 - Correct Coding Modifier Indicators and HCPCS Codes Modifiers**

*(Rev. 3, 12-09-03)*

#### **B3-4630.D**

The Correct Coding File Formats continue to include a Correct Coding Modifier (CCM) indicator for both the Comprehensive/Component Table and the Mutually Exclusive Table. This indicator determines whether a CCM causes the code pair to bypass the edit. This indicator will be either a "0," "1," or a "9." A "0" means that a CCM is not allowed and will not bypass the edits. A "1" means that a CCM is allowed and will bypass the edits. A "9" means that the use of modifiers is not specified. In addition, the "9" indicator is used for all those code pairs that have a deletion date that is the same as the effective date. This indicator was created so that no blank spaces would be in the indicator field.

Following are instructions for codes with modifiers.

- 1 - Subject **all** line items with **identical** modifiers to the CCI edit. Line items with the modifiers listed below are not subject to the CCI edit. Line items

with the following modifiers are nevertheless subject to existing instructions such as those in the Medicare Claims Processing Manual, Chapter 12, “Physician/Practitioners Billing,” §§40:

E1 - E4, FA, F1 - F9, TA, T1 - T9, LT, RT, -25, -58, -59, -78, -79, LC, LD, RC, and -91

2 - However, the -59 modifier may not be used with the following codes:

77427                      Radiation treatment management, five treatments

99201-99499              Evaluation and management services

When a provider submits a claim for any of the codes specified above with the -59 modifier, contractors process the claim as if the modifier were not present. In addition to those messages specified in subsection B, contractors convey the following message on the providers remittance notice:

“The procedure code is inconsistent with the modifier used, or a required modifier is missing.” (ANSI 4)

No additional message should be conveyed on the beneficiary’s MSN.

3 - The following is background and explanation regarding the -59 modifier.

**a - Definition**

The -59 modifier is used to indicate a distinct procedural service. The physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. This may represent a different session or patient encounter, different procedure or surgery, different site, or organ system, separate incision/excision, or separate injury (or area of injury in extensive injuries).

**b - Rationale**

Multiple services provided to a patient on one day by the same provider may appear to be incorrectly coded, when in fact the services may have been performed as reported. Because it is difficult to identify these circumstances, a modifier was established to permit claims of such a nature to bypass correct coding edits. The addition of this modifier to a procedure code indicates that the procedure represents a distinct procedure or service from others billed on the same date of service. In other words, this may represent a different session, different surgery, different anatomical site or organ system, separate incision/excision, different agent, different lesion, or different injury or area of injury (in extensive injuries).

### **c - Instruction**

The secondary, additional, or lesser procedure(s) or service(s) must be identified by adding the modifier -59.

Following are examples of the appropriate use of the -59 modifier:

#### **EXAMPLE 1**

CPT codes describing chemotherapy administration include codes for the administration of chemotherapeutic agents by multiple routes, the most common being the intravenous route. For a given agent, only one intravenous route (push or infusion) is appropriate at a given session. It is recognized that frequently combination chemotherapy is provided by different routes at the same session. When this is the case, using the CPT codes 96408, 96410, and 96414, the 59 modifier (different substance) should be attached to the lesser-valued technique indicating that separate agents were administered by different techniques.

#### **EXAMPLE 2**

When a recurrent incisional or ventral hernia requires repair, the appropriate recurrent incisional or ventral hernia repair code is billed. A code for initial incisional hernia repair is not to be billed in addition to the recurrent incisional or ventral hernia repair unless a medically necessary initial incisional hernia repair is performed at a different site. In this case, the -59 modifier should be attached to the initial incisional hernia repair code.

The following is background and explanation regarding the -91 modifier.

### **a - Definition**

The -91 modifier is used to indicate a repeat laboratory procedural service on the same day to obtain subsequent reportable test values. The physician may need to indicate that a lab procedure or service was distinct or separate from other lab services performed on the same day. This may indicate that a repeat clinical diagnostic laboratory test was distinct or separate from a lab panel or other lab services performed on the same day and was performed to obtain subsequent reportable test values.

### **b - Rationale**

Multiple laboratory services provided to a patient on one day by the same provider may appear to be incorrectly coded, when in fact the services may have been performed as reported. Because it is difficult to identify these circumstances, a modifier (-91) was established to permit claims of such a nature to bypass correct coding edits. The addition of this modifier



to a laboratory procedure code indicates a repeat test or procedure on the same day.

### **c - Instruction**

The additional or repeat laboratory procedure(s) or service(s) must be identified by adding the modifier -91.

### **EXAMPLE**

When cytopathology codes are billed, the appropriate CPT code to bill is that which describes, to the highest level of specificity, what services were rendered. Accordingly, for a given specimen, only one code from a family of progressive codes (subsequent codes include services described in the previous CPT code, e.g., 88104-88107, 88160-88162) is to be billed. If multiple services on different specimens are billed, the -91 modifier should be used to indicate that different levels of service were provided for different specimens. This should be reflected in the cytopathologic reports.

## **20.5 - Limiting Charge**

*(Rev. 3, 12-09-03)*

### **B3-4630.E**

Medicare does not make separate payment for procedures that are part of a more comprehensive group of services nor does it make payment for services that cannot be performed at the same time. These are not medical necessity denials. Instead, payment for the comprehensive procedure includes any separately identified component parts of the procedure. The limitation on liability protections in [§1879](#) of the Social Security Act (the Act) are not a consideration nor are the physician refund protections in [§1842\(l\)](#) of the Act a consideration. The maximum a provider may bill a Medicare beneficiary is whatever the limiting charge is for the comprehensive (Column I) service. This policy has been in effect since January 1, 1991.

The limiting charge provisions of the law apply to those services which are submitted on unassigned claims and are paid under the physician fee schedule, with the exclusion of those which have a Medicare Fee Schedule Data Base status code indicator of "N" (noncovered service); X (statutory exclusion) except for mammography services (which are subject to the limiting charge provisions); and R (restricted coverage), if the service is deemed non-covered.

Procedure codes that are listed in the correct coding initiative and are component parts of other procedures or cannot be performed at the same time are not separately payable when billed with the principal service. Also, these are subject to the charge limits, if the unbundled service is identified with a status code subject to Medicare charge limits.

These instances are limiting charge violations and must be included on the affected providers' Limiting Charge Exception Report.

## **20.6 - Appeals**

*(Rev. 3, 12-09-03)*

### **B3-4630.F**

When a request for redetermination/review is received as a result of an initial determination based on a correct coding initiative edit, and after determining that the claim was coded correctly, the reviewer must come to the same conclusion as the initial determination (i.e., the review does not result in an increase in payment). If the review determines that a correct code modifier not submitted with the initial claim could have been appended to either code of an edit code pair, the reviewer may change the initial determination only if the correct coding initiative edit has a modifier indicator of "1." If the correct coding initiative edit modifier indicator is a "0," the reviewer must come to the same conclusion as the initial determination. If the conclusion is the same as the initial determination, the review determination must repeat the generic language that appears in the MSN or remittance advice notice pertaining to the correct coding edit. In addition, contractors must include the more detailed explanation of the correct coding initiative edit which can be found in the standard correspondence language for Part B Medicare carriers. (See [§20.12](#), subsections L.1 and L.2.)

## **20.7 - Savings Report**

*(Rev. 3, 12-09-03)*

### **B3-4630.G**

The contractor provides a quarterly report of savings generated by the CCI edits. These quarterly reports are due on the 20th day of the month following the end of the quarter, i.e., April 20, July 20, October 20, and January 20. The savings files must be in an Extended Binary Code Decimal Interchange Code (EBCDIC) format. The files are to be submitted using the Connect:Direct.

Multiple files will not be accepted.

Record all data in EBCDIC and display mode.

Do not submit compressed data.

The contractor uses the following sample Job Control Language (JCL) for sending the savings files to CMS via Connect:DIRECT:

Sample Connect:DIRECT JCL

```
/******
```

```
/* Connect:DIRECT process to transfer files from carrier or FI to CMS */
```

```
/* - replace XXXXX with the carrier specific ID number
```

```
*/
```

```
/* - replace FROM DSN name with the file name being sent to CMS */
```

```
/* - USERID,PASSWORD refers to the specific Connect:DIRECT userid assigned to the facility */
```

```
/******
```

```
TESTPROC PROCESS SNODEID=(USERID,PASSWORD)
```

```
STEPUS01 COPY FROM (DSN=TWxx.@AAA0000.CORRCODE.FILE-
```

```
DISP=SHR
```

```
PNODE)
```

```
TO (DSN=MU00.@BF12372.CXXXXX,
```

```
DISP=(NEW,CATLG,DELETE))
```

```
CKPT=200K
```

```
COMPRESS
```

```
STEPUS02 IF (STEPUS01 = 0) THEN
```

```
RUN JOB (DSN=MU00.@BF12372.CLIST(CXXXXX)) SNODE
```

```
EIF
```

```
/*
```

```
//
```

Use the following revised record format to report savings:

**Savings Record Format**

Field	Type	Record Position	Length
Carrier Number	Numeric	1	5
Comprehensive Column 1 Code or Mutually Exclusive Column 1 Code	Character	6	5
Modifier I	Character	11	2
Modifier II	Character	13	2
Component Column 2 Code or Mutually Exclusive Column 2 Code	Character	15	5
Modifier I	Character	20	2
Modifier II	Character	22	2
Provider Specialty	Character	24	2
HCPCS Frequency	Numeric	26	10
HCPCS Savings	Numeric	36	12
Savings Type Indicator Edit “1” CCE “2” Mutually Exclusive (Recommended, but not required)	Numeric	48	1

Submit these reports to:

Centers for Medicare & Medicaid Services  
 Program Development and Information Group  
 Division of Health Plan and Provider Data  
 Mail Stop: C4-14-21  
 7500 Security Blvd.  
 Baltimore, Maryland 21244-1850

## **20.8 - National Technical Information Service (NTIS), Department of Commerce**

*(Rev. 3, 12-09-03)*

### **B3-4630.H**

The official method for providers to receive the CCI edits is through NTIS at this time. The CMS has designated NTIS as the sole distributor of the CCI edits. The narrative introduction of the NTIS product is considered public domain and may be freely reproduced. However, the specific CPT code combinations may not be reproduced. However, it must be noted neither the narrative introduction nor the narrative portion of each chapter is intended to supersede any current Medicare policy. Anyone wishing to receive the CCI edits must purchase them through NTIS.

To purchase the CCI edits, call the National Technical Information Service:

To receive the information by fax, call (703) 605-6880.

To order subscriptions, call (703) 605-6060 or (800) 363-2068.

Ordering and product information are also available via the World Wide Web at [www.ntis.gov/product/correct-coding.htm](http://www.ntis.gov/product/correct-coding.htm)

## **20.9 - Adjustments**

*(Rev. 3, 12-09-03)*

### **B3-4630.I**

Carriers adjust for underpayment if the wrong, lower-paying code is paid on the first of multiple claims submitted. If the wrong, higher-paying code is paid on the first of multiple claims submitted, carriers pay the subsequent claim(s) and initiates recovery action on the previously paid claim(s).

## **20.10 - Professional Component Modifier**

*(Rev. 3, 12-09-03)*

### **B3-4630.J**

Carriers use modifier 26 when reporting the physician component of a service separately. If this modifier is used with a Column II code that is reported with a Column I code, carriers deny the Column II code with the modifier.

## **20.11 - Ambulatory Surgical Center (ASC) Facility**

*(Rev. 3, 12-09-03)*

### **B3-4630.K**

These instructions also apply to claims for ASC facility services. However, carriers do not pay an ASC facility fee for an approved code under CCI unless that code is on the list of Medicare-covered ASC procedures.

## **20.12 - Correspondence Language**

*(Rev. 3, 12-09-03)*

### **B3-4630.L**

Standard language has been developed for use in correspondence. The carrier may receive questions related to specific code combinations or reductions in payment due to specific codes billed. It has received through standard system maintainers, a list of all CCI edits and an associated correspondence language policy/example number for each procedure code combination. The first position of the Correspondence Language Policy/Example Number refers to the appropriate section of the “General Correspondence Language.” (See subsection 1.) The entire Correspondence Language Policy/Example Number refers to examples of the general policy that can be found in the “Section-Specific Examples of Correspondence Language.” (See subsection 2.)

#### **1 - National Correct Coding Initiative Edit Policy: General Correspondence Language**

##### **a - Standard Preparation/Monitoring Services**

Anesthesia services require certain other services to prepare a patient prior to the administration of anesthesia and to monitoring during the course of anesthesia. Additionally, when monitored anesthesia care is provided, the attention devoted to patient monitoring is of a similar level of intensity so that general anesthesia may be established if needed. The specific services necessary to prepare and monitor a patient vary among procedures, based on the extent of the surgical procedure, the type of anesthesia (e.g., general, monitored anesthesia care (MAC), regional, local, etc.), and the surgical risk. Although a determination as to medical necessity and appropriateness must be made by the physician performing the anesthesia, when these services are performed, they are included in the anesthesia service. Accordingly, when reporting the anesthesia service code \_\_\_\_\_ (comprehensive code), the services described by \_\_\_\_\_ (component code) are included in the anesthesia service.

## **b - HCPCS/CPT Procedure Code Definition**

The CPT procedure code definition, or descriptor, is based upon the consistent interpretation of the procedure performed in contemporary medical practice and by many physicians in clinical practice. When a CPT code associated with a descriptor is submitted to Medicare, all services described by the narrative should have been performed. Because procedures can be performed in different ways and often, several related procedures are performed at a single session, several CPT codes may exist which describe similar procedures performed in different fashions, with different levels of complexity, or associated with other related procedures. Accordingly, several component services, which have different CPT codes, may be described in one, more comprehensive CPT code. Only the single CPT code most accurately describing the procedure performed or service rendered should be reported.

The separate component CPT codes, describing services included in a more comprehensive code, should not be billed. The code \_\_\_\_\_ (comprehensive) includes the service described by the code \_\_\_\_\_ (component) according to the CPT descriptors and therefore \_\_\_\_\_ (component code) is bundled with \_\_\_\_\_ (comprehensive code).

## **c - HCPCS/CPT Coding Manual Instruction and Guideline**

In addition to CPT procedure code definition or descriptor, instructions and guidelines in CPT are provided either as an introduction to CPT sections or parenthetically. These instructions are further clarified in companion CPT publications such as CPT Assistant, copyright by the American Medical Association. In the case of \_\_\_\_\_ (comprehensive code) and \_\_\_\_\_ (component code), CPT instructions identify appropriate methodology for code submission and accordingly, \_\_\_\_\_ (component code) is included in \_\_\_\_\_ (comprehensive code).

## **d - Mutually Exclusive Procedures**

In order to provide a sufficiently broad listing of descriptive terms and identifying codes in CPT, certain services or procedures are listed which would not reasonably be performed at the same session by the same provider on the same beneficiary. The CPT codes that represent services that are related but could not reasonably be performed together have been identified. In the case of \_\_\_\_\_ (column 1 code) and \_\_\_\_\_ (column 2 code), it would be unreasonable to expect these services to be performed at a single patient encounter and, therefore, these CPT codes have been bundled.

## **e - Sequential Procedures**

On occasions where it is necessary that the same provider attempts several procedures in direct succession at a patient encounter to accomplish the same end, only the procedure that successfully accomplishes the expected result is reported.

Generally, this occurs when a less extensive procedure fails and requires the performance of a more extensive procedure. Failed procedures (and therefore medically unnecessary procedures) followed by a more extensive procedure should not be separately reported. Procedures that are often performed in sequence have been identified and the less extensive procedure has been bundled into the more extensive procedure. In the case of \_\_\_\_\_ (comprehensive code) and \_\_\_\_\_ (component code), when these services are performed in sequence at the same patient encounter, only \_\_\_\_\_ (comprehensive code) is reported; \_\_\_\_\_ (component code) is bundled into \_\_\_\_\_ (comprehensive code).

#### **f - CPT Separate Procedure Definition**

The CPT parenthetical expression “separate procedure” following a narrative description of a code designates that the procedure or service can be performed alone and independently of, or not immediately related to, other services (in which case it is acceptable) or as a part of a related, more comprehensive procedure. When the service is performed as an integral part of a related procedure, it does not warrant separate identification and should not be reported separately. \_\_\_\_\_ (component code) is designated as a “separate procedure”; therefore, if it is reported with \_\_\_\_\_ (comprehensive code), \_\_\_\_\_ (component code) is bundled with \_\_\_\_\_ (comprehensive code).

#### **g - Most Extensive Procedures**

When a procedure can be performed with varying levels of complexity, CPT has developed code groups which describe a basic procedure but retain different definitions to qualify the codes in the group as to the level of complexity of the procedure. When submitting a CPT code included in a group of codes that describes a procedure, only the code describing the most extensive service that was actually performed is reported. Both \_\_\_\_\_ (component code) and \_\_\_\_\_ (comprehensive code) identify a similar procedure but with different levels of complexity; accordingly only the most extensive service, \_\_\_\_\_ (comprehensive code), actually performed is reported.

#### **h - “With” Versus “Without” Procedures**

Certain CPT descriptors identify, as part of the narrative, that the procedure can be performed with or without certain services. The CPT code combinations that are identical except that one code describes a procedure without a certain service and the other describes a procedure with that same service cannot be billed together. Since reporting both \_\_\_\_\_ (comprehensive code) and \_\_\_\_\_ (component code) represents such a combination and poses a contradiction to the services actually performed in the encounter, \_\_\_\_\_ (component code) is bundled with \_\_\_\_\_ (comprehensive code).



### **i - Designation of Sex Procedures**

The performance of certain procedures may require significantly different approaches when performed in a male as opposed to a female. The CPT code descriptors designate these procedures by specifying if the service or procedure is to be reported for a male or a female or by anatomical description. The CPT code combinations that are identical except that one code describes a procedure for a female and the other describes a procedure for a male cannot be reported for the same session, the same provider, and the same beneficiary. The CPT codes \_\_\_\_\_ (column 1 code) and \_\_\_\_\_ (column 2 code) represent such a combination and should not be billed together.

### **j - Standards of Medical/Surgical Practice**

Under Medicare, all of the services necessary to accomplish a procedure according to standard medical/surgical practices are included in the description of the procedure as provided by CPT codes. Many ancillary procedures that are typically necessary to accomplish a more comprehensive procedure have been assigned independent CPT codes because they may be performed independently in other settings and may be billed separately. The service described by \_\_\_\_\_ (component code) is typically included when performing the procedure described by \_\_\_\_\_ (comprehensive code) and is therefore bundled with \_\_\_\_\_ (comprehensive code).

### **k - Anesthesia Included in Surgical Procedures**

Under the Physicians' Fee Schedule, Medicare does not pay for anesthesia when provided by the same physician who performs the procedure requiring the anesthesia. The CPT codes describing anesthesia services or services that are bundled into anesthesia services should not be reported in addition to the basic procedure requiring the anesthesia services. Accordingly, \_\_\_\_\_ (component code representing the anesthesia service or service bundled into anesthesia) is included in the basic service described by \_\_\_\_\_ (comprehensive code).

### **l - Laboratory Panels**

Laboratory panels, described in CPT as "Organ or Disease Oriented Panels," represent groupings of tests which are commonly performed together in clinical practice. When a CPT code describing a panel is submitted, codes identifying the individual tests included in the panel should not be reported as well. \_\_\_\_\_ (comprehensive code representing the panel test) includes \_\_\_\_\_ (component code); accordingly, \_\_\_\_\_ (component code) is bundled with \_\_\_\_\_ (panel test or comprehensive code).

### **m - Deleted Edits**

Proposed correct coding edits were developed based on review of existing local and national edits, review of standards of medical care, review of CPT

instructions and descriptors, and review of provider billing patterns. The initial body of CPT code edits have undergone scrutiny by physicians and providers including Carrier Medical Directors, representatives of the AMA's CPT Advisory Committee, and other national medical societies. Based upon input from these sources, code edits were deleted because they were not compatible with the narrative Correct Coding Policy or the implementation of the code edit would generate logistical conflicts. The CPT code pair \_\_\_\_\_ (comprehensive code) and \_\_\_\_\_ (component code) was deleted from the policy recommendations for these reasons.

#### **n - Misuse of Column 2 code with Column 1 code**

The CPT codes have been written as precisely as possible to not only describe a specific service or procedure but to also avoid describing similar services or procedures which are already defined by other CPT codes. When a CPT code is reported, the physician or non-physician provider must have performed all of the services noted in the descriptor unless the descriptor states otherwise. (Frequently, a CPT descriptor will identify certain services that may or may not be included, usually stating "with or without" a service.) A CPT code should not be reported out of the context for which it was intended. Either intentionally or unintentionally, a provider may report a service or procedure using a CPT code that may be construed to describe the service/procedure, but in no way, was the code intended to be used in this fashion. When CPT code \_\_\_\_\_ (Column 2 code or component code) is reported as services associated with services described by CPT \_\_\_\_\_ (Column 1 code or comprehensive code), reporting the former code represents a misuse of this code and should not be separately allowed.

### **2 - National Correct Coding Initiative Edit Policy: Section-Specific Examples of Correspondence Language**

#### **a - Anesthesia (CPT Codes 00000 - 09999)**

##### **(1) - Policy Number 1.00000 - Standard Preparation/Monitoring Services**

An example of the policy for standard preparation/monitoring services integral to the anesthesia service is bundling the placement of intravenous access (CPT code 36000) prior to providing general anesthesia. This procedure is necessary to prepare the patient for a general anesthesia and, therefore, the service is included as a part of the anesthesia service. Code 36000 is bundled into all anesthesia service code.

##### **(2) - Policy Number 3.00000 - HCPCS/CPT Coding Manual Instruction/ Guideline**

For example, in the CPT manual instruction under anesthesia for diagnostic arteriography/venography (CPT code 01916), the reference note states "Do

not report 01916 in conjunction with therapeutic codes 01924-01926, 01930-01933.” Therefore, code 01916 is bundled with codes 01924-01926 and 01930-01933.

**(3) - Policy Number 4.00000 - Mutually Exclusive Procedures**

For example, a physician administering anesthesia for procedures on the heart, pericardial sac, and great vessels of chest with pump oxygenator (CPT code 00562) would not also administer anesthesia for procedures on the heart, pericardial sac, and great vessels of chest with pump oxygenator with hypothermic circulatory arrest (CPT code 00563). Only one of these two types of anesthesia would be used in the same session. Therefore, codes 00562 and 00563 are mutually exclusive of each other.

**(4) - Policy Number 9.00000 - Designation of Sex Procedures**

For example, CPT code 00920 describes anesthesia for procedures on male genitalia (including open urethral procedures) and CPT code 00942 describes anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium): colpotomy, vaginectomy, colporrhaphy, and open urethral procedures. The two procedures cannot be reported on the same beneficiary, for the same session, by the same provider. Therefore only the appropriate procedure code should be reported.

**b - Integumentary (CPT Codes 10000 - 19999)**

**(1) - Policy Number 2.10000 - HCPCS/CPT Procedure Code Definition**

In the example of comprehensive code 19162 and component code 19160 and based on the format of the “Physicians’ Current Procedural Terminology,” the description for code 19162 is indented which means that one is to refer back to a common portion of the procedure listed in the preceding entry. The common part of code 19160 (that part before the semicolon) is also considered a part of code 19162. The full description of code 19162 is mastectomy, partial; with axillary lymphadenectomy. Code 19160 is a component of code 19162 and is appropriately bundled into this procedure.

**(2) - Policy Number 3.10000 - HCPCS/CPT Coding Manual Instruction and Guideline**

For example, in the instruction under excision of benign lesions, it is noted that the excision includes simple closure. The comprehensive code of 11400, which represents excision of a benign lesion, except skin tag for the trunk, arms, or legs with a diameter of 0.5 centimeters or less, includes the component code 12001 which describes the simple repair of superficial wounds of the same site up to 2.5 centimeters in diameter. Therefore, code 12001 is bundled with code 11400.

### **(3) - Policy Number 4.10000 - Mutually Exclusive Procedures**

For example, a physician performing a destruction of a malignant lesion of the arm by laser surgery, electrosurgery, cryosurgery, chemosurgery, or surgical curettement (code 17260) would not also excise the same malignant lesion of the arm (code 11600). Only one method of treatment of the malignant skin lesion would be rendered on the same lesion in the same session. Therefore, codes 17260 and 11600 are mutually exclusive of each other.

### **(4) - Policy Number 5.10000 - Sequential Procedures**

For example, if a breast lesion is being excised after preoperative placement of a radiologic marker (code 19125), and intraoperatively the surgeon elects to obtain a confirmatory fine needle aspiration (described by code 10021) at the time of excision, the cytological biopsy (fine needle aspiration) represents a part of the excision procedure. Code 10021 is bundled into code 19125 and thus code 19125 is the appropriate code to report.

### **(5) - Policy Number 6.10000 - CPT Separate Procedure Definition**

In the example of the comprehensive code 19125 and component code 19100, the needle core biopsy of the breast represented by code 19100 is classified as a “separate procedure.” When the service represented by code 19100 is performed with an excision of a breast lesion (CPT code 19125), it is not performed alone or independent of the related and more comprehensive service described by code 19125; therefore, code 19100 cannot be reported separately but rather is bundled into code 19125.

### **(6) - Policy Number 7.10000 - Most Extensive Procedures**

For example, when a radical mastectomy is performed, the extensive resection of tissue is intended to remove all lesions, in the surgical resection field. While the primary lesion(s) is (are) generally malignant, other lesions, such as cysts, nipple lesions, may also be resected. The CPT Code 19240 describes a modified radical mastectomy, which includes removal of all breast tissue. Separate reporting of codes, such as 19120, which describe excision of breast lesions such as cysts, etc. is not appropriate with code 19240 because the latter represents the most comprehensive service. In this case code 19120 is bundled into code 19240.

### **(7) - Policy Number 8.10000 - “With” Versus “Without” Procedures**

In the example of the comprehensive code 19272 and component code 19271, the only difference in the code descriptions is the fact that code 19271 does not include mediastinal lymphadenectomy and code 19272

does include it. Reporting both codes together is a contradiction in the actual performance of the services at the same session. Therefore, procedure code 19271 is bundled with code 19272.

**(8) - Policy Number 10.10000 - Standards of Medical/Surgical Practice**

In the example of comprehensive code 11730 for the simple avulsion of a nail plate, partial or complete with the component code 11040 for skin debridement, if it was necessary to also debride skin at the same time and at the same site of the nail avulsion, then the debridement would be included in the nail avulsion and would be considered a part of the procedure.

**(9) - Policy Number 11.10000 - Anesthesia Included in Surgical Procedures**

For example, when a digital procedure avulsion of a nail plate (CPT code 11730) is performed, local anesthesia may be accomplished by the surgeon using a digital nerve block. Because digital nerve block represents anesthesia for the procedure (which is not separately payable when performed by the surgeon), it is inappropriate to report code 64450 for the digital nerve block. Code 64450 is bundled into code 11730 when the same physician performs both procedures.

**(10) - Policy Number 14.10000 - Misuse of Column 2 Code With Column 1 Code**

For example, CPT code 11900 (“Intralesional injection”) is intended to describe a therapeutic cutaneous intralesional injection. It would represent a misuse of the code to report this code with other procedures (e.g., CPT code 11400) when the only service provided was injection of local anesthesia in order to accomplish the latter procedure, which is an excision of a benign skin lesion.

**c - Musculoskeletal (CPT Codes 20000 - 29999)**

**(1) - Policy Number 2.20000 - HCPCS/CPT Procedure Code Definition**

In the example of comprehensive code 21045 and component code 21044 and based on the format of the “Physicians’ Current Procedural Terminology,” the description for code 21045 is indented, which means that one is to refer back to a common portion of the procedure listed in the preceding entry. The common part of code 21044 (that part before the semicolon) is also considered a part of code 21045. The full description of code 21045 is excision of malignant tumor of mandible; radical resection. Code 21044 is a component of code 21045 and is appropriately bundled into this procedure.

**(2) - Policy Number 3.20000 - HCPCS/CPT Coding Manual  
Instruction and Guideline**

In reference to the example of the comprehensive code 27427 and component code 29889, a parenthetical note under the code description for procedure 29889 states that procedure codes 29888 and 29889 should not be used with reconstruction procedures represented by codes 27427-27429. Thus, the arthroscopic repair or reconstruction of the cruciate ligament is bundled into the related and more comprehensive procedure designated by code 27427.

**(3) - Policy Number 4.20000 - Mutually Exclusive Procedures**

In the example of Column 1 code 27441 and Column 2 code 27442, both services describe a knee arthroplasty of the tibial plateau. In any one session on the same knee only one of the two procedures would be performed. Therefore, these two services are mutually exclusive of each other.

**(4) - Policy Number 5.20000 - Sequential Procedures**

For example, if a deep bone biopsy is performed and an initial attempt by trocar or needle is made (designated by code 20225), followed by an open biopsy at the same site as described by code 20250 in the same session, both codes should not be reported. The procedures have been performed sequentially, and the more comprehensive biopsy procedure, in this case described by code 20250, should be reported.

**(5) - Policy Number 6.20000 - Separate Procedure Definition**

In the example of the comprehensive code 29876 and component code 29870, the diagnostic knee arthroscopy represented by code 29870 is classified as a “separate procedure.” When the service represented by code 29870 is performed with an arthroscopic major synovectomy (code 29876), it is not performed alone or independent of the related and more comprehensive service described by code 29876. Therefore, code 29870 cannot be reported separately but rather is bundled into code 29876.

**(6) - Policy Number 7.20000 - Most Extensive Procedures**

For example, if in the course of obtaining a bone biopsy (code 20240), a muscle biopsy is obtained through the same incision (code 20200), the most extensive procedure represented by code 20240 is reported. Therefore, code 20200 is bundled with code 20240.

**(7) - Policy Number 8.20000 - “With” Versus “Without” Procedures**

In the example of the comprehensive code 21155 and component code 21154, the only difference in the code descriptions is the fact that code 21154 does not include LeFort I and code 21155 does include it. Reporting both codes together is a contradiction in the actual performance of the services at the same session. Therefore, procedure code 21154 is bundled with code 21155.

**(8) - Policy Number 10.20000 - Standards of Medical/Surgical Practice**

For example, in the course of a radical excision of a bursa or synovia of the wrist, as described by CPT code 25115, it is standard medical practice to attempt to preserve neurologic function by isolating and freeing nerves as necessary. Accordingly, neuroplasty is carried out, if possible, in the course of the excision. Code 64719 for neuroplasty is not reported in this case but rather bundled into the code 25115.

**(9) - Policy Number 11.20000 - Anesthesia Included in Surgical Procedures**

For example, in the course of performing a joint or ganglion aspiration (code 20600), a digital nerve block may be performed prior to the procedure. Because this block is being performed for the primary procedure which is the joint aspiration in this case, the digital nerve block (code 64450) is not reported separately but bundled with the primary procedure (code 20600).

**(10) - Policy Number 14.20000 - Misuse of Column 2 Code With Column 1 Code**

For example, code 20550 (“Injection; tendon sheath, ligament, ganglion cyst”) is intended to describe a therapeutic musculoskeletal injection. It would represent a misuse of the code to report this code with other procedures (e.g., code 28292 for Keller-McBride, or Mayo-type procedure) when the only service provided was injection of local anesthesia in order to accomplish the latter procedure.

**d - Respiratory/Cardiovascular/Lymphatic/Diaphragm (CPT Codes 30000 - 39999)**

**(1) - Policy Number 2.30000 - HCPCS/CPT Procedure Code Definition**

In the example of the comprehensive code 33612 and the component code 33611 and based on the format of the “Physicians’ Current Procedural Terminology” the description for code 33612 is indented, which means that one is to refer back to a common portion of the procedure listed in the preceding entry. The common part of code 33611 (that part before the

semicolon) is also considered a part of code 33612. The full description of code 33612 is “Repair of double outlet right ventricle with intraventricular tunnel repair; with repair of right ventricular outflow tract obstruction.” Code 33611 is therefore a component of code 33612 and is appropriately bundled into this procedure.

**(2) - Policy Number 3.30000 - HCPCS/CPT Coding Manual Instruction and Guideline**

In reference to the example of the comprehensive code 35142 and component code 35355, authors of the CPT manual, by way of a parenthetical note, instruct the coder that “Procedures 35001 - 35162 include preparation for anastomosis including endarterectomy.” Therefore, procedure code 35355 is bundled into code 35142 because the thromboendarterectomy is considered a part of the direct repair of the aneurysm.

**(3) - Policy Number 4.30000 - Mutually Exclusive Procedures**

For example, CPT codes 33820 and 33822 describe two types of repairs of the patent ductus arteriosus. Because only one type of repair would be performed at any given time in the same session, these procedures are considered mutually exclusive and would not be reported together.

**(4) - Policy Number 5.30000 - Sequential Procedures**

For example, if, at the same session, a percutaneous needle biopsy of the pleura (code 32400) is attempted and/or completed and the patient subsequently (but at the same surgical session) undergoes a thoracotomy to perform an open biopsy of the pleura (code 32402), both the open and the needle biopsy are not reported. In this instance the open biopsy, the most comprehensive service, is reported.

**(5) - Policy Number 6.30000 - Separate Procedure Definition**

In the example of the comprehensive code 30903 and component code 30801, the cautery and/or ablation by any method of the mucosa of the unilateral or bilateral turbinates, superficial (CPT code 30801) is classified in the CPT manual as a “separate procedure.” When this service represented by code 30801 is performed with the complex control of anterior nasal hemorrhage by any method (CPT code 30903), it is not performed alone or independent of the related and more comprehensive services described by code 30903 and therefore does not meet the criteria for the “separate procedure” definition. For that reason, code 30801 cannot be reported separately but rather is bundled into code 30903.



**(6) - Policy Number 7.30000 - Most Extensive Procedures**

For example, when a patient undergoes a thoracotomy for bilobectomy and tissue is removed for biopsy as part of the procedure, the most extensive service is described by CPT code 32482. It would not be appropriate to report separately for a thoracotomy for biopsy of lung as well (code 32095). This procedure is bundled into code 32482.

**(7) - Policy Number 8.30000 - “With” Versus “Without” Procedures**

In the example of the comprehensive code 31230 and component code 31225, the only difference in the code descriptions is the fact that code 31225 does not include orbital exenteration and code 31230 does include it. Reporting both codes together is a contradiction in the actual performance of the services at the same session. Therefore, procedure code 31225 is bundled with code 31230.

**(8) - Policy Number 10.30000 - Standards of Medical/Surgical Practice**

For example, if in the course of performing a thoracotomy for bilobectomy (code 32482), it is felt necessary to perform destruction by a neurolytic agent (code 64620), the destruction is believed to be necessary in order to successfully complete the thoracotomy. It is inappropriate to report separately for services described by CPT code 64620 as these services are necessary to complete the procedure. Therefore, code 64620 is bundled into code 32482.

**(9) - Policy Number 11.30000 - Anesthesia Included in Surgical Procedures**

For example, if in the course of performing a thoracotomy for bilobectomy (code 32482), it is felt necessary to perform an intercostal nerve block (code 64420), the intercostal nerve block is believed to be necessary in order to successfully complete the thoracotomy. It is inappropriate to report separately for services described by CPT code 64420 as these services are necessary to complete the comprehensive procedure and are bundled with this primary procedure.

**(10) - Policy Number 14.30000 - Misuse of Column 2 Code With Column 1 Code**

For example, code 35226 (“Repair blood vessel, direct; lower extremity”) is intended to describe an open blood vessel repair of the lower extremity. It would represent a misuse of code 35226 to report this code as a repair of the site where a percutaneous removal of an intra-aortic balloon assist device occurred (CPT code 33968).

## **e - Digestive (CPT Codes 40000 - 49999)**

### **(1) - Policy Number 2.40000 - HCPCS/CPT Procedure Code Definition**

In the example of the comprehensive code 45805 and the component code 45800 and based on the format of the “Physicians’ Current Procedural Terminology,” the description for code 45805 is indented which means that one is to refer back to a common portion of the procedure listed in the preceding entry. The common part of code 45800 (that part before the semicolon) is also considered a part of code 45805. The full description of code 45805 is closure of rectovesical fistula; with colostomy. Code 45800 is a component of code 45805 and is appropriately bundled into this procedure.

### **(2) - Policy Number 3.40000 - HCPCS/CPT Coding Manual Instruction and Guideline**

In reference to the example of the comprehensive code 49505 and component code 49568, authors of the CPT manual, by way of an instruction/guideline above code 49495, instruct the coder that “With the exception of the incisional hernia repairs (see 49560-49566) the use of mesh or other prostheses is not separately reported.” Therefore, code 49568 (mesh implantation) should not be reported with code 49505 (inguinal hernia repair).

### **(3) - Policy Number 4.40000 - Mutually Exclusive Procedures**

For example, an esophageal lesion may be excised either through a thoracic or cervical approach but not both. Accordingly, CPT code 43100 is not reported with code 43101, describing different approaches to accomplish the same procedure.

### **(4) - Policy Number 5.40000 - Sequential Procedures**

For example, if, at the same session, an anoscopy with control of bleeding (code 46614) is performed and is directly followed by an internal/external, complex hemorrhoidectomy described by code 46260 based on the findings of the endoscopic service, the more comprehensive procedure, in this case the hemorrhoidectomy, is reported as a sequential procedure to the anoscopy.

### **(5) - Policy Number 6.40000 - Separate Procedure Definition**

In the example of the comprehensive code 44150 and the component code 44005, the enterolysis represented by code 44005 is classified as a separate procedure. When the service represented by code 44005 is performed with the colectomy (code 44150), it is not performed alone or independent of the related and more comprehensive service described by

code 44150. Code 44005 cannot be reported separately but rather is bundled into code 44150.

**(6) - Policy Number 7.40000 - Most Extensive Procedures**

For example, when excision of a parotid tumor is performed, it may or may not be accompanied by a unilateral radical neck dissection; completing the parotid tumor excision with a radical neck dissection represents a more extensive procedure than without the radical neck dissection. Accordingly, it is inappropriate to report CPT codes 42425 and 42426, the latter including the radical neck dissection. Only CPT code 42426 is reported if a radical neck dissection accompanied the parotid gland excision.

**(7) - Policy Number 8.40000 - “With” Versus “Without” Procedures**

In the example of the comprehensive code 40812 and component code 40810, the only difference in the code descriptions is the fact that code 40810 does not include repair and code 40812 does include it. Reporting both codes together is a contradiction in the actual performance of the services at the same session. Therefore, procedure code 40810 is bundled with code 40812.

**(8) - Policy Number 10.40000 - Standards of Medical/Surgical Practice**

For example, in the course of a tonsillectomy (code 42821), bleeding may be expected and the control of the bleeding intraoperatively represents part of the procedure. It is inappropriate to report separately for control of oropharyngeal hemorrhage (code 42961) that occurs during the same operative session. Therefore, code 42961 is bundled with code 42821.

**(9) - Policy Number 11.40000 - Anesthesia Included in Surgical Procedures**

For example, when a local anesthetic injection is performed as a part of an inguinal hernia repair (code 49505), the local anesthetic procedure (code 64425) performed by the surgeon is included in the surgical procedure and is not reported separately. Therefore, code 64425 is bundled into code 49505.

**(10) - Policy Number 14.40000 - Misuse of Column 2 Code With Column 1 Code**

For example, CPT code 91105 (“Gastric intubation, and aspiration or lavage for treatment (e.g., for ingested poison)”) is intended to represent a non-endoscopic procedure. Accordingly, if the only service provided is endoscopic lavage in the course of an upper gastrointestinal endoscopy (e.g., code 43227 for “rigid or flexible esophagoscopy with control of

bleeding”), CPT code 91105 should not be separately reported unless performed as a distinct, non-endoscopic procedure.

#### **f - Genitourinary (CPT Codes 50000 - 59999)**

##### **(1) - Policy Number 2.50000 - HCPCS/CPT Procedure Code Definition**

In the example of comprehensive code 55605 and the component code 55600 and based on the format of the “Physicians’ Current Procedural Terminology,” the description for code 55605 is indented which means that one is to refer back to a common portion of the procedure listed in the preceding entry. The common part of code 55600 (that part before the semicolon) is also considered a part of code 55605. The full description of code 55605 is vesiculotomy; complicated. Code 55600 is a component of code 55605 and is appropriately bundled into this procedure.

##### **(2) - Policy Number 3.50000 - HCPCS/CPT Coding Manual Instruction and Guideline**

In reference to the example of the comprehensive code 52320 for “cystourethroscopy (including ureteral catheterization); with removal of ureteral calculus” and component code 52332 for “cystourethroscopy, with insertion of indwelling ureteral stent (e.g., Gibbons or double J-type),” there is an instruction above these codes in the CPT manual and under the Section: Ureter and Pelvis which states, “The insertion and removal of a temporary stent during diagnostic or therapeutic cystourethroscopic intervention(s) is included in 52320-52355 and should not be reported separately.” Therefore, procedure code 52332 is included in code 52320 based on this CPT manual guideline. If, however, a permanent self-retaining, indwelling stent is inserted during cystourethroscopic diagnostic or therapeutic intervention(s), then the -59 modifier may be appended to either code to indicate that the stent represented by code 52332 is a permanent and not a temporary stent.

##### **(3) - Policy Number 4.50000 - Mutually Exclusive Procedures**

For example, when a ureteral diversion is accomplished, it may be diverted to the intestine (ureteroenterostomy, CPT code 50800) or diverted as a ureterostomy (cutaneous, CPT code 50860). For a single ureteral diversion procedure, it is inappropriate to report both codes as these are mutually exclusive procedures.

##### **(4) - Policy Number 5.50000 - Sequential Procedures**

For example, if, at the same session, a needle or punch biopsy of the prostate (CPT code 55700) is undertaken, and is followed by an incisional biopsy (CPT code 55705) either to supplement or to obtain adequate

tissue, the appropriate CPT code to report is 55705, not both of these codes.

**(5) - Policy Number 6.50000 - CPT Separate Procedure Definition**

In the example of the comprehensive code 58150 and the component code 58700, the salpingectomy represented by code 58700 is classified as a “separate procedure.” When the service represented by code 58700 is performed with a total abdominal hysterectomy (code 58150), it is not performed alone or independent of the related and more comprehensive service described by code 58150. Code 58700 cannot be reported separately but rather is bundled into code 58150.

**(6) - Policy Number 7.50000 - Most Extensive Procedures**

For example, when a cystourethroscopy is performed and lesions are identified, biopsied, and removed by laser or cryosurgery, this service is accurately described by CPT code 52224. A less comprehensive service, described by code 52204, which includes the services described above without mention of fulguration of bladder lesions, is not reported in addition to code 52224.

**(7) - Policy Number 8.50000 - “With “ Versus “Without” Procedures**

In the example of the comprehensive code 59151 and component code 59150, the only difference in the code description is the fact that code 59150 does not include salpingectomy and/or oophorectomy, whereas code 59151 does include it. Reporting both codes together is a contradiction in the actual performance of the services at the same session; therefore, procedure code 59150 is bundled with code 59151.

**(8) - Policy Number 9.50000 - Designation of Sex Procedures**

For example, procedure code 52270 describes a cystourethroscopy with an internal urethrotomy for a female and code 52275 describes the identical procedure but only for a male. These two procedures cannot be reported for the same session, same provider, and the same beneficiary. Only the appropriate one should be submitted.

**(9) - Policy Number 10.50000 - Standards of Medical/Surgical Practice**

For example, when a bladder neck suspension is performed under endoscopic control (CPT code 51845), and endoscopy is performed prior to the procedure for assessment of the anticipated surgical field or during the procedure, the endoscopy is necessary to accomplish the procedure. It is inappropriate to submit other endoscopy CPT codes like 52005 for services performed as described above.

**(10) - Policy Number 11.50000 - Anesthesia Included in Surgical Procedures**

For example, when a conization of the cervix is performed, as described by CPT code 57520, and anesthesia is provided by the surgeon in the form of an injection of the anesthetic agent into the paracervical (uterine) nerve (CPT code 64435), separate reporting for the anesthesia services is inappropriate. Services described by CPT code 64435 are bundled into code 57520 if performed by the same physician.

**(11) - Policy Number 14.50000 - Misuse of Column 2 Code with Column 1 Code**

For example, code 44950 (“Appendectomy”) is intended to describe an incidental appendectomy during another intra-abdominal surgical procedure which would not warrant separate identification. Therefore, if this procedure was performed incidental to and reported with the more comprehensive code 58152 [“total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s); with colpourethrocystopexy (Marshall-Marchetti-Krantz type)”], then this instance would represent a misuse of this code for the appendectomy.

**g - Endocrine/Nervous System (CPT Codes 60000 - 69999)**

**(1) - Policy Number 2.60000 - HCPCS/CPT Procedure Code Definition**

In the example of the comprehensive code 60281 and the component code 60280 and based on the format of the “Physicians’ Current Procedural Terminology,” the description for code 60281 is indented which means that one is to refer back to a common portion of the procedure listed in the preceding entry. The common part of code 60280 (that part before the semicolon) is also considered a part of code 60281. The full description of code 60281 is “Excision of thyroglossal duct cyst or sinus; recurrent.” Code 60280 is therefore a component of code 60281 and is appropriately bundled into this procedure.

**(2) - Policy Number 3.60000 - HCPCS/CPT Coding Manual Instruction and Guideline**

In reference to the example of the comprehensive code 66920 and component code 66600, a CPT manual instruction is given at the beginning of the section on lens removal procedures. Iridectomy is a procedure that is included as a part of the service rendered for the extraction of the lens. Therefore, 66600 is one code for iridectomy that is a part of the more comprehensive service, the lens extraction (code 66920), and warrants bundling into code 66920.

### **(3) - Policy Number 4.60000 - Mutually Exclusive Procedures**

For example, craniectomies may be performed by various methods and different approaches. Accordingly, code 61518 is not reported with code 61526 because these describe separate methods to accomplish the same procedure, in this case the craniectomy.

### **(4) - Policy Number 5.60000 - Sequential Procedures**

For example, when a fine needle aspiration of the thyroid is attempted, failed and then is followed by a percutaneous core needle biopsy at the same session, the procedure (in this case the core needle biopsy) which was successfully accomplished should be reported. In this instance, code 10021 is bundled into code 60100.

### **(5) - Policy Number 6.60000 - CPT Separate Procedure Definition**

In the example of the comprehensive code 65855 and the component code 65860, the severing of adhesions represented by code 65860 is classified as a “separate procedure.” When the service represented by code 65860 is performed with a trabeculoplasty (code 65855), it is not performed alone or independent of the related and more comprehensive service described by code 65855. Code 65860 cannot be reported separately but rather is bundled into code 65855.

### **(6) - Number 7.60000 - Most Extensive Procedures**

For example, when a patient requires destruction of an extensive diabetic retinopathy by photocoagulation (code 67228) as opposed to the destruction of a localized retinal lesion by cryotherapy (code 67208), the more comprehensive service is reported since the destruction of the retinopathy represents the most extensive service.

### **(7) - Policy Number 8.60000 - “With” Versus “Without” Procedures**

In the example of the comprehensive code 60605 and component code 60600, the only difference in the code descriptions is the fact that code 60600 does not include excision of carotid artery and code 60605 does include it. Reporting both codes together is a contradiction in the actual performance of the service at the same session. Therefore, procedure code 60600 is bundled with code 60605.

### **(8) - Policy Number 10.60000 - Standards of Medical/Surgical Practice**

For example, when an ectropion (accompanied by an everted punctum) is repaired by performing a blepharoplasty, the blepharoplasty procedure, as described by CPT code 67917 would include the procedures necessary to correct the lesion(s), including the associated everted punctum, even if this

was accomplished by cautery. It is inappropriate to separately report code 68705 as an independent procedure when performed on the same lid.

**(9) - Policy Number 11.60000 - Anesthesia Included in Surgical Procedures**

For example, when anesthesia is provided by the same surgeon removing a cataract (CPT code 66984), the anesthesia service is included in the procedure. Reporting code 64400 for the nerve block separately from the cataract removal is inappropriate.

**(10) - Policy Number 14.60000 - Misuse of Column 2 Code With Column 1 Code**

For example, CPT code 20550 (“Injection; tendon sheath, ligament, or ganglion cyst”) is intended to describe a therapeutic musculoskeletal injection. It would represent a misuse of the code to report this code with other procedures (e.g., code 64721 for carpal tunnel release) when the only service provided is injection of local anesthesia in order to accomplish the comprehensive procedure (the carpal tunnel release) or as part of the comprehensive procedure.

**h - Radiology (CPT Codes 70000 - 79999)**

**(1) - Policy Number 2.70000 - HCPCS/CPT Procedure Code Definition**

In the example of the comprehensive code 71270 and the component code 71260, the complete description of code 71270 is “Computerized axial tomography, thorax; without contrast material, followed by contrast material(s) and further sections.” The CT scan with contrast material is included in the service described by code 71270; therefore, code 71260 is a component of code 71270 and is appropriately bundled into this procedure.

**(2) - Policy Number 3.70000 - HCPCS/CPT Coding Manual Instruction and Guideline**

In reference to the example of the comprehensive code 77600 and component code 77261, a CPT manual instruction is given at the beginning of the section on hyperthermia. It states that “The listed treatments include management during the course of therapy and follow-up care for three months after completion. Physics planning and interstitial insertion of temperature sensors, and use of external or interstitial heat generating sources are included.” Therefore, 77261 is one code for clinical treatment planning that is part of the more comprehensive service, the hyperthermia (code 77600), and warrants bundling into code 77600.



### **(3) - Policy Number 4.70000 - Mutually Exclusive Procedures**

Cineradiography/videoradiography may be described separately from other radiological procedures in two ways as reflected in the Column 1 code 76125 and Column 2 code 76120. For the same session, it would be inappropriate to report both codes in describing the services necessary to accomplish the same procedure.

### **(4) - Policy Number 6.70000 - CPT Separate Procedure Definition**

In the example of the comprehensive code 70370 and the component code 76000, the fluoroscopy represented by code 76000 is classified as a “separate procedure.” When the service represented by code 76000 is performed with a radiologic examination including fluoroscopy (code 70370), it is not performed alone or independent of the related and more comprehensive service described by code 70370. Therefore, code 76000 cannot be reported separately but rather is bundled into code 70370.

### **(5) - Policy Number 7.70000 - Most Extensive Procedures**

For example, when radiologic supervision and interpretation services (S&I) are provided for myelography, there are CPT codes describing localized areas (code 72240 for cervical myelography). The CPT code 72270 is to be used when reporting S&I services for myelography of the entire spinal canal. Accordingly, codes 72240 and 72270 are not reported together for services performed on the same session because the service described by 72270 is the most extensive service.

### **(6) - Policy Number 8.70000 - “With” Versus “Without” Procedures**

In the example of the comprehensive code 70460 and component code 70450, the only difference in the code descriptions is the fact that code 70450 does not include contrast material and code 70460 does include it. Reporting both codes together is a contradiction in the actual performance of the services at the same session. Procedure code 70450 is bundled with code 70460.

### **(7) - Policy Number 10.70000 - Standards of Medical/Surgical Practice**

For example, when intravenous contrast administration is required for a radiologic examination, such as an abdominal CT scan (reported with CPT code 74170), it is necessary to insert an intravenous catheter to administer the contrast. Since the intravenous catheter is integral to the performance of the test, submission of code 36000 in addition to 74170 is inappropriate.

**(8) - Policy Number 14.70000 - Misuse of Column 2 Code with Column 1 Code**

In the example of comprehensive code 77600 and component code 97020, the CPT manual states that “Hyperthermia is used only as an adjunct to radiation therapy or chemotherapy.” The hyperthermia may be induced by a variety of sources including application of a microwave modality. Therefore, it is a misuse of the component code 97020, the possible induction source, with comprehensive code 77600 because procedure 97020 does not represent radiation therapy or chemotherapy.

**i - Pathology/Laboratory (CPT Codes 80000 - 89999)**

**(1) - Policy Number 2.80000 - HCPCS/CPT Procedure Code Definition**

In the example of the comprehensive code 80192 and the component code 80190 and based on the format of the “Physicians’ Current Procedural Terminology,” the description of code 80192 is indented which means that one is to refer back to a common portion of the procedure listed in the preceding entry. The common part of code 80190 (that part before the semicolon) is also considered a part of code 80192. The full description of code 80192 is procainamide; with metabolites (e.g., n-acetyl procainamide). Code 80190 is therefore a component of code 80192 and is appropriately bundled into this procedure.

**(2) - Policy Number 3.80000 - HCPCS/CPT Coding Manual Instruction and Guideline**

In reference to the example of the comprehensive code 87260 and component code 87206, there is a reference note at the beginning of the series of CPT codes 87260-87999 in the CPT manual that states, “Infectious agents by antigen detection, direct fluorescence microscopy, or nucleic acid probe techniques should be reported as precisely as possible. The most specific code possible should be reported.” Therefore, code 87206 is included in code 87260 based on this CPT manual guideline.

**(3) - Policy Number 4.80000 - Mutually Exclusive Procedures**

There are different ways of performing blood counts for the purpose of obtaining distinct information as reflected by the Column 1 code 85014 and Column 2 code 85024. Both codes should not be reported together; the code that more accurately describes the service rendered should be reported.

#### **(4) - Policy Number 5.80000 - Sequential Procedures**

For example, when a screen cold agglutinin (code 86156) is positive for the presence of cold agglutinins and it is followed by a cold agglutinin titer (code 86157) in the same session, then the tests are considered sequential. Accordingly, the cold agglutinin titer (code 86157), which gives quantitative information, is the service that should be reported.

#### **(5) - Policy Number 7.80000 - Most Extensive Procedures**

For example, the results of certain laboratory determinations may require medical interpretative judgment which the pathologist renders based only on the individual test. In this case, the appropriate CPT code to report is 80500. An attending physician may request the pathologist to interpret the results in the context of the patient's medical history and records, in which case the appropriate CPT code to report is 80502. Because interpreting a test with the perspective of a patient's history and other test results is more comprehensive than interpreting the result as an isolated test, CPT code 80502 is the procedure to report.

#### **(6) - Policy Number 8.80000 - "With" Versus "Without" Procedures**

In the example of the comprehensive code 81000 and component code 81002, the only difference in the code descriptions is the fact that code 81002 does not include microscopy and code 81000 does include it. Reporting both codes together is a contradiction in the actual performance of the services at the same session. Therefore, procedure code 81002 is bundled with code 81000.

#### **(7) - Policy Number 10.80000 - Standards of Medical/Surgical Practice**

For example, when a glucose tolerance test with three specimens is performed (code 82951), a blood, reagent strip glucose (code 82948) is considered a part of the procedure. Therefore, the more comprehensive service (code 82951) is reported.

#### **(8) - Policy Number 12.80000 - Laboratory Panels**

In the example of code 80076 for the hepatic function panel, the CPT manual indicates that a serum albumin (code 82040) is a part of this laboratory panel of tests. If all seven individual tests which are included in this laboratory panel are performed at the same patient encounter, then the hepatic function panel code 80076 should be reported and not the individual test procedures such as the serum albumin (CPT code 82040). Therefore, it is considered duplicate reporting if these two procedures are billed together. The actual service performed should be reported.

**(9) - Policy Number 14.80000 - Misuse of Column 2 Code with Column 1 Code**

In the example of comprehensive code 88141 for the diagnostic cervical or vaginal cytopathology by any reporting system requiring interpretation by a physician which represents the professional component and component code G0143 for screening cervical or vaginal cytopathology by any reporting system with manual screening and rescreening by a cytotechnologist representing the technical component, code 88141 should only be used with the other technical component codes for diagnostic screening by a cytotechnologist, which are CPT codes 88142-88154 and 88164-88167 according to the CPT manual. Reporting code 88141 with G0143 would therefore be a misuse of code 88141 and therefore G0143 is not allowed with 88141 at the same encounter.

**j - Medicine (CPT Codes 90000 - 99999)**

**(1) - Policy Number 2.90000 - HCPCS/CPT Procedure Code Definition**

In the example of the comprehensive code 91012 and the component code 91010 and based on the format of the “Physicians’ Current Procedural Terminology,” the description for code 91012 is indented which means that one is to refer back to a common portion of the procedure listed in the preceding entry. The common part of code 91010 (that part before the semicolon) is also considered a part of code 91012. The full description of code 91012 is “esophageal motility study; with acid perfusion studies.” Code 91010 is a component of code 91012 and is appropriately bundled into this procedure.

**(2) - Policy Number 3.90000 - HCPCS/CPT Coding Manual Instruction and Guideline**

In reference to the example of the comprehensive code 90935 and component code 36145, at the beginning of the dialysis section, authors of the CPT Manual have instructed the coder that all other patient care services which are rendered during a dialysis procedure are included in the dialysis procedure. Since an introduction of a needle or intracatheter to the arteriovenous shunt is performed during dialysis, code 36145 is bundled into the dialysis code 90935.

**(3) - Policy Number 4.90000 - Mutually Exclusive Procedures**

For example, when 24-hour EEG monitoring for localization of seizure focus is performed by a portable 16-channel EEG recording, it is appropriate to report CPT code 95953. Because a 16-channel EEG is not also separately performed and transmitted telemetrically (CPT code

95956) over the same 24 hours, codes 95956 and 95953 are not reported together.

**(4) - Policy Number 6.90000 - CPT Separate Procedure Definition**

In the example of the comprehensive code 91105 and the component code 91055, gastric intubation and washings represented by code 91055 is classified as a “separate procedure.” When the service represented by code 91055 is performed with gastric intubation and aspiration or lavage (code 91105), it is not performed alone or independent of the related and more comprehensive service described by code 91105. Code 91055 cannot be reported separately but rather is bundled into code 91105.

**(5) - Policy Number 7.90000 - Most Extensive Procedures**

For example, when a rhythm strip is interpreted, the interpretation is limited to establishing the nature of the cardiac rhythm. This interpretation service is described by code 93042. When an electrocardiogram (CPT code 93010) is performed, interpretation of the rhythm represents a part of the interpretation of the electrocardiogram. Accordingly, when an electrocardiogram is interpreted, only the more extensive service (in this example, code 93010) is reported.

**(6) - Policy Number 8.90000 - “With” Versus “Without” Procedures**

In the example of the comprehensive code 93732 and component code 93731, the only difference in the code descriptions is the fact that code 93731 does not include reprogramming and code 93732 does include it. Reporting both codes together is a contradiction in the actual performance of the services at the same session. Therefore, procedure code 93731 is bundled with code 93732.

**(7) - Policy Number 10.90000 - Standards of Medical/Surgical Practice**

For example, when fluorescein angiography is performed (code 92235), it is necessary to obtain vascular access, described by CPT code 36000 for administration of the fluorescein; the test cannot be performed without vascular access. Since the services described by code 36000 are integral to performance of the services described by code 92235, only the latter code is reported.

**(8) - Policy Number 11.90000 - Anesthesia Included in Surgical Procedures**

For example, when electroconvulsive therapy (code 90870) is performed, anesthesia is routinely administered for the therapy (code 00104). If the anesthesia is given by the same physician who is performing the therapy, the anesthesia would be included in the therapy service.

**(9) - Policy Number 14.90000 - Misuse of Column 2 Code With Column 1 Code**

In the example of code 96912 (“Photochemotherapy; psoralens and ultraviolet A (PUVA)”) and code 77401 (“Radiation treatment delivery, superficial and/or ortho voltage”), these two procedures are not intended to describe similar services and are generally provided by different specialists. It is imaginable that one service could be construed as a form of the other but both codes should not be reported to describe one service.

**k - HCPCS/CPT Level II (Codes A0000 - V9999)**

**(1) - Policy Number 2.A-V - HCPCS/CPT Procedure Code Definition**

In the example of the comprehensive code G0004 and the component code G0005, the descriptions of both codes include a common portion. “Patient demand single or multiple event recording with pre-symptom memory loop and 24-hour attended monitoring, per 30 day period;” is a part of the definitions of both codes. Code G0004 is more comprehensive in that it also “includes transmission, physician review and interpretation” and not just the “recording (includes hook-up, recording and disconnection)” like code G0005. Code G0005 is therefore a component of code G0004 and is appropriately bundled into this procedure.

**(2) - Policy Number 3.A-V - HCPCS/CPT Coding Manual Instruction/ Guideline**

For example, in the CPT manual instruction under CPT code 76150 for xeroradiography, the reference note states “76150 is to be used for non-mammographic studies only.” Therefore, code 76150 is bundled with codes in the range of G0202-G0206, which represent various types of screening and diagnostic mammograms.

**(3) - Policy Number 4. A-V - Mutually Exclusive Procedures**

For example, colorectal cancer screening with barium enema (code G0120) is an alternative screening method to a colorectal cancer screening by colonoscopy on an individual at high risk (code G0105). Therefore, these codes are not reported together.

**(4) - Policy Number 6.A-V - CPT Separate Procedure Definition**

In the example of the comprehensive code G0104 and the component code 36410, the venipuncture represented by code 36410 is classified as a “separate procedure.” When the service presented by code 36410 is performed with a flexible sigmoidoscopy for colorectal cancer screening (code G0104), it is not performed alone or independent of the related and more comprehensive service described by code G0104; therefore, code

36410 cannot be reported separately but rather is bundled into code G0104.

**(5) - Policy Number 7. A-V - Most Extensive Procedures**

For example, when a complete patient demand single or multiple event recording with pre-symptom memory loop and 24-hour attended monitoring, per 30 day period including transmission, physician review, and interpretation (code G0004) is performed at the same time as a tracing only of a post-symptom telephonic transmission of electrocardiogram rhythm strip(s) and 24-hour attended monitoring, per 30 day period (code G0015), then only one service, the more extensive, more comprehensive procedure should be reported. In this case, G0004 should be reported because it includes both the technical and professional portions of the service and G0015 includes only the technical portion.

**(6) - Policy Number 10. A-V - Standards of Medical/Surgical Practice**

For example, if both trimming of dystrophic nails (CPT code G0127) and a debridement of partial thickness skin (CPT code 11040) of the same site at the nail bed(s) are performed, then the services described by code 11040 are considered integral and a part of the performance of the services described by code G0127. In this instance only the trimming of the dystrophic nails should be reported.

**(7) - Policy Number 14.A-V - Misuse of Column 2 code with Column 1 Code**

In the example of comprehensive code G0166 for external counterpulsation per treatment session and component code 93000 for the interpretation and report of a routine ECG with at least 12 leads, reporting code 93000 to represent the triggering by an ECG of the automatic mechanism which activates the balloon catheter in the aorta would be a misuse of code 93000. Therefore, code 93000 would not be allowed in the same encounter as G0166 for this purpose.

**3 - National Correct Coding Initiative Edit Policy: Explanation of General Correspondence Language**

The following is an explanation of the “General Correspondence Language” using, as an example, the code pair 20610 (comprehensive or Column1 code) and 20550 (component or Column 2 code).

Edits - The hard copy of the edits for 20610/20550 shows:

Correspondence Language

Comprehensive Code	Component Code	Policy /Example Number
20610	20550	14.20000

**a - Policy/Example Number 14.20000**

The “14” in 14.20000 refers to the 14th policy in the “General Correspondence Language,” which states:

“Misuse of Column 2 code with Column 1 code: CPT codes have been written as precisely as possible to not only describe a specific service or procedure but to also avoid describing similar services or procedures which are already defined by other CPT codes. When a CPT code is reported, the physician or non-physician provider must have performed all of the services noted in the descriptor unless the descriptor states otherwise. (Frequently, a CPT descriptor will identify certain services that may or may not be included, usually stating “with or without” a service.) A CPT code should not be reported out of the context for which it was intended. Either intentionally or unintentionally, a provider may report a service or procedure using a CPT code that may be construed to describe the service/procedure, but in no way, was the code intended to be used in this fashion. When CPT code 20550 (Column 2 code or component code) is reported as services associated with services described by CPT 20610 (Column 1 code or comprehensive code), reporting the former code represents a misuse of this code and should not be separately allowed”.

The number “2” in 14.20000 refers to CPT codes in the range of 20000-29999. To find examples of this policy (misuse of column 2 code with column 1 code), go to the section in “Correspondence Language Section - specific Examples,” which refers to the range of codes which encompasses the comprehensive code of the code pair in question. In this example, the comprehensive code is 20610. It is necessary to go to the section related to CPT codes 20000 - 29999 and look for policy number 14.20000. It states:

“Policy Number 14.20000 - Misuse of Column 2 Code with Column 1 Code - For example, CPT code 20550 (“Injection, tendon sheath, ligament, trigger point or ganglion cyst”) is intended to describe a therapeutic musculoskeletal injection. It would represent a misuse of the code to report this code with other procedures (e.g., CPT code 28292 for Keller, McBride, or Mayo



type procedure) when the only service provided was injection of local anesthesia in order to accomplish the latter procedure.”

#### **4 - National Correct Coding Initiative Edit Policy: Deleted Codes Examples**

##### **a - Policy Number 13. DeletePR3 - Priority 3 Example**

In the course of evaluating a breast mass, a fine needle aspiration procedure (formerly code 88170, now code 10021) is often performed and, in order to obtain sufficient tissue for receptor assay, etc., a needle core biopsy (code 19100) is performed as well. In accordance with the sequential procedure policy, the edit pair 19100-88170 was proposed. When commenters identified that the purpose of the core biopsy was not just a sequential procedure to the fine needle aspiration but is frequently performed for different reasons (receptor assays), it was decided that the edit should be deleted from the initial proposal. On the other hand, because of the similarity in the procedures (percutaneous procurement of tissue), it was felt that a potential abuse scenario could occur with a provider reporting both codes (19100 and 88170) when only one procedure was, in fact, performed. This code pair was, therefore, placed in the Priority 3 (fraud/abuse potential) category.

##### **b - Policy Number 13. DeletePR4 - Priority 4 Example**

In the example of the comprehensive code 93350 and component codes 93015 through 93018, because of changes in instruction under procedure 93350 according to the 1995 CPT Manual, these combinations of correct coding edits were deleted from the recommendations. A parenthetical note under this code now directs the provider of services to report the appropriate stress testing codes in addition to the echocardiogram code 93350.

## **20.13 - Correct Coding Edit Files**

*(Rev. 3, 12-09-03)*

### **B3-4630.M**

The following are the updated record layouts for the Correct Coding Edit Files available to the Standard Systems, Carriers, NTIS, and the Regional Offices via Connect DIRECT and CMS Data Center.

### Carrier/Standard Systems Record Format

Field	Type	Record Position	Length
Comprehensive Column 1 Code or Mutually Exclusive Column 1 Code	Character	1	5
Component Column 2 Code or Mutually Exclusive Column 2 Code	Character	6	5
Prior Rebundled Code Indicator “*” rebundled prior to 1996 edits “_” rebundled 1/1/96 or later	Character	11	1
Correspondence Language Reference	Character	12	12
Effective Date (4 position year followed by Julian day)	Numeric	24	7
Deletion Date (4 position year followed by Julian day)	Numeric	31	7
Modifier Indicators “0” No CCE modifier allowed “1” CCE modifier acceptable “9” Use of CCE modifier not specified	Numeric	38	1
Savings Type Indicator Edit “1” CCE “2” Mutually Exclusive	Character	39	1