Medicare
Carriers Manual
Part 2 - Program Administration

Department of Health and Human Services (DHHS)
HEALTH CARE FINANCING ADMINISTRATION (HCFA)

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CHANGE REQUEST 1236

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
5104 - 5106	2-104.1 - 2-104.8e (13pp.)	2-104.1 - 2-104.8d (12pp.)

CLARIFICATION/MANUALIZATION--*EFFECTIVE/IMPLEMENTATION DATE:* Not Applicable

These manual changes reflect Budget Performance Requirements (BPRs) implemented in FY 2000 for beneficiary telephone customer service.

These instructions should be implemented within your current operating budget.

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

Beneficiary and Provider Communications

5104. BENEFICIARY SERVICES

Every member of your customer service team should be committed to providing the highest level of service to our primary customer, the Medicare beneficiary. This commitment should be reflected in the manner in which you handle each beneficiary inquiry. The following guidelines are designed to help you to ensure that this high level of service is provided.

A. Written Inquiries.--

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

- o Answer inquiries timely;
- o Do not send handwritten responses;
- o Consider written appeal requests as valid if all requirements for filing are met. These requests need not be submitted on the prescribed forms in order to be considered valid. If appeal requests are valid, they are not to be considered written inquiries for workload reporting; and
- o Keep responses in a format from which reproduction is possible.

2. Guidelines for High Quality Written Responses to Inquiries.--Perform a continuous quality appraisal of outgoing letters, computer notices, and responses to requests for appeal of an initial determination. This appraisal consists of the following elements:

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

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

c. Clarity.--Letters have good grammatical construction, sentences are of varying length, and paragraphs generally contain no more than five sentences. Use HCFA-provided model language and guidelines, where appropriate.

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

d. Timeliness.--Substantive action is taken and an interim or final response is sent within 30 calendar days from receipt of the inquiry. In instances where a final response cannot be sent within 30 calendar days (e.g., inquiry must be referred to a specialized unit for response), send an interim response acknowledging receipt of the inquiry and the reason for any delay.

If you are responsible for handling both Part A and Part B claims, inquiries requiring response from both of these areas share the same timeframe for response (i.e., the 30-day period starts on the same day for both responses).

Ensure that the inquiry is provided to both responding units as quickly as possible. The response to these inquiries may be combined, or separate, depending on which procedure is most efficient for your conditions. If you respond separately, each response must refer to the fact that the other area of inquiry will be responded to separately.

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

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

1. Availability of Telephone Service--Make live telephone service available to callers continuously during normal business hours, including break and lunch periods. 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 the workday is maintained in accordance with call center standards.

Although the beneficiary should have the ability to transfer to a CSR during operating hours, automated "self-help" tools, such as interactive voice response (IVR) units, may also be used to assist with inquiries. HCFA is currently testing Medicare Beneficiary IVR scripts with the intent of implementing them at either selected or all call centers depending on the findings of the test. In the interim, contractors are encouraged to increase the use of existing IVRs based upon lessons learned and "best practices" throughout HCFA and its partners. IVRs should be updated to address areas of beneficiary confusion as determined by contractors' inquiry analysis staff and HCFA best practices.

IVR service is intended to assist beneficiaries in obtaining answers to various Medicare questions, including those relating to:

- Contractor hours of operations for live service provided after hours or during peak times when a caller is waiting on hold.
- General Medicare program information;
- Specific information regarding claims in process and claims completed;
- A statement if additional evidence is needed to have a claim processed; and
- General information about appeal rights and actions required of a beneficiary to exercise these rights.

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 Federal holidays. Allowances for claim processing system and mainframe availability, as well as for normal IVR and system maintenance shall be made. Contractors should identify what services can be provided to beneficiaries during times when the processing system is not available. Print and distribute a readily understood IVR operating guide to Medicare beneficiaries upon request.

Carriers should report the IVR handle rate which is the number of calls delivered to the IVR in which the beneficiary receives the information they require from the system.

2. Toll-Free Telephone Service.--HCFA will be expanding toll-free service for beneficiaries to all carriers. This will be accomplished through a new government-wide telephone contract negotiated by General Services Administration. This telephone service is known as Federal Telephone Service (FTS) 2001. HCFA will coordinate the transition from local and non-FTS long distance carriers and the installation of any new telephone service lines to the FTS-2001 contract carrier, MCI. The costs associated with this toll-free service will be paid centrally by HCFA. However, Medicare carriers will still be responsible for all other internal wiring and equipment (ACDs, PBX, etc.) and any local telephone services and line charges.

Any toll-free Medicare beneficiary customer service number provided and paid for by HCFA must be printed on all beneficiary notices (MSN, EOMB, etc.) immediately upon activation. Display this toll-free number prominently so the reader will know whom to contact regarding the notice.

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

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

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

Provide a training program which includes technical instructions on Medicare eligibility, coverage, benefits, claims processing, Medicare systems and administration, use of the Medicare Carriers Manual (MCM), telephone techniques, and the use of a computer terminal. The training program should also sensitize customer service personnel to the special needs of the elderly, e.g., difficulty in hearing.

4. Guidelines for High Quality Telephone Service.--Handle all beneficiary telephone inquiries in accordance with the guidelines shown below. All tasks related to this activity are mandatory and shall be reported to HCFA's web-based Customer Service Assessment and Management System (CSAMS) each month. Standard definitions and detailed calculations for each of the required telephone customer service data elements are posted on the telephone customer service website at *https://www.hcfa.gov/medicare/callcenter*.

a. Report total calls offered to the beneficiary call center for 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, Part B and other non-HCFA calls.

b. Program all systems related to inbound beneficiary calls to the center to acknowledge each call within 20 seconds (4 rings) before a CSR, IVR or automated call distributor (ACD) prompt is reached. This measure may not be required to be reported, but must be substantiated when requested.

c. Achieve a monthly all trunks busy (ATB) Rate of no more than 10% for Internal ATB measurement only. Annotate exceptions to this performance level in the monthly report. For all toll free lines, report the ATB external rate.

d. For callers choosing to talk with a CSR, answer 97.5% or more telephone calls within 120 seconds; and answer no less than 85% within the first 60 seconds.

e. Provide a recorded message advising callers in queue to speak with a CSR of any temporary delay before a CSR is available. Use the message to also request that the beneficiary have certain information readily available (Medicare card) before speaking with the CSR. During peak volume periods, indicate in the message a preferred time to call.

NOTE: IVRs 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). If call centers have IVRs that allow the recording of messages, this service should be eliminated no later than September 30, 2000.

f. Track and report call abandonment rate, which is the percentage of beneficiary calls that abandon their call from the ACD queue. This should be reported as three separate measures:

1) Calls abandoned up to and including 60 seconds;
2) Calls abandoned up to and including 120 seconds; and
3) Calls abandoned after 120 seconds.

g. Report the monthly average speed of answer. This is the amount of time that all calls waited before being connected to a CSR. It includes ringing, delay recorder(s) and music.

h. 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. CSRs should also follow local procedures for escalating calls to supervisors or managers in situations where warranted.

i. Track and report monthly average talk time (which includes any time the caller is placed on hold by the CSR), targeting call duration between 3 and 7 minutes (180-420 seconds).

j. Handle no less than 80% of calls to completion during the initial call - minimizing transfers, referrals and callbacks.

k. Track and report call center handling productivity, calculated by the total calls handled divided by the total CSR FTEs in the center, setting a minimum performance objective of 1100 calls per FTE per month for Non-Medicare Customer Service Center (MCSC) call centers and 1000 calls per month for MCSC call centers. This should be accomplished by all call centers without sacrificing the quality of calls and with minimal referrals. MCSC call centers should take advantage of handling multiple issue calls (Part A, Part B, DME, etc.) without referral to ensure maximum utilization of the MCSC desktop.

l. Track and report occupancy rate, the percent of time that CSRs spend in active call handling (i.e., on incoming calls, after call work or outbound calls).

m. Track and report monthly average after call work time (wrap-time), which includes all the time that the CSR needs to complete all administrative work associated with call activity after the customer disconnects.

n. Report the status of those calls not resolved at first contact. Those calls should be reported as follows:

1) 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) Callbacks closed within 2 workdays. This number is based on calls received for the calendar month and represents the number closed as of the last workday of the month.

3) Callbacks closed within 5 workdays. This number is based on calls received for the calendar month and represents the number closed as of the last workday of the month.

4) Callbacks pending over 20 workdays. The number represents all callbacks currently pending on the last workday of the month.

o. As needed, develop a corrective action plan to resolve deficient performance among staff in the call center, and maintain results on file for regional office (RO) review.

p. Develop a proficiency test to be used for new CSRs and as needed for existing personnel. Target no less than an 80% first time pass rate for the proficiency test. This test should include questions regarding basic aspects of the Medicare program such as benefits and claims processing; review procedures; questions to indicate familiarity with the system and ability to locate and interpret output; how to read information in the computer system and interpret beneficiary file material; new legislation or changes to policy and procedures; and include problems to solve which indicate ability to handle different situations that may arise such as seeking additional information, referring to specialized staff or involving Benefit Integrity Unit.

q. Maintain and operate a telephone device for the deaf such as TDD/TTY.

r. Maintain the ability to respond directly to telephone inquiries in both English and Spanish.

5. Customer Service Assessment and Management System (CSAMS).--CSAMS is a web-based vehicle for contractors to electronically report their call center's performance metrics. Each call center site must enter all required telephone customer service data elements between the 1st and the 10th of each month for the prior month. After the 10th of the month, users must call central office to change data.

6. Quality Call Monitoring Process.--Monitor, measure and report the quality of service continuously by utilizing the HCFA-developed quality call monitoring (QCM) process. Monitor 10 calls per CSR per quarter. Monitor the calls in any combination of the following ways: live remote, live side-by-side (shadow), or taped. Record all monitored calls on the standard scorecard, using the QCM chart as a guideline. 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.

Copies of the scorecard and chart may be obtained at the telephone customer service website at *https://www.hcfa.gov/medicare/callcenter*. Use only the official version of the scorecard posted at the website. The QCM reporting tools and format, also posted on the website, must be used to collect monitoring results which will be reported monthly in CSAMS. Train every CSR and auditor on the scorecard and chart and ensure that each person has a copy of the chart available for reference.

Where possible, rotate auditors regularly among the CSRs. Analyze individual CSR data regularly, identify areas needing improvement, implement and document corrective action plans. Analyze QCM data routinely to determine where training is indicated, whether at the individual, team, or call center level.

Monitor CSRs throughout the quarter, using a sampling routine. The sampling routine must ensure that 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.

Participate in national and regional QCM calibration sessions organized by HCFA. Conduct regular calibration sessions (monthly is a suggested minimum).

7. Beneficiary Satisfaction Surveys.--Survey a random sample of customers using the HCFA-approved, national beneficiary satisfaction survey. The official survey instrument is posted at the telephone customer service website at *https://www.hcfa.gov/Medicare/callcenter*.

This instrument measures the level of beneficiary satisfaction with the telephone customer service received. Use sampling methodology that reflects sound survey practice, such as ongoing sampling throughout the quarter. Conduct the survey by telephone. Complete 400 surveys or 10% of incoming beneficiary calls (whichever is smaller) per contract per quarter. If a contract covers multiple call centers, the sampling interval should reflect the combined call volume and each center should report their portion monthly via CSAMS.

Report the response rate in CSAMS monthly. Response rate is equal to the number of completed surveys divided by the number of eligible calls sampled. Contractors should target an approval rating of at least 95%. Approval corresponds to responses indicating that CSR's courtesy/politeness is rated "4" to "5" (where "5" is excellent).

8. Calls Regarding Claims.--When a telephone representative receives an inquiry from a beneficiary about a claim, first, verify that it is the beneficiary by gathering the following information: health insurance claim number, date of birth, and full name. Any information regarding the claim, including why the claim was reduced or denied, may then be discussed with the beneficiary.

If a relative of the beneficiary, an advocacy group, legal representative, or friend calls regarding claims information, and the beneficiary is also on the telephone, you may discuss any claims-related information with the beneficiary and the third party.

When there is written authorization from the beneficiary authorizing an individual to act on their behalf regarding their Medicare claims, any claims-related information may be discussed with that individual. The written authorization must specify: a period of time, the authorized individual, what information may be disclosed/discussed with that individual.

When a relative of the beneficiary, an advocacy group, legal representative, or friend acting on behalf of the beneficiary, calls without written authorization, but has identifying information on the beneficiary (i.e., health insurance claims number, date of birth, and full name) and the claim itself (i.e., dates of service and, if applicable, an Explanation of Medicare Benefits (EOMB) claim control number), only the following information can be released:

- o Claim has or has not been received;
- o Claim has or has not been processed; and
- o Beneficiary can expect an EOMB or MSN by a certain date.

If, as a result of a beneficiary inquiry, you discover an obvious error in a previous claims determination, take the necessary action to correct the record. Promptly process any payments due. If the beneficiary gives you information not shown on the record, and that information changes the payment amount, notify the beneficiary that he/she should request a review and indicate what information the beneficiary should provide with the request. Be as specific as possible. Inform the beneficiary he/she should submit the following, if it is available: letters explaining the necessity of the treatment, whether the service provided was more complicated than usual, or other evidence pertinent to the reason for denial or reduction. Remind beneficiaries that they can find information regarding their appeal rights in HCFA publications, e.g., The Medicare Handbook, and on the back of their EOMB or MSN notices.

Do not tell the beneficiary that the reviewer will change the determination, but explain that he/she will examine the claim and any new information once a proper request is made. Advise the beneficiary that the review department will explain what constitutes a proper request and what information is needed.

Where appropriate, make a record of the telephone contact and of any action taken based upon such contact. Make the oral statements of the beneficiary a part of the file if it appears further action is necessary. This record may assist in establishing good cause in cases where the telephone contact occurs shortly before the deadline for requesting a review. This record will also document subsequent actions you take in the case.

9. Calls Regarding Fraud and Abuse.--If a caller indicates an item or service was not received, or that the 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 complaint would be handled by the medical review unit. 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.

10. Equipment Requirements.--To ensure that inquiries receive accurate and timely handling, provide the following equipment:

- o On-line 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;
- o An outgoing line for call-backs; and
- o A supervisor's console for monitoring telephone representatives' accuracy, responsiveness, clarity, and tone.

11. Telephone Directory Listings.--Effective with the publication of these instructions carriers will not be responsible for the publication of their beneficiary inbound 800 service. HCFA will publish beneficiary inbound 800 numbers in the appropriate directories. No other listings are to be published by the carrier.

12. Telephone Service Costs.--Effective with the transition to FTS-2001 service, HCFA will pay for the rental of inbound T-1/PRI lines and all connect time charges. These costs will be paid centrally by HCFA and only for these telephone service costs. All other costs involved in providing telephone service 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 RO or CO.

C. Walk-In Inquiries.--

1. General.--Give individuals making personal visits to you the same high level of service you would give through phone contact. The interviewer must have the same records available as a telephone service representative to answer any questions regarding general program policy or specific claims-related issues.

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

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

o After contact with a receptionist, the inquirer must not wait longer than 10 minutes to meet with a service representative;

o Waiting room accommodations must provide seating; and

o Inquiries must be completed during the initial interview to the extent possible.

5105. PROVIDER SERVICES

Every member of your customer service team should be committed to providing the highest level of service to our primary partner, the Medicare provider. This commitment should be reflected in the manner in which you handle each provider inquiry. The following guidelines are designed to help you ensure this high level of service is provided.

A. Written Inquiries.--

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

o Answer inquiries timely
o Responses on speed memo forms may be handwritten. In all other cases, do not send handwritten responses;

o Consider written appeal requests as valid if all requirements for filing are met. Providers need not submit these requests on the prescribed forms in order to be considered valid. If appeal requests are valid, they are not to be considered written inquiries for workload reporting; and
o Keep responses in a format from which reproduction is possible.

2. Guidelines for High Quality Written Responses to Inquiries.-- Perform a continuous quality appraisal of outgoing letters, computer notices, and responses to requests for appeal of an

initial determination. This appraisal consists of the following elements:

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

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

c. Clarity.--Letters have good grammatical construction, sentences are of varying length, and paragraphs generally contain no more than five sentences. Use HCFA-provided model language and guidelines, where appropriate.

d. Timeliness.--Substantive action is taken and an interim or a final response is sent within 30 calendar days from receipt of the inquiry. In instances where a final response cannot be sent within 30 calendar days (e.g., inquiry must be referred to a specialized unit for response), send the interim response acknowledging receipt of the inquiry and the reason for the delay.

If you are responsible for handling both Part A and Part B claims, inquiries requiring response from both of these areas share the same timeframe for response (i.e., the 30-day period starts on the same day for both responses). You should ensure that the inquiry is provided to both responding units as quickly as possible. The response to these inquiries may be combined or separate, depending on which procedure is most efficient for your conditions. If you respond separately, each response must refer to the fact that the other area of inquiry will be responded to separately.

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

f. Legibility.--Handwritten information on speed memo forms must be easy to read.

You may use speed memo forms for correspondence with providers. However, this type of correspondence must meet the standards set forth in this section.

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

Install ARU equipment on provider telephone inquiry lines in accordance with HCFA guidelines.

Provide the availability of telephone contact as a service to providers. The service must be continuous during normal business hours. Telephone service representatives must be available to respond to calls during break and lunch periods. The only alternative to continuous service is the use of an ARU with the capability to record provider messages. You must then return the calls as soon as possible; i.e., the same working day or no later than the morning of the next work day. This service is intended to assist providers in obtaining answers to various Medicare questions including those related to:

- o General program information;

- o Specific information regarding claims in process and claims completed, e.g., explanations of methods and specific facts employed in making reasonable charge and medical necessity determinations, and/or information regarding type of service submitted;

- o Additional evidence needed to process a claim; and

- o Information about appeal rights, and actions required of a provider to exercise these rights.

1. Inquiry Staff Qualifications.--To ensure that inquiries receive timely and accurate handling, personnel responsible for answering inquiries must be fully trained to respond to provider questions or refer such questions for timely reply. To ensure that these services are provided, telephone staff should have the following qualifications:

- o Telephone communications skills, including sensitivity for special concerns of the callers;

- o Ability to handle special situations that may arise; and

- o Experience in Medicare claims processing and appeal procedures.

Prior experience in positions where these skills are utilized, e.g., claims representative or telephone operator, may be used in the telephone representative selection process, especially for designated unit situations.

Provide a training program which includes technical instructions on Medicare eligibility, coverage, benefits, claims procedures, Medicare administration, use of the MCM, telephone techniques, appeals procedures, and the use of a computer terminal.

2. Guidelines for High Quality Telephone Service.--Our commitment to providing the highest level of service to our primary partner, the Medicare provider, should be reflected in the manner in which you handle each provider telephone inquiry. The following guidelines are designed to help you ensure this high level of service is provided:

- o Provide a level of service that ensures as low a busy signal level as possible, but in no case higher than 20 percent busy;

- o Acknowledge calls as quickly as possible, but within 20 seconds;

- o Provide service representative initiation of provider telephone inquiries as soon as possible, but in all cases within 120 seconds after acknowledgment. This also includes calls routed to a representative by an ARU;

- o Inform the caller of a temporary delay before a representative is available, if appropriate, and give advice about what information might be needed to answer questions, e.g., Medicare claim number, date of service, type of service;

- o Handle calls to completion during the initial call. A completed call is one in which the caller is given all the information he/she needs to know regarding the situation about which he/she is inquiring. Do not diminish the quality of service in order to initially complete the call.

Count calls requesting information regarding review or hearing rights as completed calls;

o If you do not complete the call, make a substantive call-back within 1 working day. Control the case to ensure the required call-back is made. If it is impossible to make a final reply, make an interim status call within 1 working day. Give a final call-back or written reply as soon as the necessary information is available;

o Measure the quality of service continuously, ensuring that all employees are monitored at least quarterly for accuracy, responsiveness, clarity, and tone. Weigh accuracy higher than any other factor. Consider a call response accurate if the content is correct with regard to Medicare policy and your data. Due to restrictions on monitoring, advise both the caller and the telephone representative that calls are being monitored for evaluation purposes;

o Make ATB and 120-second waiting time data available to CO and/or RO upon request;

o Maintain your procedural process on file for RO review;

o Develop a proficiency test to be used for new customer service representatives and as needed for existing personnel, e.g., after implementation of new legislation. Maintain results on file for RO review.

This test should include questions regarding basic aspects of the Medicare program such as:

- Benefits and claims processing;
- Review procedures;
- Questions to indicate familiarity with the system and ability to locate and interpret output;
- How to read information in the computer system and interpret beneficiary file material;
- Questions based on new legislation or changes to procedures; and
- Include problems to solve to indicate ability to handle different situations that may arise such as a need for more information, a need to refer to specialized staff, involvement of fraud or abuse.

o Monitoring representatives to ensure that good telephone techniques are used and sensitivity shown for special concerns of the callers; and

o Develop a corrective action plan to resolve deficient performance, and maintain results on file for RO review.

3. Call-Back Responses.--Whenever a caller requires information or advice about specific facts of a claim that you cannot answer during initial telephone contact, assure the caller that you will examine the claim and return the call. The telephone representative handling the call must have access to specialized staff, if necessary, to obtain additional information or a decision to resolve the issues in question. Be sure to include a report of contact in the file.

Specialized staff includes medical or policy advisors and senior technical personnel. This staff may review the file, provide additional information, respond to further questions, explain program requirements and the evidence used in making the decision, and indicate types of evidence to submit to assist during any review determination. A telephone representative or member of the

specialized staff responds to the claimant after all questions are researched.

If the caller indicates that an item or service was not received, or that a provider is involved in some fraudulent or abusive activity, refer the matter to the Medicare fraud unit. Tell the caller the fraud unit will contact him/ her about the complaint. Ask the caller to provide the fraud unit with any documentation he/she may have that substantiates the allegation. Give assurance that the matter will be investigated.

Establish procedures to ensure timely call-backs. Consider the call-back, or and interim status call, timely if it is made within 1 working day from the incoming call. If it is known at the time of the call that more than 1 working day will be needed to obtain necessary documents or records, that information can be relayed to the provider in lieu of an interim status call. Document the file to show that this was done.

Document the content of telephone calls of a substantive nature; i.e., those providing information on a specific claim. Make the documentation part of the file.

4. Calls on Fully or Partially Denied or Reduced Claims.--When a telephone representative receives an inquiry from a provider about a denied or reduced claim, determine whether or not the provider was a party to the initial determination and has the right to receive further information about the denial. Physicians and other suppliers have the right to further information when they have appeal rights. Appeal rights exist when they have taken assignment or when there is a denial involving §1842(1)(1)(A) of the Social Security Act (the denial is based upon §1862(a)(1), medical necessity, and involves a non-participating physician who has not taken assignment of the claim at issue). Also, if the physician indicates he/she has been advised via a limiting charge exception report that he/she has exceeded the charge limit on an unassigned claim, you may give pertinent details about the processing of the claim. This is done because the physician is required to make a refund, if necessary.

When the provider has the right to further information, explain the basis for the denial or reduction. When the provider does not have the right to further information, do not discuss the basis for the denial or reduction. Only provide status information that the claim has been denied.

If, as a result of the provider inquiry, regardless of their rights, you discover an obvious error in a previous claim determination, take the necessary action to correct the record. Promptly process any payments due. However, if the provider gives you information not shown on the record, and that information changes the payment amount, give the provider the number for the telephone review department staff.

If a provider, who has appeal rights, does not appear satisfied after you have corrected all obvious errors on the record, give the provider the number of the telephone review department. The review department will review the claim by telephone or advise the provider how to file a written request, e.g., send the caller a request form. The review department will advise the caller of the additional supportive information which may be submitted when a review is sought, i.e., letters explaining the necessity of the treatment, whether the service provided was more complicated than usual, or other evidence pertinent to the reason for denial or reduction.

Do not tell the provider that the reviewer will change the determination, but explain that he/she will do a complete review of the claim. The review department must explain what information is needed and how to file.

Where appropriate, make a record of the telephone contact and of any action taken based upon such contact. Make oral statements of the provider a part of the file if it appears further action is necessary. This record may assist in establishing good cause in cases where the telephone contact occurs shortly before the deadline for requesting a review. This record will also document subsequent actions you take in the case.

5. Equipment Requirements.--To ensure inquiries receive accurate and timely handling, provide the following equipment:

- o On-line 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;
- o An outgoing line for call-backs; and
- o A supervisor's console for monitoring representatives' accuracy, responsiveness, clarity, and tone.

6. Telephone Directory Listings.--Include Medicare listings in telephone directories based upon the following requirements. You must include the listings in the Government sections of the directories for **each area** of claims jurisdiction. List provider inquiry numbers as "provider use only."

a. Listing Under Medicare.--Listings under "Medicare" are required. The approved entry is MEDICARE PART B INFORMATION - NAME OF CONTRACTOR - PROVIDER USE ONLY - local number or other dialing instructions. If you use a Medicare sub-listing under a contractor name, the listing under "Medicare" may say, "See contractor's company name."

b. Listing Under Company Title.--You can include a telephone number for Medicare inquiries in a sub-entry under the regular telephone directory listings. Show the sub-entry as "Medicare Part B (or Medical Insurance) Claims Information."

c. Dual Listing.--If you process both hospital and medical insurance claims, show 2 entries if 2 telephone number are provided. For example:

Medicare Claims Information
Part A (or Hospital Insurance)
Part B (or Medical Insurance)

7. Telephone Service Costs.--The costs involved in providing telephone service to Medicare providers vary consistently from location to location. These costs are not specifically identified in cost reports. Therefore, please maintain records of all costs associated with providing telephone service to providers (e.g., costs per line, costs per call). When requested by HCFA RO or CO, provide this information.

5106. SIGNATURE REQUIREMENTS FOR CORRESPONDENCE WITH PHYSICIANS AND BENEFICIARIES

To avoid confusion and misunderstanding on the part of physicians, suppliers or beneficiaries, your general correspondence must carry the signature of a person who is responsible for handling inquiries about correspondence.

Letters sent to beneficiaries to request additional information in the development of claims must contain a toll-free telephone number and a department section or module reference.