Program Memorandum Intermediaries/Carriers

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

Transmittal AB-01-116 **Date: AUGUST 27, 2001**

CHANGE REQUEST 1740

SUBJECT: Provider/Supplier Plan (PSP) Quarterly Report Format

Medicare carriers and intermediaries are required to develop a PSP Quarterly Report. The purpose of this Program Memorandum (PM) is to provide Medicare contractors with a standard format for reporting Provider Education and Training (PET) activities (Program Management activity code 14001) on a quarterly basis. The activities listed in the attachment, sections A-1 through A-8, establish standards and a uniform format for reporting information to CMS Central Office (CO) and Regional Office (RO) contacts.

Medicare Contractors should follow the instructions below:

Upon review of the Budget Performance Requirements (BPRs), and the Annual Provider/Supplier Plan, each contractor is expected to submit quarterly reports detailing their Provider Education and Training activities for the previous quarter.

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

First quarter – January 31
Second quarter – April 30
Third quarter – July 31
Fourth quarter – October 31

When mailing the quarterly reports to CO, address them to the following analysts depending on the Regional Consortium under which you fall.

Northeastern Consortium – Gloria Knight, (410) 786-7636 Gknight@cms.hhs.gov
Southern Consortium – Debra Shannon, (410) 786-9418 Dshannon1@cms.hhs.gov
Midwestern Consortium – Harvey Tzuker, (410) 786-3670 Htzuker@cms.hhs.gov
Western Consortium – Suzanne Lewis, (410) 786-7636 Slewis2@cms.hhs.gov

The Provider Education and Training team address is:

Centers for Medicare & Medicaid Services
Center for Medicare Management (CMM), PBEG, DPET
Mailstop C4-10-07
7500 Security Blvd.
Baltimore, MD. 21244-1850

In addition to sending the Quarterly Reports to CO, send a hardcopy or electronic version of the report to the RO PSP contact listed below.

Name/Address/E-mail of Regional Office PSP Contacts

REGION	PSP CONTACT	PHONE NUMBER	E-MAIL ADDRESS
1- Boston	Peter Toland Donald Uliano	(617)565-1272 (617)565-1274	Ptoland@cms.hhs.gov Duliano@cms.hhs.gov CMS (formerly HCFA) JFK Federal Building, Room 2375 Boston, MA 02203-0003
2- New York 2- New Jersey Puerto Rico	Diane Tully Kelli Robinson	(212)264-7458 (212)264-7457	Dtully@cms.hhs.gov Krobinson@cms.hhs.gov CMS (formerly HCFA) 26 Federal Plaza Room 3800 New York, NY 10278-0063
3- Philadelphia	Barbara Cerbone	(215)861-4320	Bcerbone@cms.hhs.gov CMS (formerly HCFA) The Public Ledger Bldg. 150 S. Independence Mall W Suite #216 Philadelphia, PA 19106
4- Atlanta	Sandra Brown	(404)562-7238	Sbrown5@cms.hhs.gov CMS (formerly HCFA) Atlanta Federal Bldg., 4th fl. 61 Forsyth Street, SW Suite 4T20 Atlanta, GA 30303-8909
5- Chicago	Gregory Chesmore	(312)353-1487	Gchesmore@cms.hhs.gov CMS (formerly HCFA) 233 N. Michigan Ave. Suite 600 Chicago, IL 60601
6- Dallas	Pam Kanawyer	(214)767-6419	Pkanawyer@cms.hhs.gov CMS (formerly HCFA) 1301 Young Street, Rm. 833 Dallas, Texas 75202
7- Kansas City	Uvonda Meinholdt	(816)426-5783	Umeinholdt@cms.hhs.gov CMS (formerly HCFA) Richard Bolling Federal Bldg. 601 E. 12th St., Rm. 664 Kansas City, MO 64106-2808
8- Denver	Dennis Delpizzo Frank Szeflinski	(303)844-1569 (303)844-5783	Ddelpizzo@cms.hhs.gov Fszeflinski@cms.hhs.gov CMS (formerly HCFA) Colorado State Bank Bldg. 1600 Broadway, Suite 700 Denver, Co. 80202-4367
9- San Francisco	Julia Cohen	(415)744-3781	Jcohen2@cms.hhs.gov CMS (formerly HCFA) 75 Hawthorne Street Room 408 San Francisco, CA 94105-3901
10- Seattle	Mindy Shoemaker	(206)615-2312	Mshoemaker2@cms.hhs.gov CMS (formerly HCFA) 2201 Sixth Ave., Room 810 Mailstop RX 45 Seattle, Washington 98121

FORMAT AND CONTENT

A standard format is required for the Quarterly Reports. To facilitate the review process, carriers and intermediaries must follow a standard format for each of the numbered items below.

A-1 INQUIRY AND DATA ANALYSIS PROGRAM

A-2 PET ADVISORY GROUP/PARTICIPATION IN EDUCATIONAL FORUMS

A-3 ISSUE REGULAR BULLETINS/NEWSLETTERS

A-4 SEMINARS/WORKSHOPS/TELECONFERENCES

A-5 NEW TECHNOLOGIES/ELECTRONIC MEDIA

A-6 INTERNAL STAFF DEVELOPMENT/PLAN TO STRENGTHEN THE QUALITY OF WRITTEN COMMUNICATION

A-7 HOME HEALTH BENEFIT (RESPONSIVENESS TO OIG/GAO FINDINGS)

A-8 OTHER ACTIVITIES

Attachment

The *effective date* for this PM is October 11, 2001.

The *implementation date* for this PM is October 11, 2001.

These instructions should be implemented within your current operating budget.

These instructions should be discarded August 31, 2002.

If you have any questions, contact your Regional Office PSP contacts listed in the PM, or the Central Office PET Consortium Liaison also listed in the PM.

Attachment

PSP QUARTERLY REPORT FORMAT

COVER PAGE

The Cover page should contain the following information:

- Contractor Name/Type
- Contractor 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

REQUIRED PET ACTIVITIES A-1 - A-8

ACTIVITY	A-1
INQUIRY AND DATA ANALYSIS PROGRAM	

REQUIRED ACTIVITY

All carriers will maintain a provider inquiry analysis program. The program will provide and update, on a monthly basis, a list of most frequently asked questions and areas of concern/confusion for providers. Outreach and educational efforts must be developed to address the needs of providers as identified by this program.

Problem areas as determined by claim submission errors must also be tallied and analyzed monthly. Outreach and educational efforts must be developed to address the needs of providers as identified by this program.

SPECIFIC FORMAT REQUIREMENT

Word Table or Spreadsheet

TOP TEN INQUIRIES AND CLAIMS SUBMISSION ERRORS (CSE)

TOP ten Inquiries and CSE's	I /CSE	Provider Specialty	Number of FAQ's received	Action taken/Resolution (if applicable)

SPREADSHEET HEADINGS (Top ten inquiries and claim submission errors)

- *Top ten Inquiries and Claim Submission Errors*
- *I(Inquiry)/CSE (Claim Submission Error)*
- *Provider Specialty* **(optional field)**
- *Number of inquiries/ claim submission errors received*
- *Action/Resolution*

INSTRUCTIONS FOR COMPLETING EACH FIELD

1. **Top ten inquiries and claim submission errors (FAQ's)**
   List the top 10 frequently asked questions. This should include the top ten **inquiries** and the top 10 ten **claim submission errors,** for a total of twenty entries.

2. **Inquiry/Claim Submission Error**
   Indicate whether the FAQ was an inquiry, or a claim submission error.

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

4. **Number of inquiries or claim submission errors**
   Document the number of each inquiries or claim submission errors received regarding the frequently asked question.

5. **Action taken /Resolution**
   Indicate the action taken/resolution to the problem, **if applicable**.

ACTIVITY A-2
PET ADVISORY GROUP/PARTICIPATION IN EDUCATIONAL FORUMS

REQUIRED ACTIVITY
Carriers/fiscal intermediaries must maintain a PET Advisory Group whose purpose is to provide advice and recommendations for selection of provider education and training topics as well as, dissemination avenues and types and /or locations for educational forums. Carriers should actively participate in those educational forums and professional gatherings that resulted from the discussions with, or recommendations of, the PET Advisory Group.

SPECIFIC FORMAT REQUIREMENT
Word Table or Spreadsheet

PET ADVISORY GROUP

Activity	Frequency	Date	Attachments (Yes/No)	COMMENTS

SPREADSHEET HEADINGS:

- *Activity*
- *Frequency*
- *Date*
- *Attachments*
- *Comments*

INSTRUCTIONS FOR COMPLETING EACH FIELD

1. **Identification of Activity**
   Indicate the type of activity (i.e. PET Advisory Group, Workshop, Carrier Advisory Committee, other)

2. **Frequency**
   Frequency means how often the event was held, (i.e. continuously, weekly, monthly, quarterly, annually, etc.), or as specified in the BPRs.

3. **Date**
   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 **A-3**

ISSUE REGULAR BULLETINS/NEWSLETTERS

REQUIRED ACTIVITY

Carriers/intermediaries are to issue bulletins/newsletters at least quarterly that contain program and billing information. Providers/suppliers must be encouraged to obtain electronic copies of bulletins and other notices through the contractor web site.

SPECIFIC FORMAT REQUIREMENT

Word Table or Spreadsheet

BULLETINS/NEWSLETTERS

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

SPREADSHEET HEADINGS

- *Bulletin/Newsletter*
- *Date Mailed*
- *Number of Hard Copies Mailed*
- *Major Topics Covered*

INSTRUCTIONS FOR COMPLETING EACH FIELD (Bulletins/Newsletters)

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 hard copies mailed.

4. **Major Topic Areas Covered**
   List 2-3 major topic areas covered.

ACTIVITY **A-4**
SEMINARS/WORKSHOPS/TELECONFERENCES

REQUIRED ACTIVITY

Hold seminars, workshops, classes, and other face-to-face meetings to educate and train providers regarding Medicare program and billing issues. When feasible, carriers/intermediaries must coordinate these activities with other Medicare contractors in their service area (this may include Peer Review Organizations, other intermediaries or carriers, Senior Health Insurance Programs and End Stage Renal Disease Networks). Also, carriers/intermediaries should collaborate in holding these events with interested groups and organizations as well as CMS partners in their service area. Effectiveness measures should be developed and implemented for each education and training activity. This includes, but is not limited to, customer satisfaction survey instruments and pre and post-testing at meetings and seminars. Any fees charged in conjunction with these activities must be in accordance with the policies stated in **Transmittal AB-01-12.** Additionally, teleconferences

must be held to address, and resolve inquires from providers as a method to maximize the number of providers reached.

SPECIFIC FORMAT REQUIREMENT

Word Document or Spreadsheet

SEMINARS/WORKSHOPS/TELECONFERENCES

Date	Location	Event Type	Topic	Target Audience	Number of Participants	Materials Distributed

SPREADSHEET HEADINGS

- *Date*
- *Location*
- *Event Type*
- *Topic*
- *Target Audience*
- *Number of Participants*
- *Materials Distributed*

INSTRUCTIONS FOR COMPLETING EACH FIELD

(Seminars/Workshops/Teleconferences)

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
   W=Workshop
   P=Presentation
   MPB=Medicare Program & Billing Issues
   E=Educational Forum
   S=SNF (Skilled Nursing Facility)
   ES=End Stage Renal Disease
   O=Other

4. **Topic**
   Indicate the topic of the training.

5. **Target Audience**
   Indicate the audience based on the codes below:
   P=Physician
   PR=Provider
   H=Hospital
   A=Ancillary
   D=DME
   S=Supplier
   PM=Practice/Office Manager
   BM=Billing Manager
   O=Other

6. **Number of Participants**
   Indicate the number of participants in the event.

7. **Materials Issued**
   Indicate the material issued (i.e., Manual, Cheat Sheet, CD-ROM).

ACTIVITY A-5
NEW TECHNOLOGIES/ELECTRONIC MEDIA

REQUIRED ACTIVITY

Maintain an Internet website that is dedicated to furnishing providers and suppliers timely, accessible and understandable Medicare program information. Websites and Internet applications should follow CMS Standards and Guidelines.

SPECIFIC FORMAT REQUIREMENT

Word document or Spreadsheet/Narrative

INTERNET WEBSITE (List Provider Website Address:_____)

CRITERIA	YES	NO
Website		
Newly created bulletins/newsletters		
Schedule of upcoming events		
Automated registration		
Area designated for Medicare Learning Network		
Quarterly listing of Frequently Asked Questions		
Search engine functionality		
E-mail based support		
CPT Code information		
Ability to link to other sites		
Training of providers for electronic claim submission		
Medicare Billing Average Wholesale Price and Personal Computer–Print Software		

INSTRUCTIONS FOR COMPLETING EACH FIELD

1. **Yes**
   Check Yes if the criteria has been met.

2. **No**
   Check No, if the criteria has not been met.

NARRATIVE (Website)

Provide a narrative discussion of any updates or enhancements to your website.

REQUIRED ACTIVITY

Carriers/intermediaries must hold periodic meetings with staff in appropriate areas of your organization (including medical review, EDI (Electronic Data Interchange) Systems and program integrity staff) to ensure that inquiries and shared issues raised by providers are communicated and resolved. Minutes of these meetings must be kept and filed.

Develop open communications with staff at all levels in your organization to encourage creative ideas for improving service to providers and improvements to the Medicare program in general. All staff must be encouraged to provide senior management with ideas and suggestions for cost-effective improvements to service. A documented internal process must be in place whereby improvement ideas are acknowledged and considered.

SPECIFIC FORMAT REQUIREMENT

Word Document or Spreadsheet/Narrative

INTERNAL STAFF DEVELOPMENT

Communication with Internal staff	Frequency of meetings	Date	Comments
Medical Review			
Fraud			
Customer Service			
DME			
Reimbursement			
Provider Records/Enrollment			
Provider Relations			
Communications			
Other			

SPREADSHEET HEADINGS

- *Frequency*
- *Date*
- *Comments*

INSTRUCTIONS FOR COMPLETING EACH FIELD(Internal Staff Development)

1. **Frequency**
   Indicate the frequency with which you meet in each of the individual areas.

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

3. **Comments**
   Indicate any information discussed you feel is relevant.

REQUIRED ACTIVITY

Establish and implement a plan to strengthen the quality of written correspondence with providers/suppliers. Your plan must include an internal review process and activities to ensure that the quality of your communications is continuously improving.

SPECIFIC FORMAT REQUIREMENT

Narrative

INSTRUCTIONS

Provide a summary of your progress in strengthening the quality of written correspondence.

ACTIVITY A-7
HOME HEALTH BENEFIT (RESPONSIVENESS TO OIG/GAO FINDINGS)

REQUIRED ACTIVITY (Carrier's only)

Whenever possible, incorporate into existing educational activities, materials that clearly delineate the physician's role in the creation, certification and recertification of the plan of care for home health, and the beneficiary need for partial hospitalization. Refer to transmittal B-00-16, CR #1088 for more information.

SPECIFIC FORMAT REQUIREMENT

Narrative

INSTRUCTIONS

Provide a summary of your educational efforts in this area.

OTHER ACTIVITIES A-8

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. The summary may also include the following information:

1. Any issues that you have coordinated with the DMERC this quarter;
2. The mechanism used to actively solicit feedback related to the Medicare program;
3. Efforts to promote utilization of preventive benefits; and
4. Any mechanism developed and/or implemented to measure the effectiveness of educational and training activities. This may include a customer satisfaction survey instrument, and pre and post-testing at meetings and seminar.