

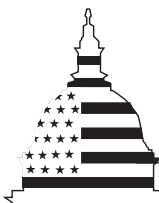
GAO

Report to the Ranking Minority
Member, Subcommittee on Health,
Committee on Ways and Means, House
of Representatives

July 2004

MEDICARE

Call Centers Need to Improve Responses to Policy-Oriented Questions from Providers



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Highlights of [GAO-04-669](#), a report to the Ranking Minority Member, Subcommittee on Health, Committee on Ways and Means, House of Representatives

MEDICARE

Call Centers Need to Improve Responses to Policy-Oriented Questions from Providers

Why GAO Did This Study

In 2002, GAO reported that the Centers for Medicare & Medicaid Services (CMS) needed to improve its communications with providers who deliver medical care to beneficiaries. GAO reported that 85 percent of the responses it received to 61 calls made to call centers operated by Medicare carriers—contractors that help manage the Medicare program—were incorrect or incomplete. GAO also found that CMS’s primary oversight tools were insufficient to ensure accuracy in communication.

GAO was asked whether call centers now provide correct and complete information to providers. GAO (1) reviewed carriers’ effectiveness in providing correct and complete responses to policy-oriented telephone inquiries and CMS’s efforts to improve communications with providers and (2) evaluated CMS’s efforts to provide oversight of carrier call centers.

What GAO Recommends

To improve the responses to policy-oriented inquiries from providers, GAO recommends that CMS develop (1) a process to route policy inquiries to staff with the appropriate expertise, (2) clear and easily accessible policy-oriented material to assist customer service representatives (CSR), and (3) an effective monitoring program for call centers. CMS generally agreed with the recommendations.

www.gao.gov/cgi-bin/getrpt?GAO-04-669.

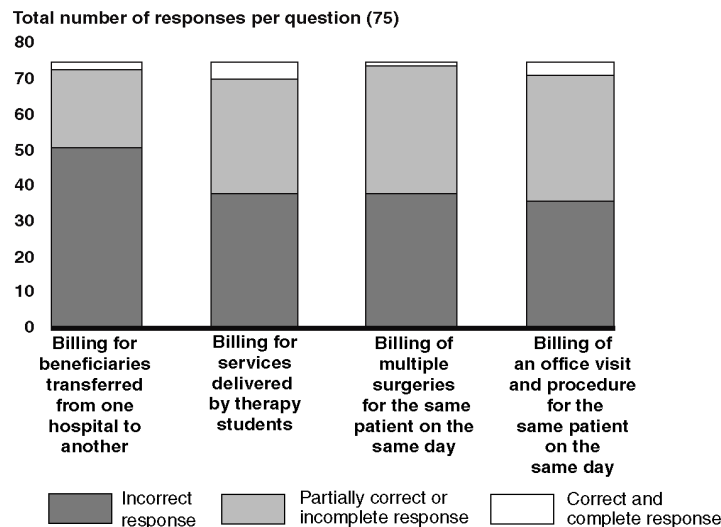
To view the full product, including the scope and methodology, click on the link above. For more information, contact Leslie G. Aronovitz at (312) 220-7600.

What GAO Found

Only 4 percent of the responses GAO received in 300 test calls to 34 call centers were correct and complete. GAO posed four policy-oriented questions 75 times each to carrier call centers. The level of correct and complete responses for each individual billing question ranged from 1 to 5 percent. The majority of remaining responses were incorrect, or partially correct or incomplete. Several factors, including fragmented sources of information, confusing policy information, and difficulties in retaining the CSRs responding to calls appear to account for the lack of correct and complete answers. There are many call centers serving other industries that triage incoming calls by first identifying the nature of the call and then distributing it to the CSR who is best qualified to respond. Although CMS has not adopted this approach, it is currently implementing two other initiatives that may improve CSRs’ access to information. However, neither initiative is specifically designed to support CSRs responding to policy-oriented questions.

In addition, CMS’s efforts to provide oversight of carrier call centers are inadequate. Although CMS requires carriers to monitor the performance of their call centers, the standards used and the technological resources available to evaluate performance do not allow carriers to thoroughly assess whether CSRs’ responses are correct and complete. In addition, CMS’s own monitoring efforts are too infrequent. CMS only performed one contractor performance evaluation related to carrier telephone services in fiscal year 2002 and none were performed in fiscal year 2003. Moreover, when performed, these evaluations did not provide sufficiently detailed information to assess CSRs’ performance.

Provider Call Centers’ Responses to Four Policy-Oriented Questions for Billing Medicare



Source: GAO.

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Abbreviations

CMS	Centers for Medicare & Medicaid Services
CPE	contractor performance evaluation
CPT	current procedural terminology
CSR	customer service representative
FAQ	frequently asked question
IVR	interactive voice response
MMA	Medicare Prescription Drug, Improvement, and Modernization Act of 2003
NGD	Next Generation Desktop
OT	occupational therapist
PT	physical therapist
PPS	prospective payment system
SLP	speech language pathologist

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United States Government Accountability Office
Washington, DC 20548

July 16, 2004

The Honorable Pete Stark
Ranking Minority Member
Subcommittee on Health
Committee on Ways and Means
House of Representatives

Dear Mr. Stark:

In fiscal year 2003, Medicare paid more than \$271 billion to health care providers for medical services to about 41 million elderly and disabled beneficiaries. Since the creation of Medicare in 1965, an extensive body of statutes, regulations, policies, and procedures has been promulgated that specifies what the program will pay for, and under what circumstances. Because of the complexity of the program and the high volume of claims submitted annually—about 930 million in fiscal year 2003—it is critical that physicians and other providers who bill Medicare have access to clear and comprehensive information about the program.

One of the responsibilities of the Centers for Medicare & Medicaid Services (CMS)—the federal agency that manages the Medicare program—is to communicate program information to medical providers so that they can bill the program properly. To facilitate communication, in fiscal year 2001, CMS expanded the responsibilities of the contractors¹ that assist it in managing the Medicare program to include the operation of toll-free assistance call centers for providers. These call centers were established to respond to the information needs of providers serving Medicare beneficiaries.

Carriers' call centers responded to over 21 million provider inquiries in fiscal year 2003. The majority of these calls were status-oriented calls, in

¹The contractors that process Part A claims, which cover inpatient hospital, skilled nursing facility, hospice, and certain home health services, are referred to as fiscal intermediaries. The contractors that process Part B claims, which include physician services, diagnostic tests, durable medical equipment, and related services and supplies, are referred to as carriers.

which providers² checked the status of a claim in the payment process or sought confirmation of an individual's eligibility for Medicare. However, providers also called with more complex, policy-oriented questions regarding a variety of topics such as Medicare coverage, medical policies, program changes, and billing requirements that affect their ability to receive Medicare payment.

In 2002, we reported³ that the responses we received to 85 percent of 61 calls we made across five carrier call centers posing policy-oriented questions were incorrect or incomplete. We found that some customer service representatives (CSR) who respond to provider inquiries lacked ready access to easily searchable databases, limiting their ability to respond to providers' inquiries. We also found that CMS's primary tools to oversee these call centers—carrier self-monitoring and contractor performance evaluations (CPE)—were insufficient to ensure accuracy in communication. In addition, we noted that there was a lack of standardization in the type of technological resources available among call centers, which affected both CSRs' access to information and carriers' ability to conduct self-monitoring. CMS agreed improvements were needed and said it had a variety of initiatives under way to help enhance carrier call center communications. At the time we performed our work, these initiatives were too new for us to evaluate. You expressed concern about whether the call centers now provide correct and complete information to providers.

You asked us to reexamine how well call centers communicate with providers. Specifically, we evaluated (1) carriers' effectiveness in providing correct and complete responses to policy-oriented telephone inquiries and CMS's efforts to improve communications with providers and (2) CMS's efforts to provide oversight of carrier call centers.

To determine carriers' effectiveness in providing correct and complete responses, we placed a total of 300 calls to 34 carrier call centers and posed questions, similar to those from Medicare providers, concerning the proper way to bill Medicare in order to obtain payment from the program. Our questions included a variety of circumstances commonly encountered

²In this report, we use the term provider to include a doctor, hospital, health care professional, and health care facility, and their billing staffs.

³U.S. General Accounting Office, *Medicare: Communications with Physicians Can Be Improved*, [GAO-02-249](#). Washington, D.C.: Feb. 27, 2002.

by physicians and other Part B providers. We compiled a group of 18 frequently asked questions (FAQ) from providers from a variety of carriers' Web sites and asked CMS to review our questions. We solicited this input to give CMS officials an opportunity to identify questions that they considered to be an inappropriate question for our test. Based on their comments, we decided to eliminate 3 questions that they considered problematic. For example, we eliminated 1 question that involved a matter that they said was the subject of an ongoing lawsuit. We then chose 4 of the 15 remaining questions to use during our 300 test calls. These questions addressed (1) billing for beneficiaries transferred from one hospital to another, (2) billing for services delivered by therapy students, (3) billing for multiple surgeries for the same patient on the same day, and (4) billing for an office visit and procedure for the same patient on the same day. We classified responses in three categories: correct and complete, partially correct or incomplete, and incorrect.⁴ CMS officials validated our assessments of whether responses were correct and complete. To evaluate CMS's efforts to enhance communications with providers, we conducted site visits to two carrier call centers where we observed CSRs responding to callers' questions. We also reviewed materials related to CMS's two ongoing initiatives to improve the accessibility of information, including the development of a computer application to increase accessibility of claims related information at carrier call centers. One of the call centers we visited was responsible for pilot testing this new application, and we observed a CSR demonstrating how it would be used. We also reviewed the agency's other key effort to improve access to policy-oriented information—the publication of clarifications regarding new policies that affect providers. Finally, we interviewed CMS and carrier officials familiar with these initiatives.

To evaluate CMS's efforts to provide oversight of carrier call centers, we reviewed CMS's protocols for CPEs of carrier call centers as well as

⁴We defined a correct and complete response as an answer that provided enough information to correctly bill Medicare, including (1) a correct explanation of how to apply the billing policy and (2) correct billing codes or a referral to specific documentation that provided coding information. A partially correct or incomplete response contained an answer that provided some explanation, but (1) did not provide assistance in interpretation or warn about special circumstances that would affect billing; (2) provided interpretation but no directions to specific documentation; or (3) was correct, but not sufficiently complete to ensure that the claim would consistently pass claims processing edits. We defined an incorrect response as an answer containing fully or partially incorrect information, such that a physician might incorrectly bill or not file a claim for a billable service. For more detailed information on our scope and methodology, see app. I.

reports for CPEs performed in fiscal years 2001 and 2002. In addition, during our site visits to carrier call centers we observed supervisory monitoring of CSRs' conversations with providers for quality purposes. We also observed CMS regional staff demonstrate the use of the agency's new remote monitoring capabilities, which enable CMS staff in their own regional offices to listen to CSRs' conversations with callers. Appendix I contains more information about the scope and methodology of our work. The specific questions we posed to call centers and the correct answers are contained in appendix II. We performed our work from September 2003 through June 2004 in accordance with generally accepted government auditing standards.

Results in Brief

During our test calls, CSRs typically provided incorrect and incomplete answers to the 300 policy-oriented questions we posed. Only 4 percent—or 12—of their responses were correct and complete. Our test suggested several factors that may account for poor performance, including the fragmented array of information available to CSRs, confusing policy information, as well as difficulties in retaining CSRs. Although CMS is currently implementing two initiatives that may improve CSRs' access to information, neither of these new tools is designed to support the CSRs' responding to providers' policy-oriented questions.

CMS requires carriers to monitor the performance of their call centers, but these monitoring activities do not effectively evaluate the accuracy and completeness of CSRs' responses to policy-oriented questions. Neither the standards used by the carriers to evaluate the CSRs' performance nor the technological resources used in the evaluations are adequate to assess whether the responses are correct. Similarly, monitoring performed by CMS does not provide a method to evaluate CSRs' performance. CMS's periodic CPEs focus more on the procedural, rather than the substantive, components of a call—for example, how long callers are kept on hold rather than whether questions were answered correctly. Moreover, in the last 2 years only one carrier call center has been the subject of such an evaluation. And while CMS has developed a new capacity to remotely listen to calls placed to carrier call centers, agency staff are unable to fully assess whether CSRs are providing callers with correct and complete answers because they cannot view the material accessed by the CSRs during these calls.

We are making recommendations to the CMS administrator to (1) create a process to routinely screen calls and route complex policy inquiries to staff with expertise; (2) develop policy-oriented information that is easily

available to CSRs in a clear and understandable format; and (3) establish an effective monitoring program for carrier call centers to assess CSRs' performance. CMS generally agreed with our recommendations.

Background

CMS develops regulations and policies to implement the statutory provisions governing the Medicare program, and it communicates the information to providers primarily through its Medicare contractors. The contractors share information with providers through their Web sites, written bulletins, and carrier call centers. To respond to inquiries from providers, carriers operate 34 call centers.⁵ Most of the carrier call centers—31 of 34—are “blended,” that is they respond to inquiries from beneficiaries as well as from providers. In most cases, CSRs at “blended” call centers answer calls from both providers and beneficiaries.⁶

More than 21 million inquiries were made to carrier call centers in fiscal year 2003. The vast majority of these were “status-oriented” calls. Typically status-oriented calls are relatively simple to answer and involve inquiries concerning the status of a claim or confirmation of an individual's eligibility for Medicare. Such calls generally do not require CSRs to provide callers with complex information. On the other end of the spectrum are “policy-oriented” questions, which involve more complicated issues, such as billing rules, covered services, and medical policies. The remaining calls include elements of both status-oriented and policy-oriented inquiries. For example, a provider may call to learn why a claim was denied. In some instances, the explanation may be simple, such as the claim form omitted necessary information. In others, the reason for the denial may be more complex and involve an assessment of whether the particular circumstance required to obtain Medicare payment was met. Although CMS requires that carriers report data that categorize calls by type, these categories are not standardized, and carriers differ in the

⁵CMS has also established beneficiary toll-free telephone lines at six other call centers to handle beneficiaries' inquiries about the program. These centers are referred to as 1-800-MEDICARE call centers. These six centers are operated by a special contractor that is neither a carrier nor a fiscal intermediary. CMS reports that in 2003 CSRs in these centers responded to almost 6 million calls regarding topics such as Medicare enrollment and coverage; replacement of Medicare identification cards; and available health plan options, such as traditional fee for service, preferred provider organizations, and health maintenance organizations.

⁶Beginning October 1, 2005, CMS will require all “blended” call centers to have CSRs that are dedicated to responding to provider inquiries.

criteria they use to define call type. CMS officials estimate the volume of calls received by CSRs involving policy-oriented questions to have been approximately 500,000 in fiscal year 2003.

In fiscal year 2001, CMS required that all carrier call centers install automated voice response systems. The interactive voice response (IVR) unit allows providers to use their telephone keypads to respond to automated prompts and obtain status-oriented information without speaking to CSRs. Use of the IVR has been growing, and in fiscal year 2003, the automated system handled more than 52 percent of provider inquiries answered at carrier call centers. CSRs are available to respond to inquiries that providers believe are beyond the capability of the IVR, including policy-oriented calls. Generally, calls to CSRs are electronically routed by the carriers' automated systems based on CSR availability. The routing process does not consider the nature and complexity of the question or the expertise of the CSRs. Despite the diversion of many calls to the IVR, CSRs recently experienced an increase in the number of calls that they answer. According to CMS, the number of calls CSRs answered increased from 9 million in fiscal year 2002 to 10 million in fiscal year 2003.

CSRs responding to status-oriented calls can typically access the relevant claims or enrollment information to respond to the inquiry. In addition, to assist CSRs, carriers have developed scripted responses to answer standard questions from beneficiaries, such as how to enroll in Medicare. To respond to inquiries from providers, CSRs may use FAQs posted on their carriers' Web sites. In addition, they may search a variety of other sources, including CMS's Web sites. If CSRs cannot locate information to respond to a provider's question, they may arrange to contact the provider—after conferring with a specialist.

In addition, CMS requires each carrier to analyze provider inquiry data and develop a list of questions most frequently asked and areas of concern or confusion for providers. They must also tally problem areas identified when providers submit erroneous claims for payment. Each quarter, carriers report the 10 most frequent inquiries and claim submission errors to CMS and update the list of FAQs on their own Web sites. Because the nature of calls may vary by carrier, the types of questions posted on these Web sites may also vary. In addition, some carrier Web sites only list FAQs that are policy related, while others list routine questions about the mechanics of claims submissions and correcting billing errors.

Carriers are required to monitor their own call centers and report to CMS on their performance, such as the average time that calls wait before being

connected to a CSR and the percentage of provider calls that are abandoned before they reach a CSR. Carriers are also required to listen to, and rate, a selection of CSR calls on customer and knowledge skills, such as the manner in which they greet callers, conduct the call, offer additional assistance at the conclusion of the call, and whether their responses are correct and complete. Through CPEs, CMS also evaluates call center compliance with performance measures it establishes. Recently, CMS piloted remote call monitoring, which allows CMS staff to listen in on provider calls.

CMS's administration of the Medicare program will undergo significant changes over the next several years as the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) is implemented. MMA provides CMS with increased flexibility in contracting with new entities to assist it in operating the Medicare program.⁷ Instead of primarily relying on the claims administration contractors to perform most of the key business functions⁸ of the program, the law authorizes CMS to enlist a variety of contractors to perform these tasks. For example, the MMA will allow CMS to use new contractors to communicate program information to its providers and deliver provider education and training. CMS is just beginning to develop plans to implement MMA's contracting reform provisions. Phase-in of certain provisions may begin as early as October 2005, and all carrier and fiscal intermediary contracts are scheduled to end by October 1, 2011. After this date, new contracts must be based on CMS's new authority. The agency expects to issue its implementation plan for contracting by October 1, 2004.

CSRs' Responses to Policy-Oriented Questions Were Largely Incorrect

CSRs at the carrier call centers we tested rarely provided correct and complete answers to our policy-oriented questions. Only 4 percent of the responses we received from CSRs were correct and complete. Our test suggested several factors that may account for poor performance, including fragmented information scattered among a variety of sources, confusing information that may be difficult for CSRs to understand and interpret, and difficulties in retaining CSRs. CMS is developing two

⁷Pub. L. No. 108-173, § 911(a)(1), 117 Stat. 2066, 2378-2386 (to be codified at 42 U.S.C. §1395kk-1 note).

⁸There are nine key business functions: claims processing, beneficiary and provider customer service, appeals, provider education, financial management, provider enrollment, reimbursement, payment safeguards, and information systems security.

initiatives that may improve CSRs' access to information; however, neither of these new tools is designed to provide a comprehensive source of information to support the CSRs who respond to providers' policy-oriented questions.

CSRs Almost Never Provided Correct and Complete Responses to Our Policy Questions

We found that CSRs provided incorrect, partially correct, or incomplete responses to 96 percent of the 300 policy-oriented test calls we made to carrier call centers. The four questions we posed concerned a variety of circumstances on the proper way to bill Medicare in order to be paid for services rendered. Our questions specifically addressed the following topics: billing for beneficiaries transferred from one hospital to another, billing for services delivered by therapy students, billing for multiple surgeries on the same day, and billing for an office visit and services on the same day. The results of our test, which CMS Medicare coding and policy experts validated, are shown in table 1.

Table 1: Summary of Accuracy of CSR Responses by Question

Question	Correct and complete response	Partially correct or incomplete response	Incorrect response	Total responses
Question 1: Billing for beneficiaries transferred from one hospital to another	2	22	51	75
Question 2: Billing for services delivered by therapy students	5	32	38	75
Question 3: Billing of multiple surgeries for the same patient on the same day	1	36	38	75
Question 4: Billing of an office visit and procedure for the same patient on the same day	4	35	36	75
Number of carrier call center responses	12	125	163	300
Percentage of carrier call center responses	4	42	54	100

Source: GAO analysis of CSR call center responses.

Notes: CMS officials validated responses for correctness and completeness. Differences between GAO and CMS assessments were reconciled.

Variety of Factors Contributed to CSRs' Incorrect and Incomplete Responses

Our analysis of CSR responses to test questions and discussions with CMS officials identified several factors that contributed to CSRs' errors. They include the following:

Fragmentation of information: When responding to Medicare inquiries from providers, CSRs rely on fragments of information from multiple electronic sources. In addition, many CSRs use printed Medicare program information, including policy changes, which CMS estimates at about 200 per year. For example, at one carrier call center, we observed that CSRs relied on electronic information from CMS and carrier Web sites, along with paper documents, including the Medicare carrier manual, program memorandums, and carrier bulletins. Further, CMS officials told us that the agency does not prepare scripted responses to follow when answering questions from providers as it does for CSRs responding to beneficiaries' inquiries.

During the site visit, we also asked one CSR to demonstrate the process that would typically be followed to answer our four policy-oriented questions. In responding to one of our questions, we observed that this CSR did not have a source of comprehensive information that she could easily access to find the answer to our question. Instead, she accessed multiple information sources, including both electronic materials and paper documents, in an attempt to respond to our question. We further noted, as we toured the call center, that other CSRs also had access to, and appeared to be using, both paper and automated resources as they responded to calls. According to CMS and carrier officials, CSRs have to learn to operate multiple information systems, including CMS's claims information processing system and carrier developed information system. They also must access other sources, such as carrier or CMS Web sites, to respond to policy-oriented questions. Although CMS required that all CSRs have access to the Internet in fiscal year 2003, some CSRs continue to rely heavily on paper documents because of their familiarity with these materials.

During our 300 test calls, CSRs referred us to a total of 13 different information sources when answering our second question regarding billing for services delivered by therapy students. Twelve of the references were either incorrect or did not include all of the information needed to give a correct and complete answer. Our review of the 13th document, which was structured in a question and answer format, included our specific test question but without the complete answer. Fragments of the answer, however, were located earlier in the document. We also found other parts of this answer on a different page, attached to a different but related

question. It was evident to us that without reading the entire document, it would be plausible for the CSR to have read the test question and mistakenly given the caller the wrong answer, while assuming that the response given was correct and complete.

Confusing information: Some of the information that CSRs must access to respond to policy-oriented questions is difficult to interpret. CMS officials acknowledged that some policies contain complex language. In addition, they told us that the agency's goal of quickly publishing a policy that is technically correct may sometimes overshadow its effort to develop a clear and understandable document. For example, we identified confusion among CSRs who responded to our second question concerning billing for services delivered by therapy students. Based on their exact responses, we were able to determine that 12 percent of the incorrect responses to this question were caused by the CSRs' confusion over a different Medicare policy, regarding the billing for services delegated by one professional provider to another, and not a student.

CMS acknowledges that specialized training is required to understand the billing codes and modifiers⁹ that providers must include on their claims forms to receive payment from the program. Although CMS requires carriers to train CSRs, the agency has determined that answering providers' coding questions about specific claims is beyond the scope of CSRs' responsibilities. CMS also indicated that CSRs do not have the expertise to instruct a provider on the nuances of coding a service. CSRs, however, are permitted to respond to general questions about codes and modifiers, including coding definitions and explanations regarding the appropriate use of modifiers. We identified confusion among CSRs when they responded to such questions. In response to two of the four questions we posed, CSRs should have included specific modifiers with their answers because our questions were general and did not involve specific claims information. However, CSRs provided specific modifiers in only 16 of the 150 responses to these two questions. And, in most of these instances—9 of 16—the modifiers they cited were incorrect. For example, in one of our test questions, we asked for the extenuating circumstances for which carriers may pay the full amount for a second surgical procedure. In eight of the calls, CSRs responded that the provider should

⁹Modifiers provide a means by which a reporting physician can indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed in its definition or code.

use either modifier “51” for multiple surgeries on the same day, modifier “59” denoting a distinct surgical procedure, modifier “58” for a staged procedure, modifier “76” indicating that a procedure was repeated by the same physician, or modifier “78” for a return to the operating room for a related procedure. The correct answer is modifier “22,” indicating that the service performed was an unusual procedure. Without the correct modifier, the claim could be inappropriately denied or improperly paid.

In addition, according to one CMS Medicare official—and confirmed by CSRs’ responses to our test questions—CSRs may gravitate toward generic explanations and apply them to questions, even when they are not specific. For example, when answering our third question regarding billing for multiple surgeries to the same patient on the same day, 56 percent of the CSRs failed to address the extenuating circumstances in which a provider would be paid for multiple surgeries. Instead, their responses were based on their knowledge of general multiple surgery payment rules, which indicate that Medicare will pay 100 percent of costs for a beneficiary’s first surgery and a reduced percentage for the second surgery. In addition, we categorized about 15 percent of CSRs’ answers to our 300 test questions as vague and nonresponsive because, in these instances, CSRs simply responded that Medicare services must be medically necessary or that they cannot be preapproved. Although the vague answers may be correct, the responses did not address the specific elements contained in our questions.

Difficulties in retaining CSRs: Difficulties in retaining staff limits carriers’ ability to maintain a core of CSRs who are proficient on a range of complex, policy-oriented issues. CMS officials told us that retaining CSRs has been a major staffing problem. According to CMS officials, many of the most qualified CSRs are promoted to different positions within the call centers or resign to pursue better opportunities elsewhere. An internal CMS study found the turnover rate for carrier call center CSRs to be as high as 23 percent from calendar years 1999 through 2001 for all carrier call centers. This is significantly higher than the attrition rate for CMS’s call centers for beneficiaries, 1-800-MEDICARE help lines, which one CMS official estimates is close to industry standards—about 10 percent. Although there are no more recent data, CMS officials view this as troubling. They explained that the CSR position is particularly challenging because, in addition to learning how to access and utilize multiple information systems, these employees must stay abreast of Medicare policy changes to answer the broad range of inquiries received by the carrier call centers.

CMS's Efforts Not Targeted to Supplying Policy-Oriented Information to CSRs

Although CMS is currently implementing two initiatives that may improve CSRs' access to information, neither of these new tools is designed to support the CSRs who respond to providers' policy-oriented questions. One is intended to enhance CSRs' accessibility to claims information; the other is aimed at clarifying information on new Medicare policies.

First, CMS has begun deployment of a new computer application, Next Generation Desktop (NGD), to provide a single source of consolidated claims and related information to assist CSRs when they respond to status-oriented questions. Although NGD also contains some policy-oriented information, such as scripted responses for CSRs who respond to questions from beneficiaries, it does not improve CSRs' ability to respond to policy-oriented questions from providers. Recognizing the broader range of issues and the relative complexity of provider inquiries, CMS officials have not attempted to develop scripted responses to such questions. Although CMS is continuing to study the role of NGD in providing policy-oriented information, agency officials told us they are uncertain whether NGD is the appropriate mechanism to enhance the availability of such information to CSRs. Until CMS makes a final determination, CSRs can continue to access policy-oriented information on the agency's Web site.

Second, CMS has developed a new strategy to clarify Medicare policy for providers, which CMS officials told us will also benefit the CSRs who respond to provider questions. CMS has retained a consulting firm to write explanatory articles about new Medicare policies. Although these articles may educate providers, they will be no more accessible to CSRs than the existing array of materials. For example, these articles are available to CSRs through CMS's Web site and carriers' Web-based bulletins. Although these articles contain citations to regulations and laws, for example, they are not electronically linked to the policies they describe. In addition, the policies they support are not annotated to reflect that an article exists, making it unlikely that CSRs can easily locate the clarifying information. Moreover, there are no plans to publish articles for the majority of existing policies.

Like CMS-sponsored call centers, there are thousands of other call centers serving a large range of businesses and government agencies in the United States. Many of these centers rely on IVRs to route calls to the next available CSR. Other call centers have implemented systems that are more advanced than those used by carriers. Many of these centers triage incoming calls through a feature known as "skill-based routing." Skill-based routing systems are designed to enhance customer service by

allowing the call center to first identify the nature of an incoming call and to then distribute the call to the CSR who is best qualified to respond to the caller's question. CSRs working in a skill-based routing environment develop expertise in key specialty areas so they can quickly and knowledgeably respond to callers' questions. Although CMS has indicated it is committed to improving communications with providers, it has not taken steps that would enable it to identify the subject of providers' policy-oriented questions and route their calls to the most appropriate CSRs.

Call Center Oversight Does Not Adequately Assess CSRs' Responses to Policy-Oriented Questions

CMS requires carriers to monitor the performance of their call centers. However, the performance standards that carriers are required to use, and the technology available to most of them, do not facilitate thorough assessments of whether CSRs provide correct and complete responses to policy-oriented questions. In addition, CMS's own monitoring efforts—CPEs and remote monitoring of select calls—do not provide sufficiently detailed or meaningful information regarding CSR accuracy.

Carrier Self-Monitoring Does Not Effectively Evaluate CSRs' Responses to Policy-Oriented Questions

CMS does not require carriers to monitor a sufficient number of calls to fully evaluate the CSRs' performance. CMS requires carriers to monitor their own call center performance by periodically listening to, and rating, a sample of each CSR's calls. On average, each CSR answers more than 1,700 calls a month. In fiscal year 2004, CMS required carriers to evaluate three calls per CSR per month. Furthermore, for the 31 "blended" call centers, which respond to inquiries from both providers and beneficiaries, carriers are only required to monitor one provider call per CSR per month. This falls short of one call center industry expert's recommendation to monitor a minimum of eight provider calls per CSR per month to obtain accurate statistics on CSR performance.¹⁰ It is also lower than the most frequent monitoring of calls per month from a survey of 735 North American call centers that represent help lines in various industries, including telecommunications, financial services, and health care.¹¹ According to this study, there is a wide variance in the number of calls monitored per month per CSR. However, the most commonly reported

¹⁰The expert is the director of a university-based center for benchmarking the performance of call centers and was a featured speaker at CMS's 2001 Telephone Customer Service Conference.

¹¹Incoming Calls Management Institute, *Call Center Monitoring Study II Final Report*. (Annapolis, Md.: 2002).

monthly monitoring frequencies by survey respondents were 4 to 5 and 10 or more—exceeding CMS’s requirement.

In addition, CMS-developed quality standards used by carriers to conduct self-monitoring do not measure CSR performance in a meaningful way. CMS requires that CSRs be evaluated on customer skills—such as vocal tone, volume and politeness—and knowledge skills—including the accuracy and completeness of responses. However, we reported in 2002 that CMS’s definition of what constitutes accuracy is neither clear nor specific. For example, according to CMS’s standards, carriers should consider a response “accurate” if the CSR “gives an accurate response or referral” as opposed to providing necessary and complete information for the provider to bill the program correctly. Without such guidance or other criteria linked to measurable outcomes, the carrier has little basis to evaluate the correctness and completeness of CSRs’ responses to policy-oriented questions. Although we recommended that CMS establish new performance standards for CSRs that emphasize providing correct and complete answers to provider inquiries, CMS has not revised the definition.

Moreover, CMS has not instituted standard requirements for the technology used by carriers when conducting self-monitoring activities. As a result, there is a broad range of self-monitoring capabilities among the carriers, which, according to CMS officials, can affect a supervisor’s ability to determine whether a CSR’s response was correct and complete. For example, only 14 of the 34 carrier call centers have the capability of recording both the audio portion of monitored calls and the associated computer screens viewed by CSRs. This technology enables the supervisors monitoring calls to follow the actions taken by CSRs, step by step, as they respond to callers. Not only can these supervisors hear callers’ questions and CSRs responses, but they can also view every computer screen accessed by CSRs during calls, enhancing their ability to determine whether CSRs supplied answers that were correct and complete. However, the remaining 20 call centers do not have this capability. While supervisors at 17 of them can record the audio portion of calls, they cannot view the computer screens accessed by the CSRs. Supervisors at 3 centers have no recording capability and are limited to listening to and evaluating “live” calls as they are received.

CMS Does Not Adequately Evaluate CSRs' Responses to Policy-Oriented Questions

Although CMS's principal oversight tools—CPEs—are designed to evaluate call centers' compliance with performance standards, they do not provide a comprehensive assessment of whether information provided by CSRs is correct and complete. As we noted in our previous report, these on-site evaluations, which are conducted by CMS staff and follow a structured protocol, focus on performance standards that address procedures. For example, in preparing that report, we observed a CPE review team concentrated on procedural items such as how long a caller was kept on hold, rather than on whether the information provided was correct and complete. Although CPE evaluators also review call center data and interview call center managers, these activities do not provide a method to measure the correctness and completeness of CSR responses.

We found that the CPE evaluation criteria are not designed to verify that CSRs' responses to providers are accurate. Instead, they focus on evaluating whether carriers are appropriately adhering to CMS's self-monitoring requirements. For example, the CPE evaluators listen to a sample of calls self-monitored by the carrier to verify that the carrier is properly evaluating and documenting the CSRs' performance. In listening to these sampled calls, the CPE evaluators are not required to evaluate the correctness or completeness of responses provided by a CSR, rather they are expected to ensure that the carrier has a system in place to monitor calls. Although our earlier report included a recommendation that CMS employ expert teams to conduct more substantive reviews of calls to strengthen CPEs, CMS told us at that time that this was not feasible. CMS officials recently told us, however, that in many instances, CPE evaluators do not have the expertise to evaluate the accuracy of CSRs' responses.

In addition, CPEs are not performed often enough to provide current feedback on either call center or CSR performance. In fiscal year 2002, only one carrier call center had a CPE covering provider telephone inquiries. Not one CPE was performed in fiscal year 2003. We also found that CPEs are based on an assessment of too few calls to provide meaningful data and are conducted too infrequently to provide current information on call center performance. The required CPE sample is too small to provide reliable results. CPE evaluators listen to a sample of 10 calls monitored by the carrier. If the call center is "blended"—as 31 of the 34 are—the CPE evaluators will listen to 5 provider calls. As a point of comparison, if a call center with the smallest number of CSRs monitors 216 provider calls from its CSRs annually, we found that CPE evaluators would have to draw a simple random sample of 138 provider calls annually to estimate the percentage of correct and complete calls within a margin of error of plus or minus 5 percent, with a 95 percent confidence level.

CPE evaluators monitoring a call center with a larger number of CSRs would have to conduct more monitoring. For example, a call center that monitors 1,800 provider calls from its CSRs annually, would require the CPE evaluators to draw a simple random sample of 317 provider calls annually to reach this same confidence level.¹²

In July 2003, CMS introduced a pilot project that provides a second means of monitoring carrier call centers. CMS can now remotely monitor calls by dialing into carrier call centers and listening to calls as they occur. Remote monitoring provides CMS with an opportunity to hear providers' questions, as well as CSRs' responses, firsthand. Initially, CMS staff listened to 10 calls per month for each center, to develop a general understanding of provider inquiries and to contribute to developing the strategy for future monitoring. However, the staff responsible for remote monitoring reported being overwhelmed by the burden inherent in the task, and in January 2004, CMS reduced the number to five calls per center per month. Staff engaged in remote monitoring can only access the audio portion of calls, limiting their ability to thoroughly evaluate the correctness and completeness of CSRs' responses. In addition, CMS officials recognize that like CPE evaluators, staff engaged in remote monitoring lack the necessary understanding of substantive policy issues involved in the call to determine whether CSR responses were correct. Agency officials stated that they are studying how to best make use of this new capability. They told us that they are uncertain whether the pilot project will be expanded because they are not convinced that remote monitoring is the most appropriate vehicle for evaluating the correctness and completeness of CSR responses to provider questions.

Conclusions

Ensuring that physicians and other providers receive correct and complete answers to their policy-oriented questions is critical to their ability to correctly bill Medicare for services rendered to the program's beneficiaries. Although policy-oriented questions may represent a small proportion of inquiries made to call centers, it is nonetheless important to ensure that providers can rely on the information they receive. Many call centers serving a variety of businesses have taken advantage of skill-based

¹²We based this analysis on the number of CSR full-time equivalents for carrier call centers in fiscal year 2003, which ranged from 6 to 55. Carriers are expected to monitor three calls per CSR per month. As a result, depending on the number of full-time equivalents for each call center, carriers would be expected to have monitored from 216 to 1,980 calls during fiscal year 2003.

routing to identify a caller's specific question and direct the call to the CSR most qualified to respond. However, CMS has not done so, nor has it developed other strategies to improve the ability of CSRs to respond to inquiries from providers. Our test calls continue to show that carrier call centers do not adequately respond to policy-oriented questions. When responding to our questions, it was evident that CSRs lacked access to comprehensive materials that would facilitate correct and complete answers. Instead, CSRs relied on fragmented information sources and were also confused about Medicare policy issues. Furthermore, while CMS is attempting to enhance its monitoring efforts, it has not established a program that can sufficiently evaluate whether providers receive correct and complete answers to their policy-oriented questions. Now that CMS has been given new authority to contract with a variety of entities to assist it with managing the Medicare program, it should take the opportunity to improve its communications with providers. The new law gives CMS the opportunity to identify organizations that can best assist it with developing policy expertise among staff who respond to providers' questions, improving access to policy-oriented materials, and enhancing call center monitoring.

Recommendations for Executive Action

In order to improve the accuracy and completeness of responses to policy-oriented inquiries from providers, we recommend that the Administrator of CMS take steps to ensure that all CSRs have the necessary tools to respond to such calls. Specifically, we recommend that the Administrator take the following three actions:

- Create a process to routinely screen and triage calls by routing complex policy-oriented questions to staff with the expertise to adequately address them.
- Develop clear and easily accessible policy-oriented materials to assist CSRs. The materials should be electronically searchable so that CSRs can expeditiously provide correct and complete responses to policy-oriented questions.
- Establish an effective monitoring program for call centers to assess CSRs' performance. The program should include the development of specific performance standards that will allow CMS to thoroughly and routinely measure the correctness and completeness of information given by CSRs in response to policy-oriented questions.

Agency Comments

In written comments on a draft of this report, CMS expressed its commitment to improving communications with providers and generally agreed with our recommendations. CMS agreed with our first recommendation to create a process to routinely screen and triage calls. CMS said it plans to establish a tiered system using specialty staff to respond to provider inquiries by fiscal year 2005. CMS also agreed with our second recommendation that clear and easily accessible policy-oriented materials should be available and electronically searchable for CSRs. However, they went further to state that clear and accessible information will also be available to specialty staff tasked with responding to complex policy-oriented questions. CMS also described its efforts to make information available to providers through customized Web pages and other educational materials. While CMS agreed with the concept of establishing an effective monitoring program—our third recommendation—it stated that it is in the process of determining how to do so once its new approach of triaging calls is implemented. CMS also said it is exploring other initiatives to enhance monitoring such as modifying its CPE requirements, developing performance-based standards for provider telephone inquiries, and surveying providers on their satisfaction with call centers' performance.

We have reprinted CMS's letter in appendix III. CMS also provided us with technical comments, which we have incorporated as appropriate.

As agreed with your office, unless you announce its contents earlier, we plan no further distribution of this report until 30 days after its issuance. At that time, we will send copies to the Administrator of CMS and other interested parties. We will then make copies available to others upon request. In addition, the report will be available at no charge on GAO's Web site at <http://www.gao.gov>.

If you or your staff have any questions about this report, please call me at (312) 220-7600. An additional GAO contact and other staff who made contributions to this report are listed in appendix IV.

Sincerely yours,

A handwritten signature in cursive script that reads "Leslie G. Aronovitz".

Leslie G. Aronovitz
Director, Health Care—Program
Administration and Integrity Issues

Appendix I: Scope and Methodology

To determine carriers' effectiveness in providing correct and complete responses, we placed 300 calls to 34 carrier call centers. We searched a variety of carriers' Web sites and compiled a group of 18 questions that physicians and other Part B providers frequently asked when contacting call centers. The questions represented common, policy-oriented questions concerning the proper way to bill Medicare in order to obtain payment from the program, as opposed to status-oriented claims inquiries. We asked Center for Medicare & Medicaid Services (CMS) officials to review our questions to determine whether they considered any of the 18 questions inappropriate for our test calls. For example, we did not want to pose a question that would unfairly test a customer service representative (CSR) knowledge and thus we did not want to include a question on a new or recently changed policy. We also did not want to pose questions that were the subject of an ongoing controversy. Based on input from CMS officials, we eliminated three questions. The first question we eliminated referred to pricing rules for multiple surgeries. CMS officials stated that the response to this question, as posted on a carrier's Web site, was unclear. The second question we excluded referred to reimbursements for nurse practitioner services. CMS officials also expressed hesitancy about the phrasing of this question and answer as shown on a carrier's Web site. Although CMS ultimately suggested language to rephrase this question and answer, we opted to remove the question from consideration. The third question we eliminated referred to an issue that CMS officials told us was the subject of an ongoing lawsuit.

After obtaining CMS's input, we selected 4 questions (see app. II) from the remaining 15 questions. These questions addressed: (1) billing for beneficiaries transferred from one hospital to another, (2) billing for services delivered by therapy students, (3) billing for multiple surgeries for the same patient on the same day, and (4) billing for an office visit and procedure for the same patient on the same day. We did not inform CMS before making the calls of the final questions we selected. Each of the four questions was randomly assigned across the 34 carrier call centers and each question was posed 75 times. Calls were placed at different times of day and different days of the week from October 20 through November 3, 2003. Twenty-eight of the carrier call centers were called nine times and the remaining six call centers were each called eight times.

To facilitate our calls, CMS officials informed call center managers of our test. They also agreed not to disclose any of the potential questions to carrier call center staff. During our calls, we identified ourselves as GAO representatives and asked each CSR to answer our question as if we were providers. To prevent us from biasing CSRs' responses and to ensure

fairness, we read each question to CSRs without offering additional information or explanations. However, we repeated questions upon request. Prompts were only given if the CSR probed for more specific information or gave conditional responses that depended upon different circumstances. In those situations, we asked the CSR to provide the correct answer for each set of circumstances. Following the response, we asked the CSR if there was any additional information he or she would like to provide. We also told CSRs we were manually recording their responses verbatim. We analyzed the CSR responses and simultaneously submitted them to Medicare coding experts at CMS. Our assessment of CSR responses and the coding experts' verification of results relied on the following criteria:

- Correct and complete: The answer provided enough information to correctly bill the Medicare program, including (1) a correct explanation of how to apply the billing policy and (2) correct billing codes or a referral to specific documentation that provided coding information.
- Partially correct or incomplete: The answer provided some explanation, but (1) did not provide assistance in interpretation or warn about special circumstances that would affect billing; (2) provided interpretation but no directions to specific documentation; or (3) was correct, but not sufficiently complete to ensure that the claim would consistently pass claims processing edits.
- Incorrect: The answer contained fully or partially incorrect information, such that a physician might incorrectly bill or not file a claim for a billable service.

Following CMS's verification, we discussed and resolved all discrepancies between our assessment of responses and CMS's verification. For example, when initially assessing CSRs' responses, we attempted to locate Web site documents that CSRs referred to during our call. If we found that the reference contained all the accurate information necessary to bill the program properly, we considered the CSRs' responses to be correct and complete even if they did not tell us the information themselves. Although CMS coding experts did not initially review these documents, and therefore may have considered the CSR's response to be incorrect and incomplete, they subsequently agreed that this was a fair and appropriate criterion to add to our assessment.

The results from our 300 test calls are limited only to those calls and are not generalizable to the population of calls routinely made to call centers by providers. Although the four policy-oriented questions we posed were

frequently asked questions obtained from carrier Web sites, they do not encompass all of the questions that providers might ask.

We also interviewed carrier and CMS officials to determine what efforts the agency had in place to enhance CSRs' access to information. We reviewed information regarding the Next Generation Desktop (NGD) application, including videotape and internal documents outlining the phase-in schedule for the application. In addition, we observed a demonstration of the NGD application and monitored its capability to facilitate CSR's responses to providers' questions.

To determine the efforts CMS has made to provide oversight, we identified CMS requirements for carrier call center operations and discussed with CMS staff the agency's oversight and monitoring of carrier call center activities. We reviewed the agency's protocol for its contractor performance evaluations (CPE) to determine the scope of work evaluators would perform and evaluated carrier call center performance standards to identify the types of problems found during their site visits. We also reviewed CPE reports from fiscal years 2001 and 2002. CMS did not perform any CPEs in fiscal year 2003. We visited two carrier call centers and consulted an industry expert on issues related to call center technology and standards. In addition, we observed carrier call centers' monitoring of calls for quality at one of the carrier call centers we visited. We also observed CMS regional staff performing remote monitoring of provider calls. We performed our work from September 2003 through June 2004 in accordance with generally accepted government auditing standards.

Appendix II: Carrier Call Center Accuracy Test Questions

The questions and answers we used to test the accuracy of carrier call center responses to policy-oriented questions are shown in table 2.

Table 2: Questions and Answers for Test of Carrier Call Centers

GAO question	Question from carriers' Web sites	Answer from carriers' Web sites
Question 1: Billing for beneficiaries transferred from one hospital to another	If Dr. Smith transfers a patient from hospital A to hospital B for treatment, will Medicare pay Dr. Smith for both the hospital discharge day management services at hospital A and hospital admission at hospital B?	Physicians may bill both the hospital discharge management code and an initial hospital care code when the discharge and admission do not occur on the same day if the transfer is between (1) different hospitals, (2) different facilities under common ownership which do not have merged records, or (3) between the acute care hospital and a PPS ^a exempt unit within the same hospital when there are no merged records. In all other transfer circumstances, the physician should bill only the appropriate level of subsequent hospital care for the date of transfer.
Question 2: Billing for services delivered by therapy students	The Current Procedural Terminology, or CPT, codes for therapeutic procedure state, the "physician or therapist are required to have direct, that is, one-on-one, patient contact." What if the therapist, for example a PT, OT, or SLP, ^b has some contact with the patient, say, 10 minutes direct patient contact time, and then the student assumes responsibility for treatment under supervision? Does Medicare cover that?	Medicare will pay for the one unit of direct services the therapist provides to the patient under Medicare Part B. If the therapy student assumes responsibility for treatment, the services are not payable under Medicare Part B. Note: However, if the qualified therapist maintains responsibility for the service and one-on-one contact with the patient, the student may participate at the direction of the therapist and Medicare will pay for the service because it is provided by the therapist.
Question 3: Billing for multiple surgeries on the same day	Are there any circumstances for which carriers may pay the full amount for a second surgical procedure performed by the same physician on the same day but during a different operative session?	If a physician believes that extenuating circumstances exist for performing multiple surgeries on the same day and that these surgeries should be paid at the full amount, he or she may bill for the surgeries with modifier "22." After reviewing the operative report, the carrier may determine that the standard adjustment rules do not apply and pay "by report."

**Appendix II: Carrier Call Center Accuracy
Test Questions**

GAO question	Question from carriers' Web sites	Answer from carriers' Web sites
Question 4: Billing for an office visit and a procedure on the same day	Will Medicare pay for a visit and a procedure on the same day if reported by the same physician for the same patient?	<p>Medicare will not pay separately for a visit on the same day as a minor surgery or endoscopic procedure unless other significant, separately identifiable services are performed in addition to the procedure. The payment amount for the procedure covers such pre- and postservice work as record keeping, counseling, and prescribing recovery therapy.</p> <p>However, if other significant evaluation and management services are performed on the same day, the physician may bill for the visit with modifier "25." In determining the level of visit to bill with the modifier, physicians should consider only the content and time associated with the separate evaluation and management service, not the content or time of the procedure.</p> <p>Visits that are related to a major surgery are not paid for separately if reported by the same physician on the same day as the surgery. However, the initial evaluation or consultation by the surgeon will be paid for separately even if reported on the same day.</p>

Source: Carrier Web sites

^aPPS stands for prospective payment system.

^bPT, OT, and SLP stand for physical therapist, occupational therapist, and speech language pathologist, respectively.

Appendix III: Comments from the Centers for Medicare & Medicaid Services




DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: JUN 29 2004

TO: Leslie G. Aronovitz
Director, Health Care-Program
Administration and Integrity Issues

FROM: Mark B. McClellan, MD, Ph.D. 
Administrator

SUBJECT: General Accounting Office's (GAO) Draft Report: *MEDICARE: Call Centers Need to Improve Responses to Policy-Oriented Questions from Providers* (GAO-04-669)

Thank you for the opportunity to review and comment on the General Accounting Office's draft report: *MEDICARE: Call Centers Need to Improve Responses to Policy-Oriented Questions from Providers.* The following are our general comments to the report.

In 2001, the Centers for Medicare & Medicaid Services (CMS) began an initiative to improve provider communications when it required its contractors fiscal intermediaries (FIs) and carriers to institute toll-free phone service to answer inquiries from providers who bill for services under fee-for-service Medicare. That initiative has continued to expand including:

- Fourteen individual Open Door Forums held on a regular basis (monthly for physicians).
- Town Hall meetings on new initiatives.
- Provider specific Web pages and listservs on www.cms.hhs.gov/providers.
- Increased number of centrally developed educational products.
- A fee-for-service provider educational Web page on www.cms.hhs.gov/medlearn.
- An extensive provider partnership network with provider associations and organizations whereby providers give input on products and CMS information tools and assist in dissemination of CMS information.

Each year the call volume handled by the 61 FI and carrier provider call centers has increased. In fiscal year (FY) 2004, the number of calls is projected to be over 41 million. Of the 41 million calls, 28.6 million are expected to be handled by the Medicare carriers.

The FIs and carriers process close to 1 billion claims annually. Most of the provider inquiries are related to specific claims that the provider has submitted to the contractor. Customer service

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representatives (CSRs) typically answer telephone inquiries in the context of a specific claim. At the time of a call, CSRs have access to claim information and Remittance Advice (RA) codes to guide their answers. Providers receive written and/or electronic RA for every claim submitted. The RA consists of Health Insurance Portability & Accountability Act (HIPAA) code sets that explain and document the actions taken on a particular claim.

Based on a recent sample of calls monitored by CMS and information reported by the call centers, about 95 percent of all inquiries are related to claims status checks, claims denial inquiries, or inquiries about a beneficiary's eligibility under the Medicare program. This report looked at the remaining small, but important percentage of calls (less than 5 percent) where the caller asks about specific Medicare policy, where there is no associated claim.

The CMS appreciates the GAO recommendations in this area and is preparing to implement a solution to improve contractor responses to complex policy questions from providers. The Medicare program is complex and broad in scope. We believe that the most efficient way to correct this problem is to establish a triage system with contractor staff, apart from the CSR pool, who have the time, training, and tools to research and carefully consider provider policy questions.

Attached are specific CMS' comments to GAO recommendations and findings.

Attachments

**CMS Comments to the GAO Draft Report:
“MEDICARE: Call Centers Need to Improve Responses to
Policy-Oriented Questions from Providers” (GAO-04-669)**

GAO Recommendations

CMS should create a process to routinely screen and triage calls by routing complex policy-oriented questions to staff with the expertise to adequately address them.

CMS Response

The CMS agrees. The CMS will soon issue a requirement that all call centers create a tiered approach to answering provider inquiries. Such a restructuring will establish an expertise continuum, with the most complex tier being handled by staff who have the time to research, investigate and respond to policy-oriented questions. We plan to establish this approach as of FY 2005.

A tiered approach may also help with retention as promotion opportunities are created within a call center.

GAO Recommendations

The CMS should develop clear and easily accessible policy-oriented materials to assist CSRs. The materials should be electronically searchable so that CSRs can expeditiously provide correct and complete responses to policy-oriented questions.

CMS Response

The CMS agrees that clear and easily accessible policy-oriented materials should be available and electronically searchable. Unlike the GAO recommendation, however, as described above, CMS envisions a staff other than the CSRs as the primary user. The CMS has made significant progress in this area in the last 2 years. For example, CMS now has an on-line manual of Medicare policy and billing instructions on www.cms.hhs.gov/manuals. We have also established customized provider Web pages where physicians, hospitals, ambulances, durable medical equipment suppliers, and other providers can quickly access relevant Medicare information. These Web pages, found on www.cms.hhs.gov/providers, have associated listservs which ensure that providers will get new information as it becomes available.

The CMS also now issues nationally consistent provider education materials to accompany contractor instructions that implement new or revised policy. “*Medlearn Matters...Information for Medicare Providers*” educational articles are written in consultation with clinicians, billing experts, and other medical professionals and are tailored in content and language to the specific provider types who are affected by the program change. They explain in layman terms what the

Page 2 – Attachment

program instructions are saying and, more importantly, explain the specific impact that the change has on the affected providers. Additionally, the articles are housed in one central, easily accessible location www.cms.hhs.gov/medlearn/matters.

GAO Recommendations

The CMS should establish an effective monitoring program for call centers to assess CSR's performance. The program should include the development of specific performance standards that will allow CMS to thoroughly and routinely measure the correctness and completeness of information given by CSRs in response to policy-oriented questions.

CMS Response

The rare occurrence of these kinds of calls would require very large sample sizes at the CSR level. We are, as stated above, proposing that complex policy-oriented calls be triaged to specialty staff when necessary, allowing the critical mass of claim-related calls to be answered by CSRs. We agree that regardless of where the responsibility falls, monitoring is important. However, we are in the process of determining how to monitor this new approach to responding to provider inquiries. The monitoring process will include both contractor self-monitoring and CMS monitoring.

For CSRs, CMS will be requiring carriers to increase their self-monitoring efforts using the Quality Call Monitoring (QCM) tool. Presently, we require carriers to monitor 3 calls per CSR per month. Because so many of the carrier call centers are "blended," those centers may only monitor 1 provider call per CSR per month. The other 2 calls may be beneficiary calls. With this requirement, it is not surprising that the knowledge skills scores are close to 100 percent given that 95 percent of the call volume is claims status, claims denial or beneficiary eligibility inquiries. In FY 2005 there will be no blended calls centers and we are increasing the QCM requirement from 3 calls to 5 calls per CSR per month. For those call centers that today only monitor 1 provider call per CSR per month, the new requirement reflects a 500 percent increase in monitoring. The increase in monitoring, added to a tiered structure to respond to inquiries, will more accurately measure the ability of CSRs to correctly and completely answer provider inquiries of varying complexity.

A second measure CMS is exploring is to modify the contractor performance evaluation (CPE) requirements to include some direct measure of call accuracy. Expanding CPE continues to be a resource problem because it requires CMS staff from around the country to spend significant time away from ongoing work. There are not enough CMS staff dedicated to perform contractor evaluations.

As part of Medicare contractor reform resulting from the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), contracts will be performance-based.

Page 3 – Attachment

The CMS must develop performance standards for each of the business functions handled by the Medicare Administrative Contractors (MACs). In preparation for MAC contracts, CMS is testing performance standards for provider telephone inquiries that get at the accuracy of the responses provided.

The CMS is, in early FY 2005, pilot testing a provider customer satisfaction survey that will include contractor call performance. Under section 911 of the MMA, such a survey is required. Once the pilot is complete and refinements made, the survey will be distributed nationally. This survey gathers information about providers' perceptions of many of the contractor business functions, but provider telephone service is a key area being surveyed.

Appendix IV: GAO Contact and Staff Acknowledgments

GAO Contact

Geraldine Redican-Bigott, (312) 220-7678

Acknowledgments

Shaunessye Curry, Margaret Weber, Helen Chung, Mary Reich, and Marie Stetser made key contributions to this report.

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