CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-09 Medicare Contractor Beneficiary and Provider Communications	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 10900	**Date: August 11, 2021**
	Change Request 12374

SUBJECT: Updates to Pub. 100-09, Chapter 6 Beneficiary and Provider Communications Manual, Chapter 6, Provider Customer Service Program

I. SUMMARY OF CHANGES: This Change Request (CR) revises Chapter 6 to remove duplicate sections, update references and revise language in the manual.

EFFECTIVE DATE: September 14, 2021
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: September 14, 2021
Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
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R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
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R	6/80.4/QWCM
R	6/90/Disclosure of Information

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-09	Transmittal: 10900	Date: August 11, 2021	Change Request: 12374

SUBJECT: Updates to Pub. 100-09, Chapter 6 Beneficiary and Provider Communications Manual, Chapter 6, Provider Customer Service Program

EFFECTIVE DATE: September 14, 2021
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: September 14, 2021

I. GENERAL INFORMATION

A. Background: This Change Request (CR) revises Chapter 6 to remove duplicate sections that were in the previous revision. It also updates references and revises language.

B. Policy: Medicare Administrative Contractor (MAC) Provider Customer Service Program established by the Medicare Modernization Act (MMA).

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
12374.1	MACs shall implement all requirements contained within Pub. 100-09, Chapter 6 Medicare Contractor Beneficiary and Provider Communications Manual.	X	X	X	X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Kimberly Anthony, kimberly.anthony@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

Medicare Administrative Contractor (MAC) Beneficiary and Provider Communications Manual

Chapter 6 - Provider Customer Service Program

Table of Contents
(Rev.10900, Issued: 08-11-21)

Transmittals for Chapter 6

Provider Customer Service Program

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

NOTES:

1. **In this chapter, the term "provider" includes all Medicare providers and suppliers unless specifically noted otherwise. In section 20 of this chapter, the terms "provider of services" and "suppliers" are used to convey specific requirements of the mandated improper payment outreach and education program.**

2. **In this chapter, the term "Medicare Administrative Contractor" ("MAC") means all MACs (A/B, HH+H, and DME), unless specifically noted otherwise, in accordance with each MAC's Statement of Work (SOW).**

3. **In this chapter, the term "Customer Service Representative" or "CSR" refers to all MAC staff who handle telephone, written, PRRS *or* Congressional inquiries. Where a requirement applies to one group specifically that group will be spelled out as follows: Telephone CSR, Written CSR, PRRS or Congressional CSR.**

4. **Deliverables, Deliverable dates, *and* requirements in a MAC's SOW supersede any such Deliverables, Deliverable dates, *and* requirements stated in this chapter, should the documents conflict. Unless stated otherwise, MACs shall continue to send contract Deliverables to the appropriate Deliverables mailbox.**

5. **The information in this chapter is applicable only to the Provider Customer Service Program at the MACs, unless specifically noted otherwise.**

10 – Introduction to Provider Customer Service Program (PCSP)

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

The Centers for Medicare & Medicaid Services (CMS) requires all MACs have a PCSP to help providers understand and comply with Medicare's operational processes, policies, new initiatives, and billing procedures. The PCSP serves to strengthen and enhance CMS's ongoing provider education efforts. The primary principle is to continuously improve Medicare provider satisfaction through the timely delivery of accurate and consistent information in a courteous and professional manner. These practices will help providers understand, manage, and bill the Medicare *Program* correctly, and reduce the Medicare paid claims error rate and improper Medicare payments both nationally and for individual MACs.

The PCSP integrates MAC provider inquiry and provider outreach and education activities creating a comprehensive program. The PCSP shall be a trusted source of accurate and relevant information, staffed with personnel who have technical and customer service expertise and experience to address various provider inquiries and to develop and deliver provider education. The PCSP consists of three major components: Provider Outreach and Education (POE), Provider Contact Center (PCC), and Provider Self-Service (PSS) Technology.

10.1 – *PCSP Electronic Mailing Lists*

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

Note: The terms "electronic mailing list" and "listserv" are often used interchangeably. "Electronic mailing list" is more technically descriptive and is the preferred term of use in this chapter.

1. Provider Customer Service Program Contractor User Group (PCUG) electronic mailing list - MACs shall subscribe to the CMS PCUG electronic mailing list to receive important and timely information from CMS related to the PCSP, including CSR training materials and quality assurance program updates. *MACs shall not share information received on the PCUG listserv with providers unless*

directed to do so. MACs shall send an *email* to the Provider Services mailbox at providerservices@cms.hhs.gov to subscribe or unsubscribe to this electronic mailing list. The *email* shall include the names and *email* addresses of the individuals who wish to subscribe or unsubscribe to the electronic mailing list. At a minimum, the MAC POE manager, the MAC PCC manager, those managing PSS technology, and quality analysts shall subscribe to the electronic mailing list. Additional MAC staff may also subscribe. There is no limitation on the number of subscribers for any MAC.

2. MLN Connects® – CMS utilizes an electronic mailing list in the form of a weekly newsletter named MLN Connects to send MACs important and timely information for them to share with their provider community, such as updates to the CMS website, provider education material, and copies of proposed and final regulations. MACs shall subscribe to MLN Connects to get this information. MACs shall send an *email* to MLNConnectsMAC@cms.hhs.gov to subscribe or unsubscribe to this electronic mailing list. The *email* shall include the names and *email* addresses of the individuals who wish to subscribe or unsubscribe to the electronic mailing list. In addition, the *email* shall identify a permanent corporate/resource box at the MAC. The MAC staff noted in item 1 above shall subscribe, as may additional MAC staff. There is no limitation on the number of subscribers for any MAC.

MACs shall subscribe to these electronic mailing lists within 30 business days after a new MAC contract award date *or* if there is a change in the MAC staff who are required to subscribe.

MACs shall request to unsubscribe staff who have access to one or both of these electronic mailing lists before staff termination or end of employment.

10.2 –*PCUG Call*

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

CMS will hold monthly PCUG conference calls. The call allows CMS to update MACs on issues, directives, and policies impacting the PCSP and provides a forum for MACs to ask questions and share ideas. MACs shall ensure staff from their PCC, POE, and PSS functions attend each monthly PCUG call. CMS strongly encourages MACs to submit agenda topics for consideration to the Provider Services mailbox at providerservices@cms.hhs.gov.

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10.3 – Integration of POE, PCC and PSS Activities in the PCSP

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

Since the PCSP is an integration of POE, PCC and PSS activities, MACs shall regularly review their operations to find ways to integrate these activities and existing resources to provide a comprehensive PCSP for providers in their jurisdiction. Examples include providing upcoming education information to CSRs so they can relay information to providers about how to access or register for upcoming provider training or available computer based-training. Another example is to have telephone CSRs or the IVR system convey information about how to subscribe to the MAC's electronic mailing list or to publicize the MAC's provider education website while callers are on hold. CMS encourages MACs to give opportunities to POE staff and PCC staff, including CSRs, to work together so both areas accomplish their respective tasks. Such sessions could periodically occur during the regularly scheduled CSR training classes so MACs do not take additional time from PCC operations.

In addition to working closely with PCSP staff, MACs shall coordinate internally with staff in appropriate areas (including personnel responsible for Medical Review (MR), Provider Enrollment (PE), Electronic Data Interchange (EDI)/systems, appeals, Medicare Secondary Payer (MSP), and program integrity) to share and communicate identified issues. At a minimum, the MACs shall hold periodic meetings with these various components to discuss any provider issues and potential resolutions. The MACs shall document these meetings and activities and provide this information to CMS upon request.

MACs shall submit a high-level organizational chart for their PCSP to the Provider Services mailbox at providerservices@cms.hhs.gov. MACs shall submit the chart within 60 calendar days after the cutover date of the MAC contract (if more than one cutover date, within 60 calendar days after the earliest cutover date) or, if the information for the chart is not available at that time, within 7 calendar days after the information becomes available. If a due date falls on a weekend or holiday, the chart is due by close of business on the next business day. MACs shall submit a revised organizational chart within 14 days of making changes.

10.4 - Partners in Progress Meeting

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

At least once a year, CMS reserves the right to hold an in-person meeting with MAC staff. The purpose of the conference is to discuss CMS priorities/initiatives; share best practices and program successes; develop new and improved approaches for the PCSP; exchange information about PCSP issues; and allow MAC staff to network and identify opportunities for collaboration.

MACs shall send representatives from all facets of the PCSP (PCC, POE and PSS).

CMS expects this meeting to last from 2-4 days.

20 – Provider Outreach and Education (POE)

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

The primary goal of the POE program is give Medicare providers the timely and accurate information they need to understand the Medicare *Program*, be informed about changes, and correctly bill. POE is driven by educating providers and their staffs about the fundamentals of the Medicare *Program*, national and local policies and procedures, new Medicare initiatives, significant changes to the Medicare *Program*, and issues identified through analyses of such mechanisms as provider inquiries, claim submission errors, MR data, CERT data, and Recovery Auditor data.

MACs shall disseminate information to their providers through outreach, education, training, technical assistance, or other activities to help reduce improper payments. Each MAC shall establish an improper payment outreach and education program that will expand and enhance efforts to reduce improper payments in accordance with guidance from CMS. In particular, MACs shall analyze data in accordance with sections 20.3 of this chapter when developing their outreach and education program.

MACs shall give priority to improper payment outreach and education program activities that are one or more of the following: (a) are for items and services with the highest rate of improper payment; (b) are for items and services with the greatest total dollar amount of improper payments; (c) are due to clear misapplication or misinterpretation of Medicare policies; (d) are other types of errors that could be prevented through activities under the improper payment outreach and education program.

MACs shall also give priority to improper payment outreach and education program activities for providers and suppliers with (a) the highest rate of improper payment, and (b) have the greatest total dollar amount of improper payments.

MACs have discretion to deliver education using the most effective and efficient strategy and method to offer Medicare providers a broad spectrum of information about the Medicare *Program*. Clinical and non-clinical staff may deliver POE education to groups or to individuals through a variety of communication channels and mechanisms—including *Web*, telephone, computer storage/read-only memory, educational messages on the inquiries line(s) and IVR, face-to-face instruction, web-based training, and presentations in classrooms and other settings. CMS encourages innovation as MACs identify provider educational priorities and delivery methods, including leveraging PCC and PSS resources to identify educational opportunities and expand delivery methods.

MACs shall use all strategies and methods to inform and educate providers of services and suppliers of (a) the most frequent and expensive payment errors over the previous quarter, (b) specific instructions regarding how to correct or avoid such errors in the future, (c) notice of new topics approved for audits conducted by Recovery Auditors under section 1893(b), (d) specific instructions to prevent future issues related to such new audits, and (e) other information as determined appropriate by CMS.

MACs shall use existing CMS educational products, including Medicare Learning Network® (MLN) products or content whenever possible in educating providers. (See section 20.4 of this chapter.)

20.2 - *Partnering with External Entities and with Other MACs*

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

MACs shall establish and maintain partnerships with external entities, as well as with other MACs, to facilitate the dissemination of Medicare information that will assist providers in submitting correct claims and in following regulatory requirements for documentation when ordering or referring certain items or services.

MACs shall establish and maintain partnerships with external entities to help disseminate Medicare provider information. Whenever feasible, events and activities shall be coordinated with other Medicare contractors and entities, including quality improvement organizations (QIOs), State Health Insurance Assistance Programs (SHIPs), and End Stage Renal Disease (ESRD) networks, as well as interested groups, organizations, and CMS partners. In addition, MACs shall routinely and directly notify other interested entities of their upcoming provider education events and activities. Partnership activities shall not take the place of MAC-led POE events but shall supplement them.

Partnering entities may be other MACs, medical, professional or trade groups and associations, government organizations, educational institutions, trade and professional publications, specialty societies, and other interested or affected groups. By establishing collaborative information dissemination efforts, providers will be able to obtain Medicare *Program* information through a variety of sources. Partnering on collaborative provider information and education efforts may include, but are not limited to:

1. Including information from partners in newsletters or publications.

2. Reprinting and distributing (free of charge) provider education materials.

3. Disseminating provider information or education materials at organization meetings and functions of partnering entities.

4. Scheduling presentations or classes for members of partnering entities.

5. Requesting information for Medicare providers be posted on the websites of partnering entities.

6. Helping partnering entities develop their own Medicare provider education and training material.

7. Partnering with other MACs to educate providers that may cross MAC jurisdictions.

8. Collaborating with other MACs to educate ordering or referring providers on such things as documentation requirements for items or services, such as orders or referrals for tests, imaging procedures, Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS), and home health services especially when the ordering or referring provider is in a different MAC jurisdiction than the servicing provider.

MACs shall report information about their partnerships with external entities, specifically on partnerships related to education on items or services with the highest improper payment rate, in Provider Customer

Service Program Customer Information Database (PCID) on a monthly basis. See section 80.2.3.3 of this chapter for more information on reporting requirements.

MACs shall work with each other to establish and maintain, on a regular basis, collaborative relationships with other MACs for the purposes of developing and implementing outreach and education offerings to providers on Medicare *Program* requirements that cross their lines of business (Part A, Part B, HH+H, and DME). The requirements for ordering home health services and DMEPOS are prime examples of two such collaborative efforts. MACs shall ensure their outreach and education plans include efforts related to: (1) educating physicians about the Medicare requirement when ordering home health services for people with Medicare and about the specific documentation requirements of those orders, and (2) educating physicians and clinicians who are permitted to order DMEPOS about the Medicare requirement when ordering DMEPOS for people with Medicare and about the specific documentation requirements of those orders.

MACs shall report information about their collaborations with other MACs, specifically about their collaborations related to education on items or services with the highest improper payment rate, in PCID on a monthly basis. See section 80.2.3.3 of this chapter for more information on reporting requirements.

20.3.4 – Analysis of Claims Submission Errors

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

Claims submission errors are those that result in rejected, denied, or incorrectly paid claims. MACs shall maintain a provider data analysis program that produces a monthly list of the most frequent collective claims submission errors from all providers in their jurisdiction. This program shall include common and inadvertent clerical or administrative errors and other types of errors that could be prevented through outreach and education. Such data analysis may include identification of aberrancies in billing patterns within a homogeneous group, or detection of patterns within claims or groups of claims. Data analysis itself may be undertaken as part of general surveillance and review of submitted claims, or may be conducted in response to information about specific problems stemming from complaints, provider input, alerts, or reports from CMS *or* other MACs. This information shall be used to develop and modify the provider education contained in MAC POE plans.

20.4.1 - Provider Bulletins/Newsletters

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

MACs may at their discretion, electronically distribute and post on their website provider bulletins/newsletters that contain Medicare *Program* and billing information.

MACs shall encourage providers to obtain electronic copies of bulletins/newsletters and other notices through their provider education websites. However, MACs shall ensure that active providers without Internet access (if known by the MAC) shall receive paper provider bulletins/newsletters via U.S. Postal Service. Active providers are those whose enrollment records in the Provider Enrollment, Chain and Ownership system (PECOS) are "active." If providers who receive paper copies are interested in obtaining additional paper copies on a regular basis, MACs are permitted to charge a fee for this service. The subscription fee shall be "fair and reasonable" and based on the cost of producing and mailing the publication.

20.4.2 – Direct Mailings for the PCSP

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

At the request of CMS, MACs shall print and distribute hardcopy mailings (known as "direct mailings") to all or a subset of their active providers. (See the definition of "active" provider in section 20.4.1 of this chapter.) MACs shall follow the business requirements in the associated Change Request (CR) when determining the address to use for a direct mailing and for other instructional information. A direct mailing may not be sent to the address of billing agencies or clearinghouses used by providers.

For these mailings, MACs shall use the letterhead and envelopes typically used for provider correspondence. In accordance with IOM Pub 100-09, Chapter 1, Section 20, all Medicare communications must include Medicare identification to distinguish Medicare correspondence, and establish program identity with physicians, suppliers and beneficiaries. The word "Medicare" *or the* CMS alpha representation should be at least as large as the organization's identification, and in a location that gives at least equal prominence. When possible CMS will send the direct mailing letter in Word format to allow MACs to set up the letters to allow the use of a window envelope. Unless otherwise instructed, MACs shall follow their internal procedures concerning undeliverable mail.

When directed, MACs shall also post a link to the letter on their provider education website.

MACs shall report direct mailing activities in accordance with Section 80.2.3.12 of this chapter.

20.4.4 - Training Tailored for Small Medicare Providers

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

MACs shall tailor education to the needs of their small Medicare providers. Small providers are defined by law as providers with fewer than 25 full-time equivalent employees or suppliers with fewer than 10 full-time equivalent employees. MACs shall use CMS-developed materials, including MLN products or content, to the extent practicable. (See section 20.4 of this chapter.) This training may involve interactive communication such as face-to-face trainings *or* web-based tutorials or instruction. CMS does not require MACs to identify or validate providers who meet the definition of small provider.

Education and training of small providers may include the provision of technical assistance, such as review of billing systems and internal controls, to determine program compliance and to suggest more efficient and effective means of achieving such compliance. Small provider technical assistance can also include educational seminars for groups of providers identified as having similar problems with their billing systems or internal controls. It also can include assistance from EDI support staff, since much of the billing system technical expertise at the MAC resides with that staff.

20.4.5.5 - Remittance Advice (RA)

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

MACs shall promote the use and understanding of the RA as an educational tool for communicating claims payment information to providers.

Providers receive an RA, which is a notice of payment and adjustment, once a claim has been received and processed. An adjustment refers to any change that relates to how a claim is paid differently from the original billing. Adjustments can include a denied claim, zero payment, partial payment, reduced payment, penalty applied, additional payment and supplemental payment. Two important non-medical code sets are used to communicate an adjustment, or why a claim (or service line) was paid differently than the provider billed. These code sets are Claim Adjustment Reason Codes and RA Remark Codes. Descriptions for both of these code sets appear at the official ASC X12 website.

When CMS does not instruct MACs to use specific Claim Adjustment Reason Codes and RA Remark Codes to communicate claim payment and adjustment information, and a code would help reduce provider inquiries, MACs shall use appropriate codes. MAC provider inquiry, POE, and systems staff shall work together to identify Claim Adjustment Reason Codes and RA Remark Codes to help communicate an adjustment and reduce provider inquiries.

MACs shall also promote the use of the free Medicare Remit Easy Print (MREP) software to obtain Electronic Remittance Advice (ERA). (See https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/AccesstoDataApplication/MedicareRemitEasyPrint.) The benefits of using MREP software include saving time and money by printing remittance information directly on the day the Health Insurance Portability and Accountability Act (HIPAA) 835 is available without waiting for

the mail, the ability to create and print special reports, and the ability to create document(s) that can be included with claim submissions to secondary/tertiary payers. The ERA is the preferred method for claims payment communication. When new versions of MREP software become available, MACs shall post this notification on their provider education websites and communicate this information to their MREP contact list *and* provider electronic mailing list(s).

If a provider elects to receive the SPR, MACs shall use the SPR provider messaging properties, when available, to convey Medicare programmatic information including, but not limited to, the promotion of their provider education websites, changes in policies and programs, and the promotion of their upcoming POE activities.

20.6.1 – POE Advisory Groups (POE AGs)

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

Each MAC shall establish and maintain a POE Advisory Group (POE AG). The primary function of the POE AG is to help the MAC create, implement, and review provider education strategies and efforts. The POE AG provides input and feedback on training topics, provider education materials, and dates and locations of provider education workshops and events. The POE AG also identifies salient provider education issues, and recommends effective ways to disseminate information to all appropriate providers and their staff. The POE AG is a provider education consultant resource but not an approval or sanctioning authority.

The POE AG *should meet three times per year.* MACs may hold POE AG meetings in-person or via teleconference. Teleconference/video conference capabilities shall be available for POE AG members who cannot be physically present for an in-person POE AG meeting.

The MAC shall maintain the POE AG. It is not permissible for the MAC to allow outside organizations to operate the POE AG. After soliciting suggestions from the provider community, the MAC shall select the appropriate individuals and organizations to be included in the POE AG. The main point of contact for all POE AG communication shall be within the MAC's POE area. At a minimum, the MAC is responsible for recruiting potential members, arranging all meetings, handling meeting logistics, producing and distributing an agenda, completing and distributing minutes, and keeping adequate records of the POE AG's proceedings.

POE AGs operate independently from other existing MAC advisory committees. However, while POE AG members can be members of other advisory committees, the majority of POE AG members shall not be current members of any other MAC advisory group. MACs shall strive to maintain professional and geographic diversity within the POE AG and have representatives of the major provider specialties or provider institutions they serve. Providers from different geographic areas, as well as from urban and rural locales, shall be represented in the POE AG.

A MAC shall consider having more than one POE AG when the breadth of its geographic service area, or range of the providers serviced, diminishes the practicality and effectiveness of having a single POE AG. Each MAC shall have at least one separate group for each of its contracts (that is, at least one POE AG for each MAC jurisdiction). In addition, a MAC may choose to have a single POE AG for all contracts the MAC oversees.

A MAC shall not reimburse or charge a fee to POE AG members for membership or for costs associated with serving on the POE AG. A MAC shall have a specific area on its provider education website that allows providers to access information about the POE AG. This information shall include, at a minimum, minutes from meetings, upcoming meeting dates and locations, list of organizations or entities comprising the POE AG, and an *email* address for a contact point for further information on the POE AG.

A MAC shall consider the suggestions and recommendations of its POE AG and implement those deemed feasible, practicable, and in the best interest of an effective PCSP. In the interest of maintaining a working

relationship, the MAC shall explain to the POE AG reasons for not implementing or adopting any POE AG suggestions or recommendations.

MACs shall distribute meeting times and agendas, which include discussion topics garnered from solicitation of POE AG members, to all members of the POE AG and to CMS Central and Regional Office staff prior to any meeting. MACs shall post the POE AG meeting minutes on their provider education website within 30 business days after the meeting.

20.6.2 – "Ask-the-Contractor" Teleconferences (ACTs)

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

"Ask-the-Contractor" Teleconferences (ACTs) provides a way for providers to ask their MAC specific questions about Medicare billing, policies, *or* procedures. MACs can share information and listen to their provider community through ACTs.

MACs shall organize toll-free ACTs to complement, but not replace, the work of the POE AG. (See section 20.6.1 of this chapter). MACs shall offer ACTs at least quarterly. In designing ACTs, MACs shall consider other technological approaches, such as web-chat capabilities. MACs shall also invite CMS Central and Regional Office staff to listen to ACTs. MACs shall post a complete question-and-answer document on their provider education website within 30 business days after each ACT. The question-and-answer document shall include all the questions asked and answered during the ACT, as well as any information presented not part of a question or answer. If no answer could be provided at the ACT for a question asked at the ACT, the question-and-answer document shall include that question and its answer. It is not acceptable for MACs to simply post the audio recording of the ACT if there were questions asked during the ACT that could not be answered during the ACT.

MACs shall use their POE AG to assist with the timing, frequency, size, topics, and provider type(s) included in ACTs. MACs shall also use other methods for ACT topic identification, such as inquiry analysis, claims submission error analysis, MR data analysis, input from PCC staff, and information gathered through partnerships.

20.7 - POE Reporting

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

MACs shall report POE activities in PCID in accordance with section *80.2.3.3* of this chapter.

MACs shall prepare and submit the PCSP documents described in sections 20.7.1 and 20.7.2 of this chapter and submit updates as necessary.

Additional reporting may be required. (See section 20.7.3 of this chapter.)

20.7.1 - Provider Service Plan (PSP)

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

Each MAC shall prepare and submit to CMS a one-time PSP that outlines the strategies, projected activities, efforts, and approaches the MAC will use throughout the duration of its contract to support provider education and communications. The PSP shall address and support all the implementation strategies and activities stated in this chapter, as well as all required activities stated in the MAC's SOW. An HH+H MAC shall prepare a separate PSP for its corresponding HH+H work.

Each MAC shall send the PSP electronically in MS Word to the Provider Services mailbox at providerservices@cms.hhs.gov, and to the appropriate Contracting Officer Representative (COR) or designee, according to the following schedule: If the *implementation start* date *is* between the 1st and the 14th of the month, the PSP shall be due by close of business the last day of the month following the *start of the implementation period*. If the *implementation start* date *is* between the 15th and the last day of the

month, the PSP shall be due by close of business the last day of the second month following the *start of the implementation period*. If the due date falls on a weekend or holiday, the PSP is due by close of business on the next business day. The PSP is required for each new MAC contract, even if the incumbent is awarded the new contract.

MACs shall use the PSP template/format and instructions located on the CMS website at https://www.cms.gov/Medicare/Medicare-Contracting/FFSProvCustSvcGen/Downloads/PSP-Template-2015.pdf. MACs shall ensure they are using the most recent version of the PSP template/format. MACs shall be notified of updated templates via the CMS PCUG electronic mailing list described in section10.1 of this chapter.

20.7.2 – Provider Customer Service Program Activity Report (PAR)

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

Each MAC shall prepare an annual PAR. The PAR summarizes and recounts the MAC's provider education and training activities. It shall include a synopsis of activities that took place throughout the year and detail activities for the year to come. These activities include efforts to reduce the error rate, training events, *web* efforts, provider education conferences and teleconferences, inquiry analyses and follow-up actions, materials development and dissemination, and ACT and POE AG meetings. The PAR must also report any changes to information contained in the PSP. HH+H MACs shall prepare separate PARs for their corresponding HH+H work. MACs are not required to include a listing of POE events because that information shall be reported to PCID in accordance with section 80.2.3.3 of this chapter.

The PAR is due to CMS on the 30th calendar day after the last day of the contract year. If the 30th calendar day falls on a weekend or holiday, the report is due by close of business on the next business day. MACs shall send all PARs electronically in MS Word to the Provider Services mailbox at providerservices@cms.hhs.gov and to the appropriate COR or designee.

MACs shall use the PAR template/format and instructions located on the CMS website at https://www.cms.gov/Medicare/Medicare-Contracting/FFSProvCustSvcGen/Contractor-Resources.html. MACs shall ensure they are using the most recent version of the PAR template/format. MACs shall be notified of updated templates via the CMS PCUG electronic mailing list described in section 10.1 of this chapter.

20.7.3 – Discretionary Reporting

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

CMS emphasizes the importance of integration of data analysis across all business functions within the MAC, as the MAC continuously assesses the effect of its outreach and education efforts upon the error rate. MACs shall work to maintain or improve their CERT scores. At its discretion, CMS may require MACs who do not maintain or improve their scores from their prior year scores to submit additional reporting related to the way they use outreach and education to achieve a reduction.

20.8 - Charging Fees to Providers for Medicare Education and Training

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

CMS expects that MACs shall not charge for the development, reproduction, *or* presentation of provider education and training materials.

However, there are some circumstances under which MACs may charge "fair and reasonable" fees to offset or recover costs associated with education and training.

This section is not applicable to POE AG meetings/conference calls or ACTs.

20.8.4 – Reimbursement from Providers for POE Staff Attendance at Provider Meetings

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

There may be times when providers or provider societies/associations offer to pay the travel costs for a MAC's POE staff so this staff can attend and participate in provider meetings. In most instances, MAC staff may accept the travel reimbursement if the event is sponsored by a provider society/association. However, if the event is sponsored by a single provider, the MAC shall not accept travel reimbursement.

If a MAC would like to accept the offer of a society or an association, the MAC shall send its Contracting Officer Representative (COR) and Contract Specialist a copy of the event invitation letter, proposed agenda, and, as applicable, issues upon which the MAC's staff is to give a presentation or discuss as part of a panel or general question/answer discussion.

In all cases, MACs shall not accept speakers' fees, but they may accept small gifts such as pens engraved with the host logo, coffee mugs, plaques, flowers, etc. MACs are not permitted to accept *or* use substantive gifts or donations associated with participation in education and training activities absent specific authority from CMS.

20.8.6 – Refunds/Credits for Cancellation of Education and Training Activities

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

MACs shall develop and implement a refund policy and apply it to any education or training activity for which they charge a fee. MACs shall ensure that providers who register for education or training activities are aware of the refund policy by including the policy or a reference to it on education and training activity registration material or advertising.

CMS understands that, in order to secure accommodations and services for planned provider education and training activities, the MAC may have to make commitments under which it will incur contractual expenses. MACs may take this into consideration when determining their refund/credit policy. The policy must, at a minimum, adhere to the following guidelines:

- MACs shall make full or partial refunds/credits to providers who pay a fee to attend an activity but who cancel before the activity date.

- MACs shall make full refunds if MACs cancel activities for which provider registrants paid fees.

30 - Provider Contact Center (PCC)

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

CMS strives to continuously improve Medicare customer satisfaction through the delivery of high quality and cost-effective customer service. High quality customer service is accurate, convenient and accessible, courteous and professional, and responsive to the needs of diverse groups. It is important all communication be coordinated to ensure consistent responses due to the various communication channels available to providers. MACs shall develop a PCC offering a range of Medicare expertise to respond to telephone, written and walk-in inquiries. The PCC assures a positive business relationship with Medicare providers through its responsiveness to providers' verbal and written inquiries. The PCC includes the provider telephone inquiries staff, the general written inquiries staff, the Provider Relations Research Specialists (PRRS) (in a joint effort with the POE unit), and walk-in inquiries staff.

With the exception of technologies discussed in sections *30.4.2* and 50 of this chapter and in chapter 2 of this manual, CMS does not require the use of any specific technologies, as long as the MAC is able to meet all performance standards and requirements in a cost-effective and efficient manner while providing a high level of quality customer service to providers that includes accurate and timely information. MACs shall ensure, at a minimum, PCC staff have readily-accessible information and tools (that is, access to claims-

related information, access to and training on the MAC's and CMS's websites, a computer, and an outbound telephone line) so that inquiries receive accurate and timely handling.

MACs shall identify at least two points of contact for each PCC. The contacts should have knowledge of provider telephone and written inquiries. MACs shall enter each contact's name, business telephone number, business *email* address and point of contact type (telephone, written, technical, etc.) in PCID. See section 80.2.2 of this chapter for PCID reporting and data certification requirements.

It is important MACs inform CMS about negative effects on MACs' PCCs. CMS monitors PCC performance on a daily basis and various factors, such as staffing changes or implementation of CRs, could negatively affect PCC performance and produce changes in PCC performance statistics. CMS detects the changes in the performance statistics but may not know the reason(s) for those changes, with the exception of reported telecommunications issues, until later—possibly even months later. To ensure CMS has immediate knowledge of factors impacting the performance of the PCCs, MACs shall send an *email* to the Service Reports mailbox at servicereports@cms.hhs.gov with the subject "Contractor Alert" as soon as *they* know about adverse affects to PCC performance. The *email* shall describe the change or event, explain the impact on the PCC and, describe what is needed, internally or from CMS, to resolve the matter. Changes or events that may produce adverse effects on PCCs include, but are not limited to, the following:

- Staffing changes including if staff from other areas help out in the PCC (due to increased staff absences or demand)

- Unexpected increase in call volume *or* written correspondence due to, but not limited to, the following: implementation of a CR *or* other Medicare policy change, release of a new *or* changed CMS initiative, shared systems issues, non-function or dysfunction of a MAC self-service application/tool, other MAC functional department issues, unavailability of data from any source used by the PCC, and a national or local emergency.

- Abnormal or unexpected changes in CSR availability (for example absences due to illness or due to participation in fire drills or other emergency or safety exercises or procedures, severe weather, or urgent training)

Reporting a Contractor Alert does not eliminate the requirements to report (1) problems that impact the ability to provide telephone service to the providers (section *30.4.4* of this chapter), (2) a call completion rate on the CSR-only, IVR-only, or IVR/CSR combined line(s) less than the applicable quarterly standard for the previous business day (section *70.2.1* of this chapter), (3) an average speed of answer (ASA) on the PCC line(s) higher than the applicable quarterly standard for the previous business day (section *70.2.3* of this chapter), (4) monthly reports to PCID of telecommunications service interruptions (section *80.2.3.7* of this chapter), or (5) monthly reports to PCID of unexpected portal service interruptions (section *80.2.3.8* of this chapter).

30.1.1 - Pre-Approved PCC Closures

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

CMS allows MACs to close their PCCs on the following days without requesting approval:

- New Year's Day
- Martin Luther King, Jr. Day
- Presidents' Day
- Good Friday
- Memorial Day
- Independence Day
- Labor Day
- Columbus Day

- Veterans Day
- Thanksgiving Day
- Day After Thanksgiving
- Christmas Eve
- Christmas Day
- Day After Christmas

Although MACs do not need to request CMS approval to close their PCCs on the days listed above, MACs shall notify CMS through PCID within 30 calendar days of the start of each contract year of PCC closures on any of the days listed above, as well as any other days the MAC plans to close the PCC (for example, MAC holidays, corporate meetings, MAC contract or systems transitions). In addition, MACs shall report if they plan to conduct PCC training on any of the days listed above in which the MAC has indicated its PCC would be closed.

See section 80.2.2 of this chapter for the PCID reporting requirements.

30.1.3 – Emergency and Similar PCC Closures

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

There may be occasions when a MAC finds it necessary to close one and/or all locations of a jurisdiction's PCC because circumstances create sufficiently adverse working conditions at a PCC location(s) (examples include lack of heat, air conditioning, or water and emergency evacuation for health, safety or security reasons) *or* because a MAC plans a drill or exercise for emergency or security preparedness, such as fire and other safety drills, even though such a closure may be only for a brief period of time. A MAC shall report each of these PCC closures even if the MAC has a plan in place for alternate call handling, as there is no guarantee that, even with a plan, calls *or* call volume would not be adversely affected by the closure. MACs shall report these PCC closures to the Service Reports mailbox at servicereports@cms.hhs.gov within 1 hour of the decision to close the PCC if the decision to close was made during normal business hours, or by 9:00 a.m. Eastern Time the next business day if the decision was made after business hours the night before or before business hours that day. The *email* shall explain the reason for the PCC closure and, if known at the time, indicate when the PCC will reopen.

See section 80.2.3.6 of this chapter for the monthly PCID reporting requirements.

30.3 – Inquiry Triage Process

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

Provider inquiries may require varying degrees of expertise to answer. Using a triage mechanism, the PCC shall be able to route general inquiries within the PCC to the system or person best equipped to respond with a minimal degree of transfer. The triage procedures shall be used for telephone inquiries, but a MAC may choose to employ a similar mechanism to triage general written inquiries as well. MACs shall develop mechanisms to quickly identify complex written inquiries needing referral to the PRRS. Figure 1 illustrates the levels of complexity and the corresponding provider inquiry volume.

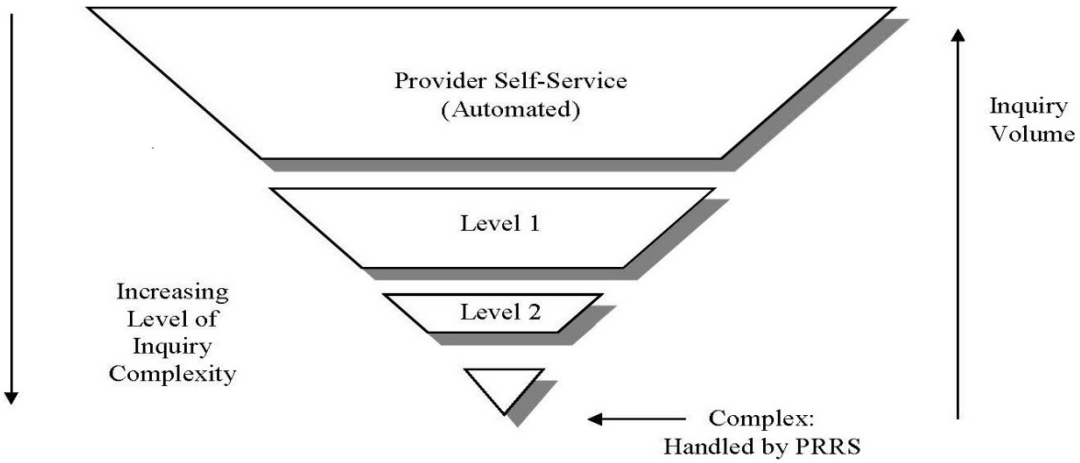
Each MAC shall organize its dedicated provider telephone CSRs into at least two levels to handle questions of varying complexity. A MAC may also choose to specialize its telephone CSRs within levels or across PCC call center locations (if a MAC has more than one call center location) to take full advantage of skills-based routing. A MAC may use technology to route callers to the appropriate level of telephone CSR.

First-level telephone CSRs shall answer a wide range of basic questions that cannot be answered by the IVR system or other interactive self-service technology. At a minimum, these telephone CSRs shall handle questions that do not require substantial research and can easily be answered during the initial call; however, MACs may choose to have first-level telephone CSRs also handle more complex inquiries. In the event a first-level telephone CSR cannot answer an inquiry, the first-level telephone CSR shall have the authority to refer more complex questions to second-level telephone CSRs.

Second-level CSRs shall have more experience and expertise, enabling them to answer more complex questions, including telephone inquiries requiring a higher level of research. MACs may organize these CSRs in any configuration that best suits the nature of the inquiries received. They may serve as consultant subject matter experts for first-level CSRs and, therefore, do not always have to speak directly to a provider. These CSRs may be used to answer first-level CSR questions, if the workload demands, and may also handle callbacks. The most complex questions shall be referred to the PRRS, discussed in section 30.7 of this chapter.

For workload reporting purposes, if a call is transferred between telephone CSR levels, the inquiry shall remain open until it is fully resolved and shall only be counted once.

Figure 1



30.3.1 - Responding to Coding Questions

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

Providers are responsible for determining the correct diagnostic and procedural coding for the services they furnish to Medicare beneficiaries. CSRs shall not make determinations about the proper use of codes for the provider. When providers inquire about interpretation of procedural and diagnostic coding, they shall be referred to the entities responsible for those coding sets. CSRs shall refer providers with questions about coding to the following information sources, as appropriate:

1. Current Procedural Terminology (CPT)[1] codes are proprietary to the American Medical Association (AMA). As such, CPT coding questions from providers (with exception noted in 4 below) shall be referred to the AMA. The AMA offers CPT Information Services (CPT-IS). This *Web*-based service is a benefit to AMA members and is available as a subscription fee-based service for non-members and non-physicians. The AMA also offers CPT Assistant. Information about these resources is found at https://www.ama-assn.org/.

2. The American Hospital Association (AHA) has a website with many resources for answers to coding questions. Information is available at http://www.ahacentraloffice.org. The website also has a direct link to the AHA Coding Clinic (http://www.codingclinicadvisor.com) whereby coding questions may be submitted and tracked.

3. Level II Healthcare Common Procedure Coding System (HCPCS) codes related to durable medical equipment or prosthetics, orthotics, and supplies are answered by the Pricing, Data Analysis and Coding (PDAC) Contractor. Information about the PDAC Contractor and the services it provides can be found at https://www.dmepdac.com.

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[1] *CPT only copyright 2015 American Medical Association. All rights reserved.*

4. Additional information can be found about these resources at: http://www.cms.gov/Medicare/Coding/MedHCPCSGenInfo/index.html.

30.4 - Provider Telephone Inquiries

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

CMS provides toll-free telephone service to providers using the General Services Administration's (GSA) designated contractor for its telecommunications network. All inbound provider telephone service will be handled by the GSA's designated contractor with the designated Network Service Provider (NSP). Therefore, MACs shall not procure or maintain their own local inbound lines. Any new numbers and the associated network circuits used to carry these calls shall be acquired via the GSA's designated contractor.

30.4.1 – Provider Inquiries Line(s)

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

A MAC's PCC shall meet standards and requirements, including those related to call handling and quality. When multiple queues come into a MAC's PCC (for example, A/B, HH+H, DME, appeals, EDI, PE), the statistics for each queue are rolled up into a single set of data that determines whether or not the PCC met the standards and requirements. A queue that fails to meet the call handling and quality standards could cause the PCC as a whole to fail to meet those standards. Each MAC has flexibility to configure the PCC in the most effective way to meet the standards and requirements of its SOW. A MAC may have a single toll-free number through which providers are routed to the appropriate area, multiple toll-free numbers bringing callers directly to each area, or a combination of the two. CMS encourages MACs to use the fewest numbers possible to meet performance standards.

MACs shall report all applicable data (for example, quality call monitoring, telephone inquiry tracking, and telephone inquiry reporting) for each queue.

At a minimum, MACs shall use the provider toll-free line(s) to handle questions related to billing, claims, eligibility, payment, appeals, EDI, and PE (EDI and enrollment are not applicable to DME MACs). If MACs need new service to handle additional Medicare applications, they shall follow the established process for adding additional toll-free numbers. CMS will consider all requests for additional toll-free numbers.

MACs may choose to require callers who do not have provider numbers, such as consultants, lawyers and manufacturers, to submit their inquiries in writing.

PCCs may limit the number of inquiries discussed during a single telephone call, but all PCCs shall respond to at least three inquiries in a single call before asking the provider to call back.

30.4.4 – Troubleshooting PCC Service Interruptions

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

MACs shall be responsible for monitoring all aspects of their PCC service operations, including the adequacy of their telecommunications operations, and shall take the necessary action to quickly diagnose and correct any issues impacting their ability to provide telephone service to providers on the IVR-only, CSR-only, and combined IVR/CSR lines, as well as issues that may cause interruptions to other PCC services, such as the retrieval of data from back-end systems. To monitor and report a problem, MACs shall follow these steps:

1. Send an *email* to the Service Reports mailbox at servicereports@cms.hhs.gov with a copy to the Provider Network Support (PNS) contractor to notify CMS of a service interruption. The *email* shall be sent within 1 hour of the start of the service interruption if it began during normal business hours, or by 9:00 a.m. *ET* the next business day if the interruption began after business hours the night

before or before business hours that day. The *email* shall summarize the problem and the steps taken to restore full service.

- A service interruption is defined as a total loss of service for any length of time or any incident lasting at least 30 minutes that impacts the PCC's ability to receive calls, answer inquiries, or retrieve data from back-end systems.

- A major service interruption is defined as a total loss of service or any incident lasting 2 or more hours and having any of the impacts described above.

2. The MAC shall send at least one daily follow-up *email* to the Service Reports mailbox at servicereports@cms.hhs.gov by 12:00 p.m. *ET* providing a status until the problem has been resolved.

3. Isolate the problem and determine whether the PCC service interruption is caused by:

    - Internal customer premise equipment or network service.

    - Internal Problem - The MAC's local telecommunications personnel shall resolve, but report as indicated above.

    - External or Network Service Problem – The MAC shall report the problem to the toll-free carrier and also report it to CMS as indicated above.

    - Some other issue (*for example,* data *is* unable to be retrieved from a back-end system, such as CWF).

MACs shall involve personnel from the PNS contractor, if needed, to answer technical questions, to escalate issues for resolution, or to facilitate discussions with the toll-free carrier's Help Desk. MACs shall also use the toll-free carrier's online system to review documentation and track trouble tickets.

4. Within 1 hour after resolution, the MAC shall send an *email* of resolution to the Service Reports mailbox at servicereports@cms.hhs.gov.

See section *80.2.3.7* of this chapter for the monthly PCID reporting requirements related to telecommunications service interruptions.

30.4.5 - Requesting Changes to Telephone Configurations

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

The ongoing management of the entire provider toll-free system requires a process for making changes, which may be initiated by either the MAC or CMS. CMS' PNS contractor shall process all change requests associated with the toll-free network (for example, adding or removing channels or T1s, office moves, routing changes). Any CMS-initiated changes (for example, adding lines, removing lines, reconfiguring trunk groups) will be based upon an analysis of telephone performance data and traffic reports. CMS reserves the right to initiate changes based on this information.

If a MAC requests a change, it shall send the request and an analysis of its current telephone environment (including a detailed traffic report) specific to the service being requested that shows the need for changes to the telephone system (for example, additional lines, trunk group reconfiguration). This information shall be sent to the Service Reports mailbox at servicereports@cms.hhs.gov. This information shall be gathered through the MAC's switch and through the toll-free carrier's reports. Based on technical merit and availability of funds, CMS will review the recommendation and make a determination. In cases where the

request is approved, CMS will forward the approved requests to the designated agency representative for order issuance.

Even if circumstances do not require immediate resolution, MACs shall make requests for changes to telephone configurations to CMS in a timely manner. MACs shall send requests to CMS at least 60 calendar days before the requested effective date of the change so all involved parties have the opportunity to review the request, ask questions and receive answers, and resolve issues.

30.4.6 - Hours of Operation

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

MACs shall make CSR telephone service available to callers continuously during normal business hours, including lunch and breaks.

Normal business hours for live telephone service are 8:00 a.m. through 4:00 p.m. for all time zones of the geographical area serviced, Monday through Friday. Where provider call volume supports it, the normal business hours may be shifted for all time zones. MACs adopting alternate hours shall request approval for this alternate schedule by sending an *email* to the Service Reports mailbox at servicereports@cms.hhs.gov within 30 calendar days of the start of the contract year, or 1 month in advance of the anticipated change within a contract year.

MACs do not need annual approvals for previously approved alternate schedules if there are no additional changes/updates for the hours of operation.

30.4.7 - Providing Busy Signals

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

PCC customer premise equipment shall not be configured/programmed to return "soft busies." PCCs shall only provide "hard" busy signals to the toll-free network. At no time shall any software, gate, vector, application, IVR system, *or* ACD/PBX accept the call by providing answer back supervision to the service provided by the GSA's designated contractor and then providing a busy signal to the caller and/or dropping the call. MACs shall optimize their inbound toll-free circuits to ensure the proper ratio of circuits to existing full-time equivalent (FTE) telephone CSRs.

30.4.9 – Provider Telephone Line Staffing

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

Provider telephone line(s) staffing, including permanent and temporary staff, shall be based on the pattern of incoming calls per hour and day of the week, ensuring adequate coverage of incoming calls is maintained throughout each workday for each geographic area serviced within a MAC's jurisdiction. In order to provide adequate coverage of incoming calls throughout the day, PCCs have the discretion to end a telephone inquiry if the CSR is placed on hold for 2 minutes or longer. MACs shall not disconnect a call prior to 2 minutes. MACs shall, if possible, give prior notice to the provider that the CSR may disconnect if the CSR is placed on hold for 2 minutes and shall politely advise the provider of the best time to call back with all the required information at hand.

In circumstances where the PCC is experiencing high call volumes *or* performance issues, the PCC has discretion in allowing CSRs to be placed on hold. When this happens, CSRs shall advise providers that, unfortunately, due to the call volume experienced by the PCC, they are unable to be placed on hold. However, CSRs, at a minimum, shall politely advise providers of the best time to call with all the required information at hand. In consideration of providers, when the PCC is contacted with the appropriate information more than once about the same transaction, MACs shall exercise discretion in assuring prompt completion of inquiries.

30.4.10.1 – Quality Call Monitoring (QCM)

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

See section *30.4.12.2* of this chapter for the guidelines and requirements of quality call monitoring.

30.4.10.2 – Quality Assurance Monitoring (QAM)

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

MACs shall provide the CMS independent monitoring contractor with remote access to their quality monitoring systems (such as NICE, QFiniti, and Verint), enabling CMS to conduct more comprehensive QAM. CMS and its independent monitoring contractor will take reasonable measures, as necessary and appropriate, to ensure the security of this access. The secured access will provide increased capability to monitor provider calls for accuracy, completeness, adherence to the Privacy Act, and professionalism.

CMS established a Communications Relational Assurance Database (CRAD) at https://crad.pccqualitymonitoring.com/login. The CRAD is accessed by CMS and MAC staffs to review QAM Scores, Issues, Rebuttals, and Reports.

MACs shall attest at the start of each contract year they are in compliance with CMS requirements for QAM as stated in this chapter. To attest, MACs shall create, sign, scan, and save as a .pdf file an Annual MAC QAM Attestation document (see the document requirements below). MACs shall submit the .pdf file as an attachment to an *email* they shall send to the QAM mailbox at QAM@cms.hhs.gov, subject: "Annual MAC QAM Attestation document." MACs shall submit their first Annual MAC QAM Attestation document when requested by CMS. Thereafter, MACs shall submit their Annual MAC QAM Attestation document within 15 business days after the start of each of their contract years.

The Annual MAC QAM Attestation document shall:

- Be prepared on MAC letterhead that includes the MAC's business address and clearly indicates the applicable MAC jurisdiction.

- Be titled, "Annual MAC QAM Attestation for [time period]." For the first Annual MAC QAM Attestation document, MACs shall enter, as the time period, the dates specified by CMS in CMS's request for the document. For subsequent Annual MAC QAM Attestation documents, MACs shall enter the start and end dates of the applicable contract year.

- Include the following statement: "This Attestation certifies that MAC Jurisdiction [jurisdiction identifier] has a quality monitoring system in place that meets the requirements of IOM Pub. 100-09, Chapter 6."

- Be signed and dated by the Manager of the MAC's PCC.

In addition to submitting the Annual MAC QAM Attestation document, each MAC shall complete the CMS Environment Change Control Form and upload it to the CRAD by the fifth of each month to alert the independent monitoring contractor about any hardware and software patches/maintenance/upgrades so there are no connectivity issues. MACs shall select one of the following Form Types when uploading the form:

- Planned Change – the MAC plans to change its QAM environment in the upcoming month. Such changes would include the application of hardware, firmware, or software patches/maintenance, *or* upgrades to its QAM environment. The form shall describe the upcoming change(s) and the scheduled implementation date(s) this helps to ensure the CMS independent monitoring contractor does not experience QAM quality monitoring system issues or problems after the change(s) is implemented. The CMS QAM Environment Change Control Form is available in the CRAD under Forms Upload. Prior to implementing any planned change, the MACs shall conduct all necessary testing of the QAM environment to ensure proper and continuous operations of QAM.

- No Planned Changes- the MAC does not plan to make changes for the upcoming month; MACs must upload the form to reflect they do not have any planned changes.

- Adverse Event - the MAC experiences an unexpected event that adversely affects, or has the potential to adversely affect, QAM. The form shall include a description of the unexpected event, the adverse or the potential adverse effect on QAM, and actions being taken to mitigate or eliminate it. The MAC shall send the form within one hour after they detected the adverse event if they detected it during normal business hours, or by 9:00 a.m. *ET* the next business day if the adverse event occurred after business hours the night before or before business hours that day. The MAC shall send at least one daily follow-up to the CRAD providing a status until the adverse effect has been eliminated.

- Emergency Change – the MAC has an emergency and must take immediate action that will effect (adverse or otherwise) the QAM environment. MACs shall upload the form within two business days after the emergency situation.

If additional Environment changes occur throughout the month, the MACs shall upload additional forms to the CRAD as needed. This will alert the independent monitoring contractor about any monthly hardware and software patches/maintenance/upgrades in order to avoid any connectivity issues.

CMS, the Independent Monitoring Contractor, and the MACs work together to complete QAM. MACs shall assist CMS in QAM by completing the following:

- Recording audio and video for at least 30 percent of incoming CSR-handled calls (while working in the PCC or remotely) for the line of business of the jurisdiction (A/B, HH+H, or DME).

- Establishing current month queries that will provide the CMS independent monitoring contractor with access to the audio and video recordings for the appropriate incoming CSR-handled calls for the line of business of the jurisdiction (A/B, HH+H, or DME).

- Ensuring the universe of calls available for QAM includes audio and video recordings for at least five calls handled by each telephone CSR in the PCC for each jurisdiction per month (this may require putting in place special accommodations and processes for QAM of remote telephone CSRs) unless circumstances exist that warrant an exception from CMS.

- Making available to the CMS independent monitoring contractor the audio and video recordings of each call within two business days from the date of the call.

- Retaining audio and video recordings for all calls for a period of 120 calendar days from the date of the calls.

- Retaining audio and video recordings for all calls scored for QAM during a contract year for a period of 150 calendar days past the contract year end date. MACs shall identify calls scored for QAM by utilizing the Scorecard Report, which is available in the CRAD.

MACs shall follow the requirements in this section and those in the QAM Handbook in conducting QAM operations. The QAM Handbook is available under Resources in the CRAD.

30.4.10.3 – Remote Monitoring

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

MACs shall maintain the ability for CMS to remotely monitor live provider calls in their entirety by specific workstation (CSR), next call from the network or next call from the telephone CSR queue, *or* specific business line. MACs shall make remote monitoring instructions, access codes, and telephone CSR IDs

available to CMS upon request. CMS will take reasonable measures to ensure the security of this access (for example, passwords will be controlled by one person).

30.4.12.2 – Telephone Responses to Provider Inquiries -- QCM Program Minimum Requirements

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

A MAC's monitoring program shall, at a minimum, follow the requirements and performance standards as set forth in the QCM program. MACs shall monitor and report data for all types of calls handled by the PCC. (See section 30.4.12.1 of this chapter.) Copies of the official QCM scorecard, User Guide, Handbook, and Scoring Chart can be obtained through the QCM database. A detailed description of the evaluation criteria can be found on the official QCM Scoring Chart and Handbook. In addition, a MAC's telephone inquiries monitoring program shall ensure:

1. All MAC staff handling provider calls are monitored throughout the month. This includes calls handled by temporary employees, part-time employees, higher-level CSRs, and the PRRS.

2. Each PCC monitors five calls per telephone CSR per month per jurisdiction.

3. Calls monitored are from providers and are of the type the telephone CSR's level typically handles (*for example*, Level 1, Level 2, PRRS).

4. Responses monitored are sampled randomly so as to be representative of varying days of the week, weeks of the month, and monitors/auditors.

5. Monitoring is done using the official QCM scorecard and Scoring Chart and recorded in the QCM database.

6. All responses are evaluated and scores are entered into the QCM database by the 10th day of the following month. For example, responses scored in December shall be entered into the QCM database by January 10th.

7. Telephone CSR trainees and new telephone CSRs are adequately monitored. However, scores for telephone CSR trainees will be excluded from QCM performance for one 30-calendar-day period following the end of their formal classroom training.

8. Monitoring is done in a way that is conducive to the success of the monitoring program.

9. Timely feedback is provided to those monitored.

10. PCC staff is properly educated about the program and its use.

11. All telephone CSRs, Reviewers, and Supervisors have copies of the official QCM scorecard, Scoring Chart, and Handbook.

12. The QCM Handbook and User Guide are followed.

30.4.12.3 – Recording Calls

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

MACs shall record incoming CSR-handled calls (while working in the PCC or remotely) as part of their contract with CMS to ensure the quality of telephone inquiries. MACs shall provide verbal notification at the beginning of the call announcing that the call may be monitored or recorded for training purposes. If a provider objects to having the conversation recorded, the telephone CSR will inform the provider the MAC

records calls for the sole purpose of quality assurance and training and the recording system cannot be stopped by an individual telephone CSR. If the provider still objects and does not want to continue with the recorded call, the telephone CSR will inform the provider that they may send the inquiry in writing. The telephone CSR shall then provide the appropriate address for written correspondence.

When recording for QCM purposes, MACs shall maintain recordings for an ongoing 90-calendar-day period during the year. All recordings shall be clearly identified by date and filed in a manner that allows for easy selection for review. MACs shall dispose of any recordings no longer used in a manner that would prohibit someone from obtaining any personally identifiable information (PII) *or* protected health information (PHI) from the recordings.

30.4.12.4 – QCM Calibration

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

Calibration is a process to help maintain fairness, objectivity and consistency in scoring calls by staff within one or more PCCs.

MACs shall participate in all national QCM calibration sessions when organized by CMS. National sessions may be held once per quarter. If CMS organizes sessions, CMS will send appointments to all PCCs via the PCUG electronic mailing list. (See section10.1 of this chapter.)

When requested by CMS, on a quarterly basis, MACs shall submit to CMS five telephone calls for each line of business in their jurisdiction—A/B, HH+H, or DME. Calls shall be submitted by the following dates:

- March 1.
- June 1.
- September 1.
- December 1.

If these dates fall on a weekend or holiday, the MAC shall submit the calls on the next business day. These calls shall be actual provider inquiries responded to within the prior MAC contract quarter. Rather than looking for perfect calls, CMS would prefer calls that generate discussion among the MAC sites. This includes calls where CSRs demonstrate exceptional or unacceptable behavior.

All calls submitted for consideration for calibration shall have been scored using the QCM tool and entered into the QCM database. All calls submitted shall have a copy of the QCM scorecard attached. CMS shall issue a Technical Direction Letter (TDL) when requesting MACs to submit calls for calibration. The TDL will provide instructions to the MACs on how to format and submit the calls.

MACs shall conduct monthly internal calibration sessions. MACs with reviewers at more than one call center location shall have all their reviewers participate in the monthly calibration sessions. PCCs shall keep written records of their internal calibration.

30.5 - Provider Written Inquiries

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

All provider written inquiries, shall be handled consistently for accuracy, professionalism and timeliness. Every provider written inquiry shall receive a final response that accurately and completely addresses the issue(s) contained in the incoming inquiry. For provider written inquiries received that could be handled by the IVR system, such as claim status and eligibility inquiries, MACs shall include language in the responses to those inquiries that the information being requested is available on the IVR. (See section 50.1 of this chapter.) MACs also have the discretion to encourage providers to use the *Web*-based provider portal if the functionality exists. Additionally, responses should include information about relevant training seminars or computer-based training on the MAC's provider education website if that is appropriate to the topic of the inquiry.

MACs handle the following three types of provider written inquiries:

1. General – provider written inquiries handled within the PCC that do not require extra research. They are subject to the performance standards in this section. Timeliness standards for general provider written inquiries are defined in section 70.3.2.1 of this chapter.

2. PRRS – provider written inquiries handled within the PCC that require extra research and cannot be handled by the general inquiries staff. (PRRS inquiries also include all beneficiary inquiries referred to the MAC from Call Center Operations (CCO). See chapter 2 of this manual for information about beneficiary written inquiries.) All PRRS provider written inquiries are subject to the performance standards in this section. Timeliness standards for PRRS provider written inquiries are defined in section 70.3.2.2 of this chapter.

3. Congressional – provider written inquiries the MAC receives either directly from a Congressional office or from either CMS Central Office or a CMS Regional Office. Congressional provider written inquiries are subject to the performance standards in this section. Timeliness standards for Congressional written inquiries are defined in section *70.3.2.4* of this chapter.

Written responses to provider inquiries shall be prepared in the language of the incoming inquiry.

If written responses to provider inquiries contain sensitive or protected information, such as PHI or PII, MACs shall apply reasonable safeguards in responding to protect that information from inappropriate use or disclosure. See section *30.5.5* of this chapter regarding specific requirements for electronic responses to provider inquiries.

MACs may use the following methods to respond to provider written inquiries regardless of the way the inquiry was received:

1. Postal - hardcopy letters sent through the USPS

2. Telephone – outbound calls to providers

3. Electronic – electronic responses sent through email, fax, internet portals or other approved electronic mechanisms

30.5.4 - Telephone Responses to Provider Written Inquiries

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

MACs may respond to general provider and PRRS provider written inquiries by telephone within 45 business days of receipt of the inquiry. MACs shall use their discretion when identifying which provider written inquiries (for example, provider correspondence that requires a general response) can be responded to by telephone.

For tracking and evaluation purposes, the MAC shall develop a report of contact for each telephone response to a provider written inquiry. The report of contact shall be retained in the same manner and time frame as written responses. All reports of contact shall contain the following information:

- Provider name; when applicable, MACs shall also include the Name of the provider's representative *or* billing company name that contacted the PCC on the provider's behalf.
- Provider telephone number.
- Provider number (National Provider Identifier [NPI] or Provider Transaction Access Number [PTAN]).
- Date of contact.
- Internal inquiry control number.

- Subject/nature of inquiry.
- Summary of discussion.
- Status: closed, pending research, open.
- Follow-up action required (if any).
- Name of the written CSR who handled the inquiry.

If the provider requests a copy of the report of contact, the MAC shall send a response letter containing all the information in the "Summary of Discussion" section of the report of contact. MACs may send the information via *email* or fax, if requested by the provider; if the *email* or fax response would contain any protected or sensitive information, such as PII or PHI, MACs shall follow the requirements of section *30.5.5* of this chapter. It is not acceptable to send the report of contact itself. All timeliness and quality guidelines for a written response apply to the response sent.

If the MAC cannot reach the provider by telephone, the MAC shall develop a written response within 45 business days of receipt of the incoming inquiry. It is not acceptable to leave a message/response on the provider's voicemail.

30.5.5 – Electronic Responses to Provider Written Inquiries

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

In some cases, provider written inquiries can be responded to by *email*, fax, provider internet portal or through other approved electronic mechanisms. Since all represent official correspondence with the public, it is paramount MACs use sound practices and proper etiquette when communicating electronically. MACs shall ensure electronic responses follow the same timeliness and quality guidelines that pertain to all provider written inquiries. MACs shall transmit electronic responses that contain protected or sensitive information in accordance with the CMS Acceptable Risk Safeguard controls *and* other CMS directives for secure communications.

When responding via fax, MACs shall first confirm the fax number with the intended provider recipient. MACs may pre-program frequently used fax numbers directly in their fax machines to avoid misdirecting information.

Email content, including attachments, must be section 508 compliant. (See https://www.cms.gov/About-CMS/Agency-Information/Aboutwebsite/Policiesforaccessibility for information about section 508 compliancy.)

30.5.7 - Guidelines for High Quality Responses to Provider Written Inquiries

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

MAC's written provider inquiry responses shall be professional accurate, complete, responsive, and clearly written.

MACs shall ensure written provider inquiry responses adhere to the basics of the Plain Writing Act of 2010, to the extent practicable. The Plain Writing Act of 2010 requires all federal agencies and, by extension, their contractors to use plain writing in any document that (1) is necessary to obtain a federal benefit or service, (2) gives information about a federal benefit or service, *or* (3) explains how to comply with federal requirements. MACs shall refer to the document entitled, "Toolkit for Making Written Material Clear and Effective" to help meet the requirements of the Plain Writing Act of 2010. The Toolkit is a CMS health literary. It is available at https://www.cms.gov/Outreach-and-Education/Outreach/WrittenMaterialsToolkit/index.html.

In addition, MACs shall use the CMS Writing Guide to help prepare written responses to provider inquiries. The Writing Guide can be found in the Documentation Section of the QWCM database.

Because the Toolkit and CMS Writing Guide does not address every issue, MACs may also use other resources (for example, grammar guides) to supplement their writing process.

30.5.8 – Stock Language/Form Letters

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

Periodically, CMS may request MACs submit their most frequently used stock language *or* form letters they send to providers. CMS will review the stock language *or* form letters and provide suggestions to improve the language. If CMS determines the stock language *or* form letters have errors or issues affecting the readability *or* meaning of the response, MACs shall make revisions within 60 business days from the day CMS gave notice. Please refer to the Toolkit and the CMS Writing Guide described in section *30.5.7* of this chapter for additional guidance.

30.5.9.2 – QWCM Calibration

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

Calibration is a process to help maintain fairness, objectivity and consistency in scoring written responses to provider inquiries prepared by staff within one or more PCCs.

MACs shall participate in all national QWCM calibration sessions when organized by CMS. If sessions are organized by CMS, CMS will send appointments to all PCCs via the PCUG electronic mailing list. (See section 10.1 of this chapter.)

When requested by CMS, on a quarterly basis, MACs shall submit to CMS five written provider inquiry cases for each line of business in their jurisdiction—A/B, HH+H, or DME. Cases shall be submitted by the following dates:

- March 1.
- June 1.
- September 1.
- December 1.

If these dates fall on a weekend or holiday, the MAC shall submit the cases on the next business day. The cases shall be actual provider written inquiries responded to within the prior MAC contract quarter. In addition, all cases must have been scored using the QWCM tool and entered into the QWCM database. Each case shall contain the incoming inquiry, response, screenshots showing any associated research done in order to supply the response, and a copy of the QWCM scorecard. CMS shall issue a TDL when requesting MACs to submit cases for written inquiry calibration. The TDL will provide instructions to the MACs on how to format and submit the cases.

MACs shall conduct monthly internal calibration sessions. MACs with reviewers at more than one location shall have all the reviewers participate in the monthly calibration sessions. PCCs shall keep written records of their internal calibration sessions, which shall include attendance lists. These records shall be provided to CMS upon request.

30.7 - PRRS Operations

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

MACs shall maintain PRRS operations as a joint effort between the PCC and POE units to provide consistent, accurate, and timely information to Medicare providers regarding complex inquiries that cannot be answered by the MAC's telephone or written inquiries staff *or* require significant research. Therefore, MACs shall design and staff the PRRS component so questions beyond the expertise of the CSRs which require more time to adequately research can be answered in a timely and efficient manner. The PRRS staff shall also identify provider education topics based on the complex inquiries received if the MAC determines general provider education on these specific topics would be practical and useful to the provider community

and reduce inquiries. (The PRRS shall also handle complex beneficiary inquiries that cannot be resolved by CCO.)

For workload reporting purposes, upon referral of a provider telephone inquiry to the PRRS, the telephone inquiry shall be closed and a written inquiry shall be opened. A written inquiry that is referred to the PRRS shall remain open and only be counted once.

30.7.1 - Complex Provider Inquiries

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

Once a provider inquiry is referred, the PRRS shall take ownership of the inquiry and research and resolve it. The PRRS staff shall respond to the more complex provider questions including those related to coverage policy, coding, and payment policy. Staff shall use the full spectrum of the MAC's resources (*for example,* MAC provider education website, MR staff, MAC medical directors, claims processing staff), and CMS resources (*for example,* Internet-Only Manual, MAC instructions, training packages, Medicare laws and regulations, the CMS website, MLN products or content, provider-specific web pages, and CMS Regional Office staff) when researching answers to complex inquiries.

The PRRS shall include at least one certified coder to ensure adequate coding expertise although that staff does not have to be assigned exclusively to the PRRS. DME MACs are exempt from the requirement to have a coding expert since the PDAC resolves DME coding questions. The coding questions appropriately answered by the PRRS are those concerning the underlying Medicare payment or coverage policy. Pure coding questions (not related to a Medicare payment or coverage policy) shall be answered with referrals to the correct organizations such as the American Medical Association and the American Hospital Association's Coding Clinic. For more information, see section *30.3.1* of this chapter.

30.7.2 - Complex Beneficiary Inquiries

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

Complex beneficiary inquiries will be identified and referred to the PRRS by CCO or the CMS Regional Office via the Next Generation Desktop (NGD) and may include, but are not limited to, telephone, written, and *email* inquiries. See chapter 2 of this manual for information about handling, controlling, and responding to beneficiary inquiries.

30.8 - Provider Inquiry Tracking

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

CMS requires MACs to track and report the reason for telephone and written inquiries using categories and subcategories found in the CMS Standardized Provider Inquiry Chart. The chart can be found at https://www.cms.gov/Medicare/Medicare-Contracting/ContractorLearningResources/Downloads/Standardized_Provider_Inquiry_Chart.pdf. MACs also have the flexibility to add contractor-specific subcategories to track provider inquiries that may arise within its jurisdiction (See Section *30.8.D*).

Inquiry logging, tracking and reporting applies for all PCC call center locations (i.e., if a MAC has multiple call center locations), all PCC triage levels (*for example,* Level 1, Level 2, PRRS), and all provider inquiries handled by the PCC (i.e., general inquiries, escalated inquiries within CSR levels, Congressional inquiries), including other inquiries handled within the PCC (*for example,* PE, Appeals, EDI, Adjustment/Reopening, MR, Audits and Reimbursement), and in accordance with the MAC's SOW.

A. Inquiry Tracking Requirements

MACs shall maintain an Inquiry Tracking System for all provider inquiries that identifies at a minimum:

1. Type of inquiry (telephone, written, walk-in).

2. Person responsible for answering the provider inquiry

3. Information about the inquirer (name, NPI and PTAN).

4. Nature of the inquiry (according to the categories and subcategories in the CMS Standardized Provider Inquiry Chart and contractor-specific subcategories, when appropriate). The nature of the inquiry relates to the reason or the issue that caused/originated the provider contact to the PCC.

5. Disposition of the inquiry, including referral to other PCSP areas or areas elsewhere at the MAC (for example, MR, MSP) and in the referral information about how to contact the provider in case there is a need to clarify the question.

6. Timeliness of the response.

B. Inquiry Tracking Data Use

MACs shall use inquiry tracking data to enhance and improve their PCSP. Inquiry tracking data at the PCSP is/can be used to:

1. Develop reports (CMS encourages MACs to review inquiry tracking data as often as possible to prevent inquiry volume from rising, to identify patterns of providers' inquiries, and to monitor provider inquiry trends).

2. Identify areas for broader provider and CSR education.

3. Conduct analysis of the number and types of inquiries to develop FAQs to be posted on the MACs' provider education websites.

4. Assess, evaluate *and* monitor the effectiveness and efficiency of Medicare and MAC internal and external policies, process *and* procedures.

5. Assess *and* document enhancements and innovations to improve the Medicare provider customer service experience (*for example,* provider self-service technology, POE website content), effectiveness *and* efficiency of operations, when appropriate.

6. Assess/estimate PCC staff skill level needs based on the frequency, complexity *or* trends on provider inquiries

7. Identify areas or processes within the MAC's organization that may need follow-up (*for example,* to maintain/reduce provider inquiries, to meet response and/or processing targets, to meet POE objectives/targets, to reduce provider burden).

C. Requirements for Classifying the Nature of Inquiries

MACs shall follow these additional requirements when classifying the nature of the provider inquiries received:

1. Use categories and subcategories in the CMS Standardized Provider Inquiry Chart to classify and log all written and telephone inquiries. MACs develop and implement contractor-specific subcategories to capture an additional level of detail, if necessary, to support CMS in developing new inquiry types, and to identify provider education or CSR training needs.

2. Use categories and subcategories in the CMS Standardized Provider Inquiry Chart to capture the reason/issue for the inquiry, not the status, the disposition (*for example,* Referrals to the

IVR), or the action taken. To capture the most relevant and accurate inquiry data when logging a provider inquiry in the MAC Inquiry Tracking System, all PCC staff shall exercise best judgement in identifying the true issue of the provider contact to the PCC.

3. Track multiple issues raised by a provider during a single call or in a single written inquiry, as long as MACs are able to identify the information related to an inquiry (See Section *30.8.A*) and to comply with the inquiry tracking reporting requirements in this chapter.

4. Report inquiries that do not fall under any of the existing predefined subcategories using the "Not Classified" field for the appropriate category (with the exception of the "General Information" category that uses the "Other Issues" subcategory instead of "Not Classified"). However, MACs shall minimize the number of "Not Classified" and "Other Issues" inquiries by suggesting updates to the CMS Standardized Provider Inquiry Chart or by creating contractor-specific subcategories (See Section *30.8.D*).

D. Guidance for Creating Contractor-Specific Subcategories

MACs shall adhere to the following requirements when creating contractor-specific subcategories:

1. MACs shall maintain and promote a dynamic process to identify and create contractor-specific subcategories that could potentially lead to new or enhanced inquiry types when the need arises. Although no specific target will be implemented at this time, MACs shall create contractor-specific subcategories to continuously identify and to reduce the number of inquiries that do not fall under any of the existing standardized inquiry categories/subcategories CMS will monitor contractor-specific subcategories to assess inquiry trends *and* determine future inquiry developments.

2. MACs shall not create contractor-specific subcategories when the CMS Standardized Provider Inquiry Chart provides existing standard existing subcategories that can be used to log and report those inquiries. Example: A MAC should not create a contractor-specific subcategory called "HCPCS" under the "Coding" category because the chart already provides "Procedure Codes" as one of the standard subcategories under "Coding."

3. MACs shall assign a specific descriptive name and a descriptive definition to each contractor-specific subcategory they create and report to CMS. This is essential to identify what is being reported. Do not use "Subcategory 1" or "Subcategory 2" or "Contractor-Specific" as the descriptive names. CMS encourages the MACs to consider using the following when creating contractor-specific subcategories:

    - Number(s) of an MLN Matters Article that describes the nature of the inquiry
    - RARC/CARC code combinations normally included in CRs.
    - Shared Systems/CWF edits codes with their definitions.
    - Specific claim improper payment issues (for example, specific coding error, specific missing information to determine medical necessity to justify level of service)
    - Specific claim submission errors (for example, specific missing documentation, lack of signature)

4. MACs shall create contractor-specific subcategories for issues that have a significant impact on their operations *or* represent a significant amount of inquiries related to a topic.

5. MACs shall regularly review their contractor-specific subcategories and deactivate them when there is low inquiry volume (less than 10 inquiries) for three months in a row. This does not apply to those contractor specific sensitive subcategories related to Program Integrity or specific to POE operations.

6. MACs shall not create contractor-specific subcategories under the "Temporary Issues" category that could be added as contractor-specific subcategories under a more related category. Example: A MAC should not create a contractor-specific subcategory called "HMO Refunds" under the "Temporary Issues" category because a subcategory of "HMO Refunds" would more appropriately belong under the "Financial Information" category.

7. MACs shall not use provider types/specialties as contractor-specific names since inquiry tracking reports can be run by provider types/specialties (*for example,* hospitals, home health agencies physicians and cardiology). However, CMS encourages MACs to use a POE training topic as a contractor-specific subcategory.

8. MACs shall add a contractor-specific subcategory as CMS directs. Although CMS does not plan to use this option frequently, CMS may need to immediately assess specific provider inquiries. In this instance, CMS may add a contractor-specific subcategory in the PCID Contractor-Specific Subcategories Module.

30.8.1 – Updates to the CMS Standardized Provider Inquiry Chart

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

CMS will update the chart as needed, including adding subcategories under the Temporary Issues category to track inquiries that may be short-lived. Changes to the CMS Standardized Provider Inquiry Tracking Chart, including reporting timeframes, will be issued through CRs or TDLs. Upon issuance MACs shall update their MAC Inquiry Tracking Systems with any updates or additions (See Section *30.8.A* of this chapter). Between updates, MACs may create and add contractor-specific temporary subcategories for their jurisdiction(s) if their call volume dictates. Per section *30.8.D* of this chapter, CMS may also request MACs to assess recommended inquiry types using contractor-specific subcategories.

The latest version of the CMS Standardized Provider Inquiry Tracking Chart is located at https://www.cms.gov/Medicare/Medicare-Contracting/ContractorLearningResources/Downloads/Standardized_Provider_Inquiry_Chart.pdf.

As necessary, MACs shall recommend changes to the CMS Standardized Provider Inquiry Chart, including modifications to existing categories and subcategories and the addition of new inquiry categories and subcategories. MACs shall submit changes or comments related to the CMS Standardized Provider Inquiry Chart via the Provider Services mailbox at providerservices@cms.hhs.gov. Suggested changes shall include the following information:

- Name of the proposed category *or* subcategory.
- Definition of the proposed inquiry category *or* subcategory.
- Examples of questions received where the proposed inquiry category *or* subcategory could be used.
- Information about the number of inquiries the MAC received associated with the proposed category *or* subcategory.

30.8.2 – MAC Inquiry Tracking Self-Data Review and Self-Validation Process

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

MACs shall document inquiry tracking data review activities and validation procedures, including major components of the process (*for example,* analyzing inquiry trends), developments and/or enhancements (*for example,* Inquiry Tracking System, inquiry types, CSR desk procedures to log inquiries, resources to complement inquiry analysis), and identification and mitigation for areas vulnerable to errors.

At least monthly, MACs shall analyze their PCSP inquiry data. MACs shall look at changes in the inquiry volume/proportion/trends and by provider specialty.

CMS encourages MACs to explore additional MAC resources to adopt focused, effective, and efficient analyses practices. This may include collaborating with other MACs.

1. Monitoring of "Not Classified" Inquiries
   MACs shall regularly analyze the "Not Classified" subcategories to ensure CSRs do not report a high number of similar inquires in these subcategories when the MAC should create a contractor-specific subcategory instead.

2. Provider Inquiry Proportional Changes
   MACs shall monitor their inquiry tracking volume to determine the proportional changes over at least the previous month and with the same period last year to identify the following:

   - Whether inquiry data is in correct categories/subcategories
   - New patterns, "spikes" and trends of inquiry types

3. Inquiry Tracking Rate
   MACs shall monitor their Inquiry Tracking Rate and compare:

   - Telephone Inquiries - (Total Telephone Inquiries in the Inquiry Tracking System/ Total PCC Calls Answered by CSRs) multiply by 100
   - Written Inquiries - (Total Written Inquiries in the Inquiry Tracking System/ Total Provider Written Correspondence Received to be Answered by the PCSP) multiply by 100

   CMS encourages each MAC to increase their rate.

4. MAC Provider Inquiry Tracking Updates
   MACs shall send CMS Provider Inquiry Tracking Updates to providerservices@cms.hhs.gov with the subject line "MAC Provider Inquiry Update," when the MAC finds:

   - Root causes for abrupt changes *or* "spike" throughout the month and any action take related to the issue.
   - Root causes for inquiry trends that last for at least two or more consecutive months and any actions taken related to the issue.

5. Inquiry Tracking Report Review and Validation
   MACs shall adhere to the requirements in Section 80.2.3.1 of this chapter to review the accuracy of the Inquiry Tracking Report before its submission to CMS. This includes ensuring all new contractor-specific subcategories are properly documented before submitting data to CMS.

30.9 - Fraud and Abuse

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

The term Medicare beneficiary identifier (*MBI*) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, *MBI* references both the Health Insurance Claim Number (HICN) and the MBI during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

MACs shall immediately send any provider inquiry or complaint about fraud and abuse, along with a referral package, to the Unified Program Integrity Contractor (UPIC). The referral package shall include:

1. Provider/Supplier name, NPI, provider/supplier number, and address.
2. Type of provider involved in the allegation and the perpetrator, if an employee of the provider/supplier.
3. Type of service involved in the allegation.

4. Place of service.
5. Nature of the allegation(s).
6. Timeframe of the allegation(s).
7. Narration of the steps taken and results found during the MAC's screening process (discussion of beneficiary contact, if applicable, information determined from reviewing internal data, etc.).
8. Date of service, procedure code(s).
9. Beneficiary name, Medicare Beneficiary Identifier (MBI), telephone number.
10. Name and telephone number of the MAC employee who received the complaint.

This is not an all-inclusive list, the UPIC may request additional information to resolve the complaint/referral or during the subsequent development of a related case (*for example,* provider/supplier enrollment information).

The MAC shall maintain a copy of all referral packages.

40 - PCSP Staff Development and Education

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

MACs shall be fully responsible for the education, development, evaluation, and management of PCSP staff. This shall be accomplished by MACs providing initial and ongoing education and training of all PCSP staff. Training for the PCSP staff should vary due to the wide spectrum of subjects, resources and tasks handled by the PCSP, and due to the level of complexity *and* nature of the workload the PCSP staff is or will be responsible to handle. In addition, MACs shall have an education and development plan in place and documented for each staff member that addresses the education of new staff and the continued education and development of existing staff. Education and reference materials and tools, as well as policy manuals, shall be made readily available and accessible to all staff. MACs shall ensure that educational opportunities are afforded to all PCSP staff, and that staff are afforded promotion pathways through the design and implementation of the PCC and POE functions.

40.2 - PCC Staff Development and Training

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

MACs shall provide training for all new PCC personnel and refresher training updates for existing personnel. This training shall enable the CSRs to answer the full range of customer service inquiries and equip them with the knowledge and tools to meet CMS's performance requirements. MACs shall have a training evaluation process in place for new hires and ongoing training to certify the CSR is ready to independently handle inquiries on the topics covered.

Ongoing data analysis shall be used to determine training topics for PCC staff. MACs shall consider data sources such as inquiry analysis, quality scores, monitoring results, and error rate data analysis when developing training topics. The PRRS shall be involved in the development of training materials for the general inquiries staff. Training shall be tailored to the level/degree of specialization of the CSR. In addition to formal classroom training, regular feedback to CSRs and PRRS regarding their performance shall be a part of the staff development at the PCC.

MACs shall ensure CSRs are equipped with the tools they need to handle providers' inquiries while meeting CMS's performance requirements for telephone and written provider inquiries. These tools, at a minimum, shall include the use of the CMS website, the MAC's provider education website and CMS-produced provider education materials.

CMS will also continue to increase and improve the consistent national training information available to CSRs. When available, MACs shall use training materials provided by CMS. Within 5 business days after

receipt of CMS-developed standardized training materials or other CMS-developed information for use by CSRs, MACs shall initiate processes to implement these materials for all CSRs on duty and to ensure these materials will be implemented for those hired in the future. Since the development of these materials will be done by CMS, there will not be any costs to the MACs to use these materials. MACs may supplement the CMS-developed materials with their own materials as long as there is no contradiction of policy or procedures.

40.2.1 - Required Training for PCC Staff

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

In addition to the training topics determined by MACs, all MACs shall train their CSRs on the following topics at least once during the contract year. If a CSR is hired after the training has occurred for the year, MACs shall include the training as part of their new hire training. MACs shall train their CSRs on the following:

1. How to find, navigate and use their provider education website (including the MAC's FAQs, the schedule of upcoming outreach and education events, and all available online education) and other self-service tools, to include the IVR system and the provider Internet-based portal.

2. How to find, navigate and use the CMS website. This includes the CMS FAQs and all online education resources provided through the MLN at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.

3. How to find, navigate, and use the PCSP website located at https://www.cms.gov/Medicare/Medicare-Contracting/FFSProvCustSvcGen/Spotlight. This website strengthens MACs' PCSPs by providing support information and documents, performance data, and helpful resources.

4. The MLN. (See section 20.4 of this chapter.)

5. The CMS Standardized Provider Inquiry Chart categories, subcategories, and definitions, and they shall be trained to accurately log inquiry types according to the CMS Standardized Provider Inquiry Chart in the tracking system used by the MAC. The CMS Standardized Provider Inquiry Chart is in the PCID database under Documentation.

6. The Privacy Act of 1974 and HIPAA.

7. The use of the Desk Disclosure Reference (DDR) Guide. The DDR Guide provides MACs with information they need to authenticate Medicare providers and the access and disclosure guidelines to be followed when disclosing elements of PII or PHI to authenticated Medicare providers. The DDR Guide is available in the Documentation section of PCID.

Education and training opportunities shall provide PRRS staff with the knowledge and tools to enable them to answer the full range of complex provider inquiries while meeting CMS performance requirements and standards for PRRS. The PRRS will need specialized training in the use of the CMS Internet-Only Manuals, the CMS website, the http://www.medicare.gov/ website, the MAC's provider education website, regulations, laws, and other information tools to accurately and completely respond to complex provider inquiries. (PRRS also handle complex beneficiary inquiries. See chapter 2 of this manual for information about complex beneficiary inquiries.)

See section *80.2.3* of this chapter for the monthly PCID reporting requirements.

40.2.2 - PCC Training Program

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

MACs may choose to close their PCCs to provide ongoing training for their CSRs, correspondents, and PRRS. MACs may choose to close their PCCs to provide training *or* staff development for up to 8 hours per month per contract per jurisdiction (not per PCC call center location and not per application, queue, or toll-free line within a PCC). The goal is to help PCC staff, particularly CSRs, improve the consistency and accuracy of their answers to provider questions, to increase their understanding of issues, and to facilitate retention of the facts of their training by increasing its frequency.

Continuous training for PCC staff, particularly for CSRs and correspondents, is highly recommended. MACs should implement an approach that best fits their operation and performance. PCC training closures, as well as 8 hours of training each month, are not mandatory. If a MAC closes its PCC for training, the requirements in sections *40.2.2.1* – 40.2.2.5 of this chapter apply.

The MACs shall adhere to the following guidelines when closing their PCC for training on days other than those listed in section *30.1.1* of this chapter:

- The 8 hours per month shall be used for training only.
- The 8 hours per month shall not be used for corporate meetings.
- MACs shall assume approval of PCC closures for training that they have reported to PCID unless they receive notification to the contrary from CMS within 5 business days after the PCID reporting deadline.
- Training time not used within a specific month shall not be carried over to the next month.
- See section *80.2.3.2* of this chapter for the monthly PCID reporting requirements.

40.2.2.5 - PCC Training Documentation

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

Copies of the MAC's PCC staff training schedule, training plan, training materials, training assessments, training feedback and PCC staff attendance sheets, shall be made available to CMS upon request.

50 - Provider Self-Service (PSS) Technology

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

MACs shall use self-service and electronic communication technologies as efficient, cost-effective means of disseminating Medicare provider information, education, and assistance. As such, MACs shall take every opportunity to market, educate providers about, and encourage the use of their self-service technologies. At a minimum, such educational opportunities shall include incorporating messages to providers in marketing materials, educational seminars, electronic mailing list messages, and instructions on the MAC's provider education website and IVR system.

One important way to successfully manage the provider inquiry workload is to increase and enhance the self-service technology tools available to Medicare providers and to require providers to use these tools when appropriate. Use of self-service technology enables the PCCs to more efficiently handle provider calls by allowing providers access to certain information without direct personal assistance from MAC staff. MACs shall offer a variety of self-service options to providers including, but not limited to:

1. IVR system for telephone inquiries.
2. Provider education website.
3. *Web*-based provider educational offerings.
4. Electronic mailing lists.
5. Social media, if used (usage is at the discretion of the MAC).

6. *Web* technology (see the "MAC Internet-based Provider Portal Handbook" located at https://www.cms.gov/Medicare/Medicare-Contracting/FFSprovCustSvcGen/downloads/Portal-handbook.pdf).

MACs shall expand the use of their self-service options and offerings, as appropriate, and shall routinely analyze the options they offer, as well as the utilization of such offerings, in order to decide whether and how to expand those offerings.

50.1 - Interactive Voice Response (IVR) System

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

Although the provider shall have the ability to speak to a telephone CSR during normal PCC operating hours, automated "self-help" tools, such as IVR systems, shall also be used by all MACs to assist with handling inquiries. IVR system service is intended to assist providers in obtaining answers to various Medicare questions, including those listed below:

1. MAC hours of operation for telephone CSR service.

2. 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 IVR system.)

3. General Medicare *Program* information. (MACs shall target individual message duration to be under 30 seconds. MACs shall have the technical capability to either require callers to listen or to allow them to bypass the message as determined by CMS. In cases where CMS makes no determination, the MAC shall use its own discretion.)

4. Specific information about claims in process and claims completed. (For claims status inquiries handled in the IVR system, all PCCs shall adhere to the Privacy Act of 1974 and HIPAA Privacy Rule by authenticating providers as required by the Disclosure Desk Reference (DDR), which is referenced in section 80 of this chapter and is available in the Documentation Section of PCID.

5. Official definitions for the 100 most frequently used Remittance Codes as determined by each MAC. (MACs are not limited to 100 definitions and may add more if their IVR system has the capability to handle the information. This requirement may be satisfied by providing official Remittance Code definitions for specific provider IVR system claim status inquiries.)

6. Routine eligibility information. (Eligibility inquiries handled in the IVR system shall adhere to the Privacy Act of 1974 and HIPAA Privacy Rule by authenticating providers as required by the DDR, which is referenced in section *90* of this chapter and is available in the Documentation Section of PCID.

At a minimum, the MACs shall require providers to use the IVR system to access claim status and beneficiary eligibility information; however, MACs have discretion to also require providers to use any other functionality available through the IVR. Telephone CSRs shall refer providers to the IVR system for applicable questions. Telephone CSRs may give the information if it is clear the IVR system is not functioning and the provider cannot access the information. Each MAC shall update the IVR systems to address provider needs as determined through the MACs' PCSP inquiry analysis at least once every 6 months.

NOTE: Each MAC has the discretion to also require providers to use the Internet-based provider portal for existing IVR functionality if the portal also has the same functionality.

The IVR system shall be available to providers 24 hours a day, 7 days a week with allowances for normal claims processing and system mainframe availability, as well as normal IVR system maintenance. When

information is not available to IVR system users, MACs shall post a message alerting providers on the IVR system.

MACs shall print and distribute a clear IVR system operating guide to providers upon request. The guide shall also be posted on the MAC's provider education website. MACs with a combined IVR/CSR configuration, shall ensure the guide details how callers can bypass the IVR and speak with a telephone CSR when they have general questions that do not require the caller to pass authentication or the caller does not have the required authentication elements (*for example,* consultants, attorneys, enrolling providers, etc.). As IVR system functionality changes, the operating guide shall be updated timely and the revisions posted to the provider education website.

MACs shall report the IVR system type and options in PCID. See section 80.2.2 of this chapter for PCID reporting and data certification requirements.

50.2 - Provider Education Website

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

MACs shall offer a provider education website as a PSS technology to serve as a self-help tool for Medicare providers in gaining information and assistance regarding the Medicare *Program*. This provider education website shall be dedicated to furnishing providers with timely, accessible, and understandable Medicare *Program* information.

MACs shall consider the use of their provider education website for every educational offering they provide to Medicare providers, including approaches such as web-based conferencing and trainings and computer-based training. However, MACs shall have solutions in place for providers who lack *web* access, such as hosting sites for web- and computer-based training. (See section 20.4 of this chapter for the requirements to include MLN products or content, and the MLN Button.)

50.2.1 – General Requirements

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

The information contained on the MAC's provider education website shall be structured in such a way information is easily found and searchable, so as to reduce the number of pages users have to go through in order to gain access to the information they are seeking. In designing their websites, MACs shall adhere to basic, research-based website usability guidelines, including the use of plain language, a task-based design, and the elimination of redundant, outdated, and trivial content detected in periodic content audits. MACs shall also be aware of and adhere to federal website best practices found at www.digital.gov.

To reduce costs, MACs shall use existing resources and technologies whenever possible. MACs shall provide a user interface for each jurisdiction to allow providers the ability to clearly find their specific jurisdiction on the provider education website and all of its contents. MACs are ultimately responsible for the structure of their provider education website but shall design it so it is clear to providers they are accessing a provider education website for their particular jurisdiction and interest, specifically, A/B MAC, HH+H MAC, or DME MAC. For example:

Jurisdiction X A/B MAC—Part A, Part B
Jurisdiction Y HH+H MAC—Part A, Part B, HH+H
Jurisdiction Z DME MAC – DME

MACs shall ensure information posted is current and does not duplicate information posted at http://www.cms.gov/ and http://www.medicare.gov/. MACs may post, on their own provider education website, LCD information that is contained in the Medicare Coverage Database. (See Pub.100-08, Medicare Program Integrity Manual, section 13, which details the LCD provider education website posting requirements).

MACs shall make improvements to, and ensure the integrity of, their provider education website on a continuing basis (for example, by ensuring section 508 compliance and correcting broken links).

MACs shall have the capability to capture and report to CMS, by jurisdiction and by line of business (A, B, HH+H, DME), analytic data for their provider education website. Analytic data include statistics on provider education website visits, page views, and on-site search queries. See PCID documentation for definitions and more information. This requirement is not applicable to MAC provider Internet-based portals.

See section *80.2.3.10* of this chapter for the monthly PCID provider education website analytic data reporting requirements.

50.2.2 – Webmaster and Attestation Requirements

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

MACs shall assign a Webmaster responsible for maintaining and updating relevant portions of the MAC's provider education website in a timely manner. The Webmaster shall ensure that the provider education website complies with CMS's Contractor Website Guidelines available at https://www.cms.gov/About-CMS/Agency-Information/Aboutwebsite/contractorwebguidlines. Webmasters shall pay close attention to the requirements for compliance with the requirements outlined in Section 508 of the Rehabilitation Act of 1973. (See http://www.cms.gov/About-CMS/Agency-Information/Aboutwebsite/Policiesforaccessibility.html.)

See section 80.2.2 of this chapter for the PCID Webmaster identification reporting and data certification requirements.

MACs shall periodically review the CMS Contractor Website Guidelines to determine their continued compliance. Within 30 calendar days after a MAC contract cutover date of the MAC contract (if more than one cutover date, within 30 calendar days of the earliest cutover date), and, thereafter, by the end of the sixth month of a contract year, MACs shall send two statements from their Webmaster attesting their provider education website complies with:

- *CMS Contractor Website Guidelines.*
- *Requirements stated in Pub. 100-04, Medicare Claims Processing Manual, chapter 23, section 20.7 regarding the use of Current Procedural Terminology (CPT)[2] codes and descriptions.*

If a Webmaster determines the MAC's provider education website is not in compliance with any of the CMS requirements, including the requirements outlined in Section 508, the MAC shall outline the steps it is taking to become compliant. This information shall be submitted with the attestation statement.

MACs shall submit their attestations using the appropriate MAC Deliverables mailbox.

50.2.2.1 – Website Governance

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

CMS and its contractor will conduct Website Governance scans to ensure MAC websites are compliant with Federal 504/508 policy as well as to search for dead URLs throughout the MAC webpages. MACs shall use the scan results as a tool to improve their individual MAC websites.

CMS and its contractor will conduct monthly Website Governance scans of the MAC websites to ensure MACs comply with the U.S. Health and Humans Services (HHS) acceptable score (https://www.hhs.gov/sites/default/files/web/508/compliance/leaderboards/hhsleaderboard.html). MACs will

[2] *CPT only copyright 2015 American Medical Association. All rights reserved.*

also have the ability to run scans more frequently to test things like web updates *or* to test the resolution of any findings from the monthly scans.

The overarching goal of the Website Governance Program is to give the MACs a tool to improve their individual MAC websites, which should translate into increased provider satisfaction.

50.2.3 – CMS Feedback

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

Each MAC shall include the CMS regional office contact on its provider education website.

MACs shall provide information about how providers can offer comments to CMS about the MAC's performance in dealing with providers. Each MAC shall provide the *email* address of the resource mailbox at the CMS regional office that has jurisdiction over the MAC. The resource mailbox address for each regional office, along with the MAC jurisdictions served by each regional office, is available under "Feedback Mechanism" found at https://www.cms.gov/Medicare/Medicare-Contracting/FFSProvCustSvcGen/Contractor-Resources. Users shall be able to easily reach this information from the provider education website.

This feedback mechanism is separate from the feedback provided through the satisfaction surveys outlines in Section 60.1.

50.2.4 – Contents

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

Each MAC's provider education website shall consist of information that is easy to use and easily searchable and shall contain, at a minimum, the following:

1. Information on how to subscribe to the MAC's provider electronic mailing list(s).

2. Frequently Asked Questions (FAQs), updated at least quarterly (see section 50.2.4.2 of this chapter for more information about the FAQs).

3. A schedule of upcoming POE activities (for example, seminars, workshops, fairs).

4. Ability to register for MAC-sponsored education and outreach activities.

5. Search engine functionality.

6. A "What's New" or similarly titled section that contains important information that is of an immediate or time sensitive nature.

7. A site map that shows in simple text headings the major components of the provider education website and allows users direct access to these components through selecting and clicking on the titles. This feature shall be accessible from the home page of the provider education website using the words "Site Map."

8. A tutorial explanation of how to use the provider education website accessible from the home page. The tutorial shall describe how to navigate through the provider education website and how to find information, and shall explain the features. The tutorial information can be on a "help" page as long as the "help" feature is accessible from the home page.

9. Information for providers on electronic claims submission.

10. Information about the MAC, at a minimum including the telephone number(s) for provider inquiries, a fax number(s) for provider inquiries, and a mailing address for provider written inquiries.

11. An IVR system operating guide.

12. CMS products, articles and messages posted or linked, as directed.

13. A feedback mechanism as described in section 50.2.3 of this chapter.

14. The embedded link to MLN Connects as mentioned in section 50.2.4.1 of this chapter.

15. MLN products or content links, and the MLN Button.

16. Information from CMS for providers (see section 50.2.4.1 of this chapter.)

17. A dedicated alerts page where providers can get information and educational announcements around claims processing issues including reprocessing/reopening claims due to under *or* overpayments (see Section 50.2.4.5 of this chapter)

In addition, the provider education website shall contain the following links to other web addresses:

1. CMS website at http://www.cms.gov/.

2. CMS website at http://www.medicare.gov. (If a prominent part of the MAC's provider education website or if a landing page on the MAC's provider education website references an individual(s) who is entitled to Medicare benefits, MACs shall use the term "person(s) with Medicare" to describe that individual(s).

3. Links to CMS social media pages

    - YouTube: https://www.youtube.com/user/CMSHHSgov
    - Twitter handle: @CMSGov
    - RSS Feeds and Podcasts: https://www.cms.gov/Outreach-and-Education/Outreach/CMSFeeds/index?redirect=/cmsfeeds/

4. MLN at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo.

5. Sites for downloading CMS manuals and transmittals at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/index and https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/index.

6. CMS's Quarterly Provider Update (QPU) web page at https://www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/QuarterlyProviderUpdates/index.

7. Website that contains descriptions for RA reason codes and remark codes at the official ASC X12 website.

8. CMS's HIPAA web page at https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/HIPAA-ACA/index.

9. CMS's central provider web page at https://www.cms.gov/center/provider-type/all-fee-for-service-providers-center.html.

10. CMS's ICD-10 web page at http://www.cms.gov/Medicare/Coding/ICD10/index.html.

11. Other CMS Medicare contractors, partners, QIOs, and other websites that may be useful to providers.

12. CMS's MREP Software information at https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/AccesstoDataApplication/MedicareRemitEasyPrint.html.

13. Provider Satisfaction Survey web page at https://www.cms.gov/Medicare/Medicare-Contracting/MSI/index.

MACs shall correct or remove specific information or links from their provider education websites when directed to do so by CMS.

50.2.4.1 – Dissemination of Information from CMS to Providers

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

MACs shall receive messages from CMS, via the MAC electronic mailing list(s) described in section 10.1 of this chapter. The messages sent by CMS to the MACs via this electronic mailing list contain information for providers and instructions for the MACs on how, and sometimes when, to disseminate the information to providers.

The instructions from CMS and the information for MACs to disseminate to providers contained within MLN Connects (weekly *or* Special Edition). The instructions for the MACs are located below the heading "Instructions to MACs" and the information for the providers is located below the heading "CMS Provider Education Message." On occasion, CMS may include an Editor's Note within the "CMS Provider Education Message." In such instances, MACs shall distribute the Editor's Note along with the other content in the "CMS Provider Education Message."

When MACs distribute MLN Connects to providers via their electronic mailing list(s), MACs shall use the same format/medium (that is, web link, .pdf file) that CMS used to distribute it to the MACs. MACs may supplement MLN Matters Articles with localized information benefitting their provider community in billing and administering the Medicare *Program* correctly. MACs shall post the direct link to the article on their website, bulletin, or newsletter (if published).

If MACs have questions or concerns regarding the receipt or content of MLN Connects (weekly or Special Edition), they may send their questions or concerns to CMS at MLNConnectsMAC@cms.hhs.gov.

1. Timeliness of Dissemination of Information to Providers

    a. Unless specifically directed otherwise in the instructions from CMS, MACs shall distribute the information to providers via their electronic mailing list(s) and post relevant information from CMS on their provider education website within 2 business days after the date CMS sent the instructions and information to the MACs. MACs shall include the information in their next MAC bulletin or MAC newsletter if the information is current at the time the MAC bulletin or MAC newsletter is published. If the information is not current at that time, MACs have the discretion to include the information if they include a statement in the MAC bulletin or MAC newsletter that informs the readers that the information was included in MLN Connects (weekly *or* Special Edition) dated [MACs shall insert the date] and the information is being provided for informational purposes only because it was time-sensitive information or it is no longer applicable *or* in effect.

    b. Urgent or time-sensitive information will be identified as such in the instructions from CMS. Unless the urgent or time-sensitive information is identified by CMS as requiring "immediate release" or as requiring "specific date and time of day release" to providers, MACs shall distribute the urgent or time-sensitive information to providers via their electronic mailing list(s) and post relevant information from CMS on their provider

education website by close of business the next business day after the date CMS sent the instructions and information to the MACs. MACs shall include the information in their MAC bulletin or MAC newsletter if the information is current at the time the MAC bulletin or MAC newsletter is published. If the information is not current at that time, MACs have the discretion to include the information if they also include a statement in the MAC bulletin or MAC newsletter informing the readers that the information was included in MLN Connects (weekly *or* Special Edition) dated [MACs shall insert the date] and that the information is being provided for informational purposes only because it was time-sensitive information or it is no longer applicable *or* in effect.

Urgent or time-sensitive information will be infrequent.

- Urgent or time-sensitive information requiring "immediate release"
  If CMS identifies the information for providers as urgent or time-sensitive and requiring "immediate release" to providers, MACs shall distribute that information to providers via their electronic mailing list(s) and post relevant information on their provider education website no later than 2 hours after receipt of the instructions and information from CMS. If the instructions and information from CMS are received by a MAC within 2 hours of the time the MAC would close for the day and the MAC is unable to distribute and post the information that day, the MAC shall distribute and post the information at the start of the next business day. MACs shall include the information in their next MAC bulletin or MAC newsletter if the information is current at the time the MAC bulletin or MAC newsletter is published. If the information is not current at that time, MACs have the discretion to include the information if they also include a statement in the MAC bulletin or MAC newsletter informing the readers the information was included in MLN Connects (weekly *or* Special Edition) dated [MACs shall insert the date] and the information is being provided for informational purposes only because it was time-sensitive information or it is no longer applicable *or* in effect.

  Urgent or time-sensitive Information that requires "immediate release" will be rare.

- Urgent or time-sensitive information requiring "specific date and time of day release"
  If CMS identifies the information for providers as urgent or time-sensitive and requiring "specific date and time of day release" to providers, MACs shall distribute that information to providers via their electronic mailing list(s) and post relevant information on their provider education website on the specified date and at the specified time. MACs shall include the information in their next MAC bulletin or MAC newsletter if the information is current at the time the MAC bulletin or MAC newsletter is published. If the information is not current at that time, MACs have the discretion to include the information if they also include a statement in the MAC bulletin or MAC newsletter informing the readers the information was included in MLN Connects (weekly *or* Special Edition) dated [MACs shall insert the date] and the information is being provided for informational purposes only because it was time-sensitive information or it is no longer applicable *or* in effect.

  Urgent or time-sensitive information that requires "specific date and time of day release" will be rare.

2. Distribution and Posting

   a. Unless directed to do so by CMS (for example, in a TDL), MACs shall not edit or supplement the CMS information for providers.

   b. MACs shall distribute and post all information received from CMS for providers and post relevant information on their provider education website. If specified by CMS in its instructions to the MACs, MACs shall highlight information that is especially, or solely relevant, to a particular line of business (A/B, HH+H, or DME) or provider type (if the MAC

has an appropriate targeted electronic mailing list for the specified provider type). (See section 50.3.1 of this chapter for information about targeted electronic mailing lists.)

c. When distributing information from CMS to providers via their electronic mailing list(s), MACs shall clearly differentiate the information that was generated by CMS from other information that MACs send to them via their electronic mailing list(s). In both the subject line of the electronic mailing list message and within the body of the electronic mailing list message, MACs shall make it clear to providers when the information is from CMS. To avoid possibly confusing the providers, MACs shall omit from the subject line *and* the body of the message any reference to the actual CMS vehicle that transmitted the information to the MACs.

d. Occasionally, some information from CMS is related to a TDL. When explicitly stated to do so in a TDL, MACs may use the information contained in a TDL to conduct normal operations in order to respond to inquiries from the provider community and to educate providers when appropriate, including the discretion to do local messaging as needed. However, MACs shall not reference a TDL number.

e. The information for providers from CMS shall remain on the provider education website for 2 months or until the MAC bulletin or MAC newsletter in which the information is appearing (if the MAC publishes a bulletin or newsletter) is posted on the provider education website, whichever is later. (See items 1.a. and 1.b. of this section for information about including the information in MAC bulletins or MAC newsletters.) MACs have the discretion to remove information from the provider education website if it becomes outdated before the end of the 2-month period.

f. If CMS revises information MACs have already disseminated to providers, MACs shall ensure the revised information is distributed to providers via their electronic mailing list(s) and relevant information is posted on their provider education website within 2 business days after the date CMS sent the revised information to the MACs (see item 1.a. of this section), or sooner if the information is urgent or time-sensitive (see item 1.b. of this section).

g. MACs shall ensure CMS information posted on their provider education website represents the most current information from CMS. MACs shall remove the outdated information after receiving revised information from CMS. If there is an accompanying CR that cancels information from CMS, MACs shall remove that information from their provider education website no later than close of business the next business day after the date the MAC received the CR from CMS.

50.2.4.4 - *Web-based Provider Educational Offerings*

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

MACs shall offer *web*-based training and educational resources, such as, but not limited to, computer-based training and webcasting, as self-help tools to acquire information about the Medicare *Program*. MACs shall encourage providers to use the CMS website and their provider education website for these offerings, as well as to subscribe to MAC electronic mailing lists so they can learn of them. Materials from all webcasts shall be archived and made available, upon request, to providers who were unable to attend a webcast.

50.2.4.5 – Provider Claims Payment Alerts

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

MACs shall develop and regularly update a dedicated webpage that alerts providers of confirmed system-related claims processing issues that have been identified by CMS, the MAC *or* the Shared Systems Maintainer. The page shall provide information and educational announcements around claims processing

issues that are currently active as well as provide an archive of resolved issues. At a minimum the page shall include the following information for each reported issue:

- Date Reported
- Provider Type(s) Impacted
- Reason Codes, as applicable
- Claim Coding Impact (i.e. HCPCS/ICD codes etc.), as applicable
- Description of the Issue
- Action Required by the MAC, if any
- Action Required by the Provider, if any
- Proposed Resolution/Fix (including automatic reprocessing of claims or not)
- Status (Open, Closed)
- Date Resolved

MACs may include additional jurisdiction-specific information providers may need in order to understand the issue.

50.3 - *Electronic Mailing List*

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

MACs shall offer electronic mailing lists to assist Medicare providers in gaining information about the Medicare *Program*. These electronic mailing lists shall notify subscribers via *email* of important, time-sensitive Medicare *Program* information, upcoming provider communications events, and other announcements necessitating immediate attention. CMS recommends MACs use electronic mailing list(s) for only one-way communication (i.e., from MACs to subscribers). MAC electronic mailing list(s), including information about subscribers (*for example,* email addresses) are the property of CMS and shall be shared with CMS upon request.

1. Subscribe/Unsubscribe

   Providers shall be able to subscribe or unsubscribe to electronic mailing list(s) via their MAC's provider education website. A MAC's electronic mailing list(s) shall be capable of accommodating all of the providers served within the MAC's jurisdiction.

2. Protection of Electronic Mailing Lists

   MACs shall protect electronic mailing list(s) addresses from unauthorized access or inappropriate usage. Electronic mailing list(s), or any portions or information contained therein, shall not be shared, sold, or in any way transferred to any other organization or entity. In special or unique circumstances where a MAC deems such a transference or sharing of electronic mailing list information to another organization or entity to be in the best interests of CMS or the Medicare *Program*, the MAC shall first obtain express written permission from its COR to transfer or share the information. MACs shall transfer electronic mailing lists(s), and all information contained therein, to incoming contractors during transition of a jurisdiction.

3. Electronic Mailing List Records

   MACs shall maintain usage records of their electronic mailing list(s). These records shall include when the electronic mailing list(s) was used, the text of the messages sent, the number of subscribers to whom messages were sent (per message), the authors of the messages, and any transference or sharing that may have occurred (see item 2 above). Records shall be kept for 1 year from the date of usage.

50.3.1 - *Targeted Electronic Mailing Lists*

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

Targeted electronic mailing lists shall be used to send messages and information regarding the Medicare *Program*, policies, or procedures of relevance or interest to specific provider audiences. MACs shall use the list of provider types listed on the Medicare PE applications located at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html to determine applicable and appropriate audiences. MACs may combine provider types listed on the PE applications or resort the provider types or create more finite provider type groupings, as necessary, to create targeted electronic mailing lists.

50.3.2 – *Electronic Mailing List Promotion*

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

MACs shall actively market and promote the benefits of being a subscriber to the electronic mailing list(s) through the use of all regular provider communications tools and channels (*for example,* workshops, education events, POE AG meetings, ACTs, PCCs, and written materials). MACs shall consider having telephone CSRs subscribe providers to the electronic mailing list(s) during calls if the providers are not currently subscribed and the telephone CSRs believe the providers would benefit from the information provided through the electronic mailing list(s). MACs shall also coordinate internally with other MAC departments to encourage electronic mailing list subscription.

50.4 – Social Media

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

MACs may, at their discretion, use social media in their PCSP. Social Media are *Web* or cellular phone-based technologies that allow the sharing of information. Social media include, but are not limited to, Facebook, YouTube, Twitter, and LinkedIn. MACs who use social media shall market offerings on high priority CMS items and, if applicable, use any available CMS social media offerings.

MACs who use social media shall submit their data in PCID. See Section 80.2.3.11 of this chapter for the monthly PCID reporting requirements.

50.5.1 – Internet-based Provider Portal Service Interruptions

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

MACs shall report Internet-based portal service interruptions to CMS as soon as they become aware of the issue. MACs shall send an *email* to the Service Reports mailbox at servicereports@cms.hhs.gov with the subject "Portal Interruption." The *email* shall describe the issue, the impact on service to providers and what is being done to resolve the issue. Updates shall continue to be sent daily until the issue is resolved.

Portal service interruptions include any unexpected portal downtimes *or* loss of one or more portal functions that cause the portal or function(s) to be unavailable to providers for any period of time. If a portal service interruption adversely affects the PCC (for example, by increasing the call volume or by increasing the volume of written provider inquiries), the MAC shall send a "Contractor Alert" in accordance with the instructions in section 30 of this chapter.

See section *80.2.3.8* of this chapter for the requirement to report portal service interruptions to PCID.

60 - Surveys

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

CMS requires MACs to complete periodic surveys about their PCSP operations, such as PCC technology, staffing profiles, and training needs. Survey completion timeframes are dependent on the activity or service to be surveyed.

60.1 - *Provider Satisfaction Survey*

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

Executive Order (EO) 12862 requires Federal Agencies to be customer-driven by providing customer service equal to the best in business. The EO tasks Agencies to survey customers to determine the type and quality of services they want and their level of satisfaction with existing services. CMS complies with this EO by measuring providers' satisfaction with the MACs' performance using survey tools. MACs shall assist CMS in our effort to develop and implement these tools to meet this requirement.

Currently, CMS uses the MAC Customer Experience (MCE) to survey providers. The purpose of the MCE is to improve processes and procedures within the MACs and CMS based on the data CMS receives. The MCE program is not meant to provide a way for respondents to circumvent the MACs' existing inquiry handling processes. MACs may redirect respondents who leave contact information to the appropriate inquiry channels.

60.1.1 – MAC Survey Participation Requirements

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

At the request of CMS, MACs shall administer provider satisfaction surveys and:

- Assign up to two points of contact for each jurisdiction to serve as liaisons between CMS and the MAC,
- Participate in meetings, conference calls, focus group evaluations and in-depth interviews with CMS and the Survey Contractor to implement and manage the satisfaction surveys and analyze the results;
- Assist in developing/refining survey tools by:
    - Providing insight on what information is important to collect
    - Testing/piloting new survey tools
    - Suggesting innovative survey tool strategies and technologies
- Develop MAC specific questions for the satisfaction survey, as instructed by CMS
- Add code from the Survey Contractor to the MAC's website and portal and initiate action to activate the code as instructed by CMS;
- Make surveys available to MAC customers by:
    - Publishing custom survey URLs to websites *and* portals as directed
    - Distributing custom survey URLs via direct email, *electronic mailing* lists, social media, or other communication channels, as directed
    - Adding survey access (*for example,* URLs, QR codes) to written or other forms of communication, when applicable
- Review survey results on a regular basis;
- Perform ongoing marketing and outreach for the survey by:
    - Disseminating information about the survey on electronic mailing lists and other provider communications channels, as appropriate.
    - Posting information about the survey on provider education websites, provider Internet-based portals, social media channels, and IVR messaging.

Promoting the survey at conferences, webinars, workshops, events, and meetings.

60.1.3 – Closed-Loop Ticketing

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

Closed-Loop Ticketing enables MACs to create follow-up tickets to track and resolve issues and comments from their survey feedback. Each MAC shall use the closed-loop ticket system provided by CMS. A ticket generates when a response is submitted and when certain criteria are met based on each survey. Every ticket does not require a personalized response, even if a respondent leaves contact information.

MACs have the discretion about how to close a ticket including, but not limited to:

- Sending a personalized email response to close the ticket or initiate a discussion with the respondent
- Sending a canned response explaining what resources are available to resolve a respondent's issue (*for example,* directing them to a resource on your website)
- Sending a canned response directing the respondent to the appropriate inquiry mechanism to resolve their issue (*for example,* directing them to the PCC or Portal Help Desk)
- Sending a canned response thanking the respondent for their feedback when contact information is provided, but a response is not needed
- Closing the ticket because a response is not needed and no contact information is provided

60.2 – MAC Satisfaction Score

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

Satisfaction with the services provided by MACs shall be monitored throughout the contract year for each jurisdiction using the results from the MCE survey. In addition to measuring satisfaction with individual MAC functions (*for example,* appeals, digital services, PE) the MCE provides an overall MAC satisfaction score per jurisdiction called the MAC Satisfaction Score. Using this score each MAC jurisdiction shall achieve an average score of 3.6 out of 5.0 for their contract year. The MAC Satisfaction Score is derived from the Shared Dashboard within the Survey Contractor Platform and measures the average score for the entire contract year.

70 - PCSP Performance Management

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

70.1 - *POE – Electronic Mailing List Subscribership*

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

This section is not applicable to targeted electronic mailing lists described in section 50.3.1 of this chapter.

MACs shall promote their electronic mailing list(s) to providers as much as possible including using their events, website and association partnerships.

MACs shall, to the extent possible, eliminate duplicate *email* addresses in their electronic mailing list subscribership.

70.2.1 - Call Completion

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

- Each CSR/IVR combined line shall have a completion rate of no less than 80 percent. This standard is measured quarterly and is cumulative for the quarter.

- Each CSR-only line shall have a completion rate of no less than 80 percent. This standard is measured quarterly and is cumulative for the quarter.

- Each IVR-only line shall have a completion rate of no less than 95 percent. This standard is measured quarterly and is cumulative for the quarter.

- MACs shall send an *email* to the Service Reports mailbox at servicereports@cms.hhs.gov by 11:00 a.m. *ET* if their PCC completion rate for the previous business day was less than the applicable standards described above. The *email* shall report the decreased completion rate roll-up for the jurisdiction and the decreased completion rate by individual toll-free number and shall identify the MAC's toll-free number by MAC name, jurisdiction, line of business, configuration (IVR, CSR, IVR/CSR), and numerical toll-free number. The *email* shall also specify if the completion rate was impacted by staffing, call volume, or technical telecommunications or connectivity issues. The *email* shall be sent with the subject line "Completion Rate."

70.2.3 – Average Speed of Answer (ASA)

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

The average speed of answer (ASA) is the average time callers spend in the telephone CSR queue waiting to be connected to a telephone CSR. When determining the ASA, the wait time begins when the caller enters the telephone CSR queue and ends when the caller is connected to a telephone CSR. MACs are held to quarterly ASA performance standards on their PCC line(s). The ASA standard is applied to the speed at which the initial call is answered by a telephone CSR. Should the caller need to be transferred to another level CSR, the time associated with that transfer shall not be included in the ASA calculation. MACs shall maintain an ASA of 60 seconds or less. This standard is measured quarterly and is cumulative for the quarter.

MACs shall send an *email* to the Service Reports mailbox at servicereports@cms.hhs.gov by 11:00 a.m. *ET* if the ASA on the PCC line(s) was higher than the applicable quarterly standard for the previous business day. The *email* shall specify the overall ASA for the jurisdiction and if the elevation in ASA was impacted, or partially impacted, by staffing, call volume, or technical telecommunications or connectivity issues. The *email* shall be sent with the subject line "ASA."

70.2.4 – Callbacks

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

MACs shall ensure telephone CSRs collect necessary information from a caller to perform research and respond. For callback completion and closeout, MACs shall make one attempt to reach a provider. The MAC may leave a message requesting a return call, including the reference number and beneficiary's name if appropriate, but no other PHI or PII shall be left on the message. MACs shall not leave responses on provider voicemail systems. If the MAC cannot leave a message then the MAC shall send a written response referencing the inquiry, date and time of the callback attempt, and request the provider call the MAC if they still need assistance to resolve their inquiry. *Once the MAC has attempted to reach the provider, either thru the phone or written response, the callback is considered completed and closed.*

All callbacks shall be completed and closed out within 10 business days of receipt of the original inquiry and documented in the inquiry tracking system, discussed in section 30.8 of this chapter. MACs shall not have a telephone CSR callback rate greater than 10 percent for those telephone inquiries handled by CSRs. The standard is measured monthly and is cumulative for the quarter. A callback shall be considered completed and may be closed out if a final response has been sent to the provider or if the MAC has informed the provider the inquiry was escalated to a different department within the MAC for resolution. Inquiries not closed out within 10 business days of receipt of the original inquiry are considered untimely.

80 - PCSP Data Reporting

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

The PCSP System is an interactive web-based tool that is password protected and accessible only to authorized users. The system includes four databases: PIES, PCID, QCM, and QWCM.

Upon a jurisdiction award, the MAC shall identify a Database Supervisor and an alternate for each of the four databases. Each Database Supervisor and alternate shall assume responsibility for approving, denying, and maintaining MAC staff access to the PCSP System database(s) for which he/she is responsible. A Database Supervisor and alternate may have responsibility for more than one PCSP System database. Within 30 calendar days after the first MAC cutover date, the MAC jurisdiction shall furnish CMS with the name, telephone number, and *email* address of the Database Supervisor and alternate for each PCSP System database by sending an *email* containing that information to the Provider Services mailbox at providerservices@cms.hhs.gov, with the subject: "Database Supervisor." If the 30th calendar day falls on a weekend or holiday, the MAC shall send the information by close of business the next business day.

After CMS receives the names of the Database Supervisors and alternates, CMS will send them the PCSP System User Access Request Form to fill out and return to CMS to the Provider Services mailbox at providerservices@cms.hhs.gov, with the subject: "PCSP System Access Form." Once the form is returned and the request is approved by CMS, the Database Supervisors and alternates will have access to the requested PCSP System database(s) and shall begin assuming PCSP System database access responsibility for other MAC staff in accordance with sections *80.1.1, 80.2.1, 80.3.1* and *80.4.1* of this chapter. The PCSP User Access Request Form can be found in the documentation section of each of the PCSP System databases.

80.1 - PIES

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

CMS collects and displays PCC performance data on a monthly basis. These data are collected through PIES. Definitions, calculations and additional information for each of the required data elements as well as associated standards are posted on the PIES website. PCCs shall regularly review and use their performance data to improve their overall performance.

MACs shall report data by jurisdiction and, where necessary, by queue. (See section *30.4.1* of this chapter.)

80.1.2 - Due Date for Data Submission to PIES

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

Each PCC shall enter required PCC data elements into PIES on a monthly basis between the 1st and 10th of each month for the previous month. Because the data on the number of callbacks closed within 10 business days may not be available by the 10th of the month, MACs shall report callback data via the PIES Callback Data entry form, which is available to the MACs each month from the 11th through the 16th as a link in the PIES menu.

After the 10th of the month, the data entry capability will no longer be available to the MACs. After the 10th of the month, any missing data will be considered late and will need to be entered into PIES by CMS staff. Callback data *is* not considered late until after the 16th of the month.

If a MAC did not report data timely, the MAC shall inform CMS of the data to be entered into PIES by submitting that information within 2 business days after it becomes available to the PIES mailbox at pie-system@cms.hhs.gov.

If a MAC entered data timely but, after the PIES reporting due date, determined that the data needed to be changed, the MAC will not be able to change the data; the changed data will need to be entered by CMS staff. In this situation, MACs shall inform CMS of the data to be changed, the reason(s) for the change(s), and the field(s) to be changed. This information shall be submitted to the PIES mailbox at pie-system@cms.hhs.gov.

80.2.2 - MAC Contract and PCSP Data to be Reported in PCID

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

MACs shall be responsible for entering and maintaining the following MAC contract and PCSP data in PCID:

- IVR System Information
- MAC Mailing Address
- MAC Provider Education Website Address
- Written Inquiry Storage Location (Primary, Alternate)
- PCC Toll-free Numbers (Each Toll-free Number at Each PCC Location) – Line(s) of Business and Program Area Applications Handled (A, B, HH+H, DME, Appeals, EDI, PE, other), and Use (CSR, IVR, TDD)
- MAC PCSP Points of Contact and Contact Information
    - PCSP Program Manager
    - POE Contact (Primary)
    - PCC Contacts
    - Webmaster
    - MLN Connects Contact
    - MAC Liaisons (for MAC-to-MAC collaboration)
- Pre-Approved PCC Closures – MACs shall report PCC closures that fall on CMS pre-approved days and any other planned PCC closure dates the reasons for the closures.

MACs shall report the above data to PCID within 60 calendar days after the cutover date of the MAC contract (if more than one cutover date, within 60 calendar days after the earliest cutover date) or, if the data *is* not available at that time, within 7 calendar days after the data become available. If a due date falls on a weekend or holiday, the information is due by close of business on the next business day.

On a monthly basis, MACs shall review these data in PCID, make updates or changes as necessary, and certify that the data *is* correct.

80.2.3 – Additional Data to be Reported Monthly in PCID and Reporting Due Dates

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

MACs shall report in PCID the data described below in sections *80.2.3.1 – 70.2.3.12* of this chapter on a monthly basis between the 1st and the 10th of each month for the previous month's data and, for certain data required by section *80.2.3.2* of this chapter, between the 1st and the 10th of the month for the upcoming month. After the 10th of the month, the data entry capability will no longer be available to the MACs. After the 10th of the month, any missing data will be considered late and will need to be entered into PCID by CMS staff. If a MAC did not report data timely, the MAC shall inform CMS of the data to be entered into PCID by submitting that information within 2 business days after it becomes available to the PCID mailbox at pcid@cms.hhs.gov.

If the MAC entered data timely but, after the PCID reporting due date, determined the data needed to be changed, the MAC will not be able to change the data; the changed data will need to be entered by CMS staff. In this situation, MACs shall inform CMS of the data to be changed, the reason(s) for the change(s), and the field(s) to be changed. This information shall be submitted to the PCID mailbox at pcid@cms.hhs.gov.

80.2.3.1 – Inquiry Tracking Data to be Reported in PCID

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

MACs shall log all PCSP inquiries in their Inquiry Tracking System and enter them in the PCID Inquiry Tracking module between the 1st and the 10th of each month for the previous month's data.

1. MACs shall include all PCC triage levels (Level 1, Level 2, PRRS), all PCC queues and sites, and inquiries handled by the PCC (i.e., general inquiries, escalated inquiries within CSR tiers, Congressional) including inquiries handled by other functions under the PCC (*for example,* PE, Appeals, EDI, Reopening) in the Inquiry Tracking Report. MACs shall ensure any automatic programs that consolidate data from other functions captures all required data.

2. MACs shall not duplicate the inquiry count reported to CMS except when MACs transfer inquiries from a telephone to a written response.

3. MACs shall ensure they report all required information about any contractor-specific subcategories created during the month. See Section 30.8.D for more information on contractor-specific subcategory development.

4. MACs shall use the PCID comment field to inform CMS about relevant information impacting their monthly data submission. Examples of information to include:
    i. MAC PCSP/PCC transition
    ii. Inquiry Tracking System transition
    iii. Root causes for abrupt changes *or* "spikes" in PCC inquiries
    iv. Root causes that impact the volume *or* trends of provider inquiries (*for example,* emergency conditions in the jurisdiction, specific initiatives/pilots, processing errors, system issues)

5. MACs shall certify in PCID all MAC Inquiry Tracking Data Review and Validation Procedures as described in Section 30.8.2 have been completed before submitting the monthly data. (CMS acknowledges further analyses is required to complete the inquiry analyses cycle; however, the objective of the attestation is to assure minimum procedures have been completed before submitting the Inquiry Tracking Report to CMS).

80.2.3.2 – PCC Training Closure Information to be Reported in PCID

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

MACs shall report PCC training closure information in PCID on a monthly basis between the 1st and the 10th of each month for PCC training closures planned for the upcoming month (if any) and for PCC training closures that occurred in the previous month. MACs shall report the following information for each PCC training closure:

- Date, start and end times, and location of PCC training closures for the upcoming month if any such closures are planned. If no such closures are planned for the upcoming month, the MAC shall send an *email* to the Provider Services mailbox at providerservices@cms.hhs.gov indicating that it has no plans to close for PCC training during business hours in the upcoming month;

- Topics and subtopics of CSR training that occurred in the previous month; and,

- Categories and subcategories (from the Standardized Provider Inquiry Tracking Chart) that correspond to the CSR training that occurred in the previous month.

Reporting example: By July 10, MACs shall report planned training dates, start and end times, and locations for PCC training closures for the month of August. At the same time, MACs shall report training topics and subtopics, and standardized provider inquiry categories and subcategories for training that occurred for the month of June.

80.2.3.4 – *Provider Electronic Mailing List Subscriber Data to be Reported in PCID*
(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

Each MAC shall enter provider electronic mailing list subscriber data in PCID on a monthly basis between the 1st and the 10th of each month for the previous month's data. To the extent possible, MACs shall report the number of unique (non-duplicated) subscribers. This reporting requirement does not apply to MACs' targeted mailing lists described in section 50.3.1 of this chapter.

HH+H MACs shall separately report the number of subscribers to their A/B and HH+H electronic mailing lists; these numbers shall not be combined.

It is not necessary for MACs to report the number of electronic mailing list subscribers in their Monthly Status Reports.

80.2.3.5 – Special Initiatives Activities to be Reported in PCID
(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

When CMS issues TDLs requiring MACs report on activities related to special initiatives, MACs shall enter their special initiatives activities in PCID on a monthly basis between the 1st and the 10th of the month for the previous month's data. Special initiatives activities may include direct mailings, electronic mailing list messages, POE events, website postings, *or* IVR system messages.

80.2.3.6 – Emergency and Similar PCC Closure Data to be Reported in PCID
(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

If an emergency or similar PCC closure occurred (see section *30.1.3* of this chapter), the MAC shall enter that closure in PCID between the 1st and the 10th of the month for the previous month's data. No reporting is necessary for months in which there were no such closures.

80.2.3.7 – Telecommunications Service Interruptions to be Reported in PCID
(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

If a telecommunications service interruption (toll-free carrier-related or in-house) occurred, the MAC shall enter that interruption in PCID between the 1st and the 10th of the month for the previous month's data. No reporting is necessary for months in which there were no such interruptions. See section *30.4.4* of this chapter for information about telecommunications service interruptions in general and other required service interruption reporting.

The data to be entered in PCID to report telecommunications service interruptions are as follows:

- Date the telecommunications service interruption occurred.
- Time of day (local time) the telecommunications service interruption occurred.
- Date and time of day (local time) the telecommunications issue was resolved.
- Line of Business affected -- A, B, HH+H, DME, and Other Program Area Application(s) Affected – Appeals, EDI, PE.
- Channel: Impacted line(s) – IVR-only, CSR-only, combined IVR/CSR.
- Impacted location -- The PCC call center location impacted.
- Source -- Internal or External (network service).
- Overview/Description -- A description of the problem.
- Resolution -- How the interruption was resolved.

80.3 –QCM

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

CMS strives to continuously improve Medicare customer satisfaction through the delivery of high quality and cost-effective customer service. High quality customer service is convenient and accessible, accurate, courteous and professional, and responsive to the needs of diverse groups. QCM is a web-based database that is used for accuracy, courtesy and professionalism.

MACs shall complete scorecards and enter data into the QCM the 10th of each month. See section 30.4.12 of this chapter for additional information.

80.4 –QWCM

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

CMS strives to continuously improve Medicare customer satisfaction through the delivery of high quality and cost-effective customer service. High quality customer service is convenient and accessible, accurate, courteous and professional, and responsive to the needs of diverse groups. QWCM is the primary way for CMS to assess if Medicare customer service is meeting the performance standards established for accuracy, completeness, courtesy, and professionalism.

MACs shall complete scorecards and enter data into the QWCM.

90 - Disclosure of Information

(Rev.10900; Issued:08-11-21; Effective:09-14-21; Implementation:09-14-21)

MACs shall protect the confidentiality of PII and PHI as well as provider PII in accordance with the Privacy Act of 1974 and HIPAA. MACs shall comply with the requirements in the DDR prepared and made available by CMS. The DDR Guide applies to all telephone, written, portal and congressional inquiries. The Disclosure Desk Reference is available in the Documentation Section *of PCID*.