

Medicare Administrative Contractor (MAC) Beneficiary and Provider Communications Manual

Chapter 6 - Provider Customer Service Program

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Provider Customer Service Program

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NOTES:

1. In this chapter, the term “provider” includes all Medicare providers and suppliers unless specifically noted otherwise.
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 (*CSR*)” refers to all MAC staff who handle telephone, written, *Provider Relations Research Specialist (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 *Contracting Officer Representative (COR) or designee*.
5. The information in this chapter is applicable only to the Provider Customer Service Program (*PCSP*) at the MACs, unless specifically noted otherwise.

10 – *Introduction to the PCSP*

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

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 *strengthens* and *enhances* 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.

The PCSP *creates a comprehensive program by integrating* MAC provider inquiry and provider outreach and education activities. 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 – *Electronic Mailing Lists for MACs*

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

The PCSP uses the following electronic mailing lists to communicate relevant program information to the MAC PCSP staff:

1. Provider Customer Service Program Contractor User Group (PCUG) electronic mailing list – *We use* this electronic mailing list to send important and timely information related

to the PCSP. MACs shall not share information they get on the PCUG electronic mailing list with providers unless directed to do so.

MACs shall send the names and email addresses of the people who wish to subscribe or unsubscribe to the electronic mailing list to the provider services mailbox. There's no limit on the number of subscribers for any MAC, but at a minimum, the following staff shall subscribe:

- MAC POE manager
- MAC PCC *manager*
- PSS *technology managers*
- Quality analysts

Send the required requests to subscribe within 30 days after the award of a new MAC contract. Remove staff who leave your organization or who no longer need access to the electronic mailing list within 7 days of the change.

2. *MAC-specific MLN Connects® electronic mailing list – We use this electronic mailing list to send you important and timely information to share with your provider community (for example, the MLN Connects® newsletter). MACs shall send the names and emails of the people who wish to subscribe or unsubscribe to the electronic mailing list by emailing the MLN Connects mailbox. At a minimum you shall include a permanent MAC component/resource box to get the information we share.*

Send the required requests to subscribe within 30 days after the award of a new MAC contract. Remove staff who leave your organization or who no longer need access to the electronic mailing list within 7 calendar days of the change.

3. *MAC-specific MLN Connects® electronic mailing list – We use this electronic mailing list to send you important and timely information to share with your provider community (for example, the MLN Connects® newsletter). MACs shall send the names and emails of the people who wish to subscribe or unsubscribe to the electronic mailing list by emailing the MLN Connects mailbox. At a minimum you shall include a permanent MAC component/resource box to get the information we share.*

Send the required requests to subscribe within 30 days after the award of a new MAC contract. Remove staff who leave your organization or who no longer need access to the electronic mailing list within 7 calendar days of the change.

10.2 PCUG Call

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

CMS will hold monthly PCUG conference calls. The call allows *us* 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 call. *We* strongly *encourage* MACs to submit agenda topics for consideration to the provider services mailbox.

Each MAC shall present a minimum of one time each calendar year during a monthly PCUG call. MACs shall work with CMS on the subject and timing of the presentation(s).

10.3 – Integration of Provider Outreach and Education (POE), Provider Contact Center (PCC) and Provider Self-Service (PSS) Activities in the PCSP

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

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 *having* CSRs relay information to providers about how to access or register for upcoming provider training or *how to use* available *self-service tools* or to publicize the MAC's provider education website *and portal* while callers are on hold. *We encourage collaboration between POE and PCC staff, including CSRs*, to accomplish their respective tasks. *This collaboration may* occur during regularly scheduled CSR training classes *to avoid taking* additional time from PCC operations.

MACs shall coordinate internally with staff in appropriate areas including *medical review (MR)*, *provider enrollment (PE)*, *electronic data interchange (EDI)*, *systems*, *appeals*, *Medicare secondary payer (MSP)*, and *program integrity (PI)* to share and communicate identified issues. At a minimum, the MACs shall hold periodic meetings with these various components to discuss provider issues and potential resolutions. 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 *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 within 7 calendar days after the information becomes available* to the provider services mailbox. If *the* due date falls on a weekend or holiday, *MACs shall submit* the chart 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. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

At least once a year, *we may* hold an in-person *or virtual* meeting with MAC staff. *CMS expects this meeting to last from 2-4 days. MACs shall send representatives from all facets of the PCSP (PCC, POE and PSS) to:*

- *Discuss* CMS priorities *and* initiatives
- *Share* best practices and program successes

- *Develop* new and improved approaches for the PCSP
- *Exchange* information about PCSP issues
- *Allow* MAC staff to network and identify opportunities for collaboration

10.5– Feedback

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MACs shall respond to periodic information requests from CMS about their PCSP operations, such as PCC technology, staffing profiles, and training needs. This will help CMS maintain program integrity and facilitate proactive risk mitigation on time sensitive issues and emerging trends requiring immediate attention. These requests can be sent through the PCUG listserv mentioned in section 10.1 or using the Survey contractors third party platform, see section 60.1.6.

10.6– PCSP Upgrades

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MACs shall notify CMS of all MAC PCSP upgrades and initiatives involving the purchase or development of hardware, software, or telecommunications technology with costs of \$50,000 or more. Contractors must submit this information to their COR for review and include the Business Function Lead (BFL) and the service reports mailbox. CMS will follow up if additional information is needed. This doesn't replace existing approval processes.

20 – POE

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

The primary goal of the POE program is to give Medicare providers the timely and accurate information they need to understand the Medicare Program, *stay* informed about changes, and correctly bill. POE *educates* providers, their *staff and billing agency representatives* about Medicare Program *fundamentals*, national and local policies and procedures, new Medicare initiatives, significant *program* changes, and issues identified through analyses of provider inquiries, claim submission errors, MR data, *Comprehensive Error Rate Testing (CERT)* data, and Recovery Auditor data.

MACs shall disseminate information to their providers *and agencies representing the 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. MACs shall analyze data in accordance with sections **20.2** of this chapter when developing their outreach and education program.

MACs shall give priority to improper payment outreach and education program activities that *address* one or more of the following:

- *Items* and services with the highest rate of improper payment
- *Items* and services with the greatest total dollar amount of improper payments
- *A* clear misapplication or misinterpretation of Medicare policies
- *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 with the highest rate of improper payment and *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 *individuals* through a variety of communication channels and mechanisms—including Web, telephone, educational messages on the inquiries line(s) and IVR, face-to-face instruction, web-based training, and presentations in classrooms and other settings. *We encourage* 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

- the most frequent and expensive payment errors over the previous quarter
- specific instructions regarding how to correct or avoid such errors in the future
- notice of new topics approved for audits conducted by Recovery Auditors under section 1893(b)
- specific instructions to prevent future issues related to such new audits
- 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 *20.3.1* of this chapter.

20.1 - Partnering with External Entities and with Other MACs ***(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)***

MACs shall establish and maintain partnerships to help disseminate Medicare provider information *through a variety of sources*. *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. When relevant, MACs shall notify partners of their upcoming provider education events and activities.* 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. Partnership activities shall not take the place of MAC-led POE events but shall supplement them.

MACs shall work with each other to establish and maintain collaborative partnerships to educate 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 educating

- *Physicians about the Medicare requirement when ordering home health services for people with Medicare and about the specific documentation requirements of those orders*
- *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*

Partnering efforts may include, but *aren't* limited to:

- *Including information from partners in newsletters or publications*
- *Reprinting and distributing (free of charge) provider education materials*
- *Disseminating provider information or education materials at organization meetings and functions of partnering entities*
- *Scheduling presentations or classes for members of partnering entities*
- *Requesting information for Medicare providers be posted on the websites of partnering entities*
- *Helping partnering entities develop their own Medicare provider education and training material*
- *Partnering with other MACs to educate providers that may cross MAC jurisdictions*
- *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, 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) *monthly*. See section *80.3.2.3* of this chapter for more information on reporting requirements.

20.2 - Data Analysis - Overall

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MACs shall conduct comprehensive data analysis to identify educational priorities and develop targeted outreach strategies that address the most significant compliance challenges within their jurisdictions. This analytical approach transforms provider education from a one-size-fits-all model into a precision-focused system that directly addresses the root causes of billing errors and improper payments.

MACs shall analyze all available data *sources to understand provider billing patterns and educational needs. This comprehensive data collection provides MACs with a complete picture of where providers struggle most and where educational interventions can achieve the greatest impact.*

The data *sources listed in this section represent examples rather than exhaustive requirements, and MACs should exercise professional judgment to determine whether their PCSP would benefit from analyzing additional data not specifically mentioned. This flexibility allows MACs to adapt their analytical approach to address unique challenges within their specific geographic regions or provider populations.*

MACs shall use their analytical findings to develop and continuously modify their POE strategy, ensuring that educational content directly addresses the most prevalent and impactful errors

identified through their analysis. To maintain consistency and maximize effectiveness, MACs must build their educational activities on existing CMS products and MLN content, using proven materials that have demonstrated success across the Medicare program. MACs should also proactively recommend topics to CMS for new MLN products based on specific needs and knowledge gaps identified through their data analysis, establishing a collaborative feedback loop that strengthens the entire Medicare education framework. Topics can be emailed to the [MLN mailbox](#).

This creates a continuous improvement cycle where data analysis drives educational priorities, and educational effectiveness can be measured through subsequent reductions in identified error patterns. MACs should track the effectiveness of their educational interventions by monitoring whether targeted errors decrease following specific educational campaigns, allowing for ongoing refinement of both analytical methods and educational approaches.

This data-driven approach to provider education maximizes the return on educational investments by focusing resources where they will achieve the greatest impact on reducing improper payments, improving claims accuracy, and enhancing overall program integrity. By systematically analyzing data and translating findings into targeted educational interventions that align with established CMS educational framework, MACs can demonstrate measurable improvements in provider compliance while reducing administrative burden for both providers and Medicare program.

20.2.1 - Improper Payments Data Analysis

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MACs shall analyze Recovery Auditors data from the Recovery Audit Contractor (RAC) Data Warehouse in accordance with the Medicare Access and CHIP Reauthorization Act (MACRA) 2015 section 505. This analysis serves as the foundation for developing targeted educational interventions that address the most significant sources of improper payments within each MAC's jurisdiction.

MACs shall analyze data to identify:

- *High Risk Providers – Providers with the highest improper payment rates*
- *High Dollar Providers – Providers responsible for the greatest total dollar amounts of improper payments*
- *High Risk Services - Items and services with the highest improper payment rates*
- *High Dollar Services - Items and services generating the greatest dollar amounts of improper payments*
- *Additional CMS-Specified Data – Other data elements CMS determines necessary for program improvement*

program *improvement*

20.2.2 - CERT Error Rate Reduction Analysis

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MACs shall *develop comprehensive education plans specifically focused* on reducing the CERT error rates. *This analysis required integration of multiple data sources to create a complete picture of error patterns and educational opportunities within the MACs jurisdiction. The primary data sources include CERT program data (including inpatient claims error rates), RAC program data, provider inquiry tracking data and claims submission error data.*

To ensure effective error rate reduction, MACs shall maintain robust data analysis program that use national data reports whenever CMS makes them available, as these provide valuable benchmarking opportunities and identify nationwide trends. MACs shall also analyze local data to pinpoint specific providers who drive unusual error patterns within their jurisdiction, enabling targeted interventions where they will have the greatest impact.

20.2.3 - Provider Inquiry Analysis

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MACs shall *establish and maintain a systematic approach to analyzing provider inquiries identifying common areas of confusion or misunderstanding. This analysis enables MACs to develop proactive educational interventions that address recurring issues before they result in claim errors. By implementing a comprehensive inquiry analysis program, MACs can transform reactive customer service into proactive education that prevents problems at their source.*

MACs shall maintain a provider inquiry analysis program that generates monthly reports of frequently asked questions (FAQs) that indicate systemic knowledge gaps. MACs shall use CMS-approved classification systems for categorizing inquiries to ensure consistency across jurisdictions and enable meaningful trend analysis. Based on identified patterns, MACs shall develop targeted education that directly addresses provider needs and knowledge gaps revealed through the inquiry data. Additionally, MACs shall create comprehensive training programs for PCSP staff based on inquiry trends to ensure staff can effectively address common provider concerns and provide accurate guidance.

20.2.4 –Claims Submission Error Analysis

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MACs shall maintain a comprehensive analysis program to identify and address the most common claims submission errors across their jurisdiction. This proactive approach helps prevent errors before they occur, reducing administrative burden for both providers and MACs while improving overall claims processing efficiency and accuracy.

Claims submission errors are those that result in rejected, denied, or incorrectly paid claims. *MACs shall analyze rejected claims, denied claims, incorrectly paid claims, common clerical administrative errors, and inadvertent errors that providers make unintentionally but could be prevented through targeted outreach and education. MACs shall maintain a comprehensive data*

analysis program that *examines claims submission patterns to identify educational opportunities. This program shall generate monthly reports documenting the most frequent collective claims submission errors from all providers in their jurisdiction, enabling MACs to prioritize their educational efforts based on actual error frequency and impact. MACs may identify billing pattern aberrancies within homogeneous provider groups, such as unusual coding patterns among similar specialty practices of systematic errors within specific provider types that may indicate widespread misunderstanding of billing requirements.*

The analysis shall also detect patterns within individual claims or groups of claims that may reveal systematic issues requiring targeted intervention. MACs shall conduct this data analysis through ongoing general surveillance of submitted claims but must also be prepared to conduct focused analysis in response to specific triggers including:

- *Provider complaints, or input regarding billing difficulties*
- *CMS alerts or reports highlighting emerging issues*
- *Reports from other MACs identifying cross-jurisdictional problems*

MACs shall use their analytical findings to develop and continuously modify their POE approach, ensuring educational content directly addresses the most prevalent and impactful submission errors identified through their analysis. This creates a continuous feedback loop where data analysis drives educational priorities, and educational effectiveness can be measured through subsequent reductions in identified error patterns. MACs should also track the effectiveness of their educational campaigns, allowing for refinement of both analytical methods and educational approaches over time.

20.2.5 – Medicare Policy Error Analysis

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MACs shall conduct *focused analysis to identify improper payments that stem from a clear misapplication or misinterpretation of Medicare policies rather than intentional non-compliance. This analysis helps distinguish between educational opportunities and potential fraud or abuse situations.*

20.2.6 MR Referral Analysis

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

POE staff must maintain comprehensive tracking and analysis of MR referrals to ensure effective educational interventions and measure outcomes. This analysis creates a feedback loop between MR activities and provider education efforts. In accordance with Pub. 100-08, Medicare Program Integrity Manual, Chapters 1 and 3, POE staff shall provide education resulting from MR referrals. POE staff shall maintain information about

- *MR referral details and trends*
- *Provider education requests*
- *Follow-up communications with MR, and*
- *Problem resolution documentation*
- *Types of education provided*
- *Outcomes and effectiveness measures. See section 20.3.6.2 of this chapter.*

20.3 - Provider Education

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MACs shall use CMS national educational materials like CMS.gov, MLN products and the MLN Connects newsletter in POE activities. If a MAC plans to translate materials into another language, they must make CMS aware by emailing the provider services mailbox with the subject line: “MAC name – Language Translation.” Note: this is for awareness not clearance.

20.3.1 – National Education Publications

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

Medicare Learning Network® (MLN), MLN Connects® and MLN Matters® are registered trademarks of *HHS* and *represent official* brand names for provider educational products, outreach activities, and information resources. *CMS* designed *these materials* to promote national consistency *in* Medicare provider information. MLN products *encompass a comprehensive range of educational materials including:*

- Publications *such as* fact sheets, educational tools, and booklets
- MLN Matters Articles *that explain policy changes and updates*
- MLN Connects newsletter *that provides regular updates and announcements*
- Web-based training *modules for convenient online learning*
- Multimedia *resources that accommodate different learning preferences*

MACs shall use these MLN products and content to deliver planned and coordinated provider education *programs* that *accommodate* health care professionals’ busy schedules with *minimal* disruption to their normal business operations. *This requirement applies to all educational topics and extends specifically to* specialty provider groups *including* new Medicare providers *who may have limited resources for staying current with Medicare requirements. While MACs must build their educational foundation on* MLN products and other CMS materials, *they shall supplement these resources* with specific information unique to their jurisdictions.

MACs shall include or link to relevant MLN products *in all their educational materials and communications. This ensures providers have immediate access to the most current authoritative information available. Additionally, MACs must* train their CSRs at least once per contract year on *three critical areas:*

- *Navigating and using* the MLN webpage *effectively*
- *Accessing and using* MLN products or content *to answer provider questions accurately*
- *Understanding* the MLN Connects newsletter *format and content to help providers stay information about important updates and changes.*

If *MACs plan to translate any CMS national educational materials into another language, they shall notify CMS by emailing the provider services mailbox with the subject line “MAC name – Language Translation.” This notification is for awareness only and does not require CMS clearance or approval.*

When MACs identify gaps in available information about specific topics through their data analysis or provider feedback, they shall proactively suggest new topics by emailing the MLN mailbox. This creates a valuable feedback loop that helps CMS identify emerging educational

needs and develop new resources that address real-world provider challenges. MACs should document the rationale for their suggestions, including data supporting the need for additional educational materials, to help CMS prioritize development of new MLN products that will benefit providers nationwide.

20.3.2 - Provider Bulletins and Newsletters

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MACs *have the* discretion *to* electronically distribute and post *provider bulletins and newsletters containing* Medicare Program and billing information *on their websites.*

When MACs offer these communications, they shall actively encourage providers to access electronic copies through their provider education websites rather than requesting paper versions. Electronic distribution ensures providers receive information quickly and allows MACs to update content efficiently when Medicare policies change. MACs shall promote electronic access through multiple channels including their websites, provider communications and customer service interactions.

MACs that distribute bulletins or newsletters shall ensure equitable access by providing paper copies via U.S. Postal Service to active providers without internet access, when MACs are aware of this limitation. MACs determine active providers by verifying that enrollment records in PECOS show “active” status. This requirement prevents digital barriers from limiting access to essential Medicare information that affects provider compliance and payment.

When providers who already receive complementary paper copies request additional paper copies on a regular basis, MACs may charge a subscription fee for this service. Any subscription fees shall be “fair and reasonable” and be based on the actual cost of producing and mailing the publication. This fee structure allows MACs to recover expenses while providing ongoing service to providers who prefer or require paper communications.

20.3.3 – Direct Mailings for the PCSP

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

When CMS requests, MACs shall send letters (known as “direct mailings”) via email or hardcopy to all or a subset of their active providers. Refer to 20.3.2 of this chapter for the definition of “active” providers. MACs shall follow the specific business requirements in the associated Change Request (CR) to determine the delivery method (email or hardcopy), the correct address to use, and any other instructional information.

MACs shall send these letters directly to providers and shall not send them to the addresses of billing agencies or clearinghouses that providers use for their billing services. This ensures that important Medicare communications reach the intended recipients directly rather than third-party intermediaries who may not forward the information promptly or accurately.

For *hardcopy* mailings, MACs shall use *their standard* letterhead and envelopes *that they typically use* for provider correspondence. *For email distributions, MACs shall only include the*

letter content in the email without additional attachments or formatting that could cause confusion or delivery issues. All Medicare communications shall comply with IOM Pub 100-09, Chapter 1, section 20, which requires Medicare identification to distinguish Medicare correspondence and establish program identity with physicians, suppliers, and beneficiaries. The word “Medicare” or the CMS alpha representation must appear at least as large as the organization’s identification and placed in a location that provides equal or greater prominence to ensure clear Medicare program identification.

When possible, CMS will *provide* the direct mailing letter in Word format to allow MACs to *format* the letters *for* use *with* window *envelopes*. Unless otherwise instructed, MACs shall follow their internal procedures *for handling* undeliverable mail.

When *CMS directs*, MACs shall also post a link to the letter on their provider education website *to ensure broader access and allow providers to reference the information online at their convenience. This dual distribution approach helps ensure that providers receive important information through multiple channels and can access it even if they miss the initial communication.*

MACs shall report direct mailing activities *according to the requirements in section 80.3.2.10 of this chapter. This reporting helps CMS track the effectiveness of direct communication efforts, measure provider engagement, and ensures accountability in provider outreach activities. This reporting should include details about the number of letters sent, delivery methods used, response rates when applicable, and any issues encountered during the distribution process that could inform future mailing strategies.*

20.3.4 - Training for New Medicare Providers **(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)**

MACs shall offer *comprehensive training programs specifically* tailored to *meet* the needs of new Medicare providers and *their* billing staff. *This training serves as a critical foundation for successful participation in the Medicare program and helps prevent common billing errors that can lead to claim denials and payment delays.*

MACs shall use CMS-developed materials, including relevant MLN products or content *as outlined in section 20.3.1 of this chapter. This ensures consistency across all MAC jurisdictions and provides new providers with authoritative, up-to-date information about Medicare requirements. The training shall cover* fundamental Medicare policies, programs, and procedures *with particular emphasis on Medicare billing requirements, claims submission processes, and compliance obligations that new providers need to understand immediately.*

As part of their comprehensive training approach, MACs must actively encourage new providers to register for the MAC’s secure internet portal. MACs should demonstrate portal functionality during training sessions and provide step-by-step registration assistance to ensure providers can effectively use these digital resources. Additionally, MACs shall encourage new providers to become familiar with the MAC’s provider education website, which serves as an ongoing

resource for policy updates, educational materials, billing guides and FAQs that support continued learning beyond the initial training period.

20.3.5 - Training Tailored for Small Medicare Providers

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MACs shall tailor education to *meet* the needs of their small Medicare providers. Small providers are defined by law as providers with fewer than 25 full-time equivalent (*FTE*) employees or suppliers with fewer than 10 *FTE* employees. *MACs may use* interactive communication such as face-to-face training *sessions* or web-based tutorials *and* instruction. MACs *aren't required* to identify or validate providers who meet the definition of small provider.

Education and training *for* small providers may include the following:

- Reviewing billing systems and internal controls to determine program compliance and suggest more efficient and effective *ways to achieve* compliance
- Holding educational seminars for groups of providers *who have* similar issues *and* providing technical assistance from EDI support staff

20.3.6 – Educational Topics

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MACs *have* discretion to determine the educational topics most relevant to their provider population. MACs shall use various sources of information *to determine these topics*, including provider feedback, policy and procedure changes, and MAC data analysis. *However*, at a minimum, MACs shall educate providers on the topics outlined in this section.

20.3.6.1 – Local Coverage Determinations

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MACs shall educate their provider community on new or significantly revised final *Local Coverage Determinations* (LCDs). MACs shall include pertinent information about the LCDs on their provider education website and as part of regular bulletin distributions (if published), including articles drafted by the MR personnel.

Clinical questions about the LCDs, such as the rationale behind coverage of certain items or services versus other similar ones, shall be directed to MR personnel who will respond in accordance with Pub. 100-08, Medicare Program Integrity Manual, Chapter 13.

MACs may send a POE representative to the MAC's Contractor Advisory Committee (CAC). This participation helps the POE staff understand, and address provider concerns more effectively. For additional information about CACs, refer to Pub. 100-08, Medicare Program Integrity Manual, Chapter 13.

20.3.6.2- Education Resulting from MR Referrals

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

In accordance with Pub. 100-08, Medicare Program Integrity Manual, Chapters 1 and 3, the MAC's MR area shall analyze MR data and make two types of education referrals to POE: probe *review referrals* and priority referrals.

- A. Probe Review Referrals: *Providers receive a notification letter when* MR staff *perform* a probe review *that may* include an offer for provider education to address the issues found in the probe. *If a provider requests* education in response to one of these letters, POE staff shall be responsible for providing this education. *MACs determine the* appropriate *type of education*, including one-on-one training *or referring* the provider to available web training *or* upcoming workshops *about* the topic. *POE staff shall have* access to the probe notification letters *in case* a provider *contacts* POE staff to request education.
- B. Priority Referrals: MR staff *initiate priority referrals when they believe* education *will help* a provider or small group of providers prevent further errors and reduce fraud. POE staff should collaborate with MR staff *to evaluate* these referrals *and* determine what type of education, if any, is appropriate and whether this education *aligns* with the overall MAC strategy to reduce error *rates*.

The MAC *has* no obligation to provide specific education *for* all MR referrals. *Instead, the MAC shall determine the* education *they provide because of MR referrals based on their* goal *to reduce* the error rate *using available* resources. *MACs have discretion over the* type of education and *clinical staff* involvement. MACs shall not charge for this education. (See section *20.7.1* of this chapter.)

POE staff shall provide timely feedback to MR staff about *referral dispositions*, including whether a provider requested education in response to a probe letter. POE staff shall work with MR staff to develop an effective *communication* system that, at a minimum, *tracks MR staff* referrals, *provider education* requests, follow-up *communications* with MR staff, and *problem* disposition, including type of education *provided*.

20.3.6.3 - Medicare Preventive Service Benefits

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MACs shall promote the use of preventive services and other benefits *that* the Medicare program *provides* to beneficiaries. For more information see the [*Preventive Services*](#) website.

20.3.6.4- Electronic Claims Submissions

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MACs shall conduct training for providers *and* their staff on electronic claims to educate them *about* Medicare billing software and *expand their use of* EDI transactions *that Medicare supports*. *MACs may direct* providers to contact EDI support staff directly for technical billing system assistance. DME MACs should *provide instructions on* how to contact the Common Electronic Data Interchange (CEDI) *contractor*.

20.3.6.5- Remittance Advice

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MACs shall promote the use and understanding of the Remittance Advice (RA) as an educational tool for communicating claims payment information to providers. *When MACs receive and process claims, they send providers an RA*, which is a notice of payment and adjustment. An adjustment refers to any change that *affects* how *MACs pay a claim* differently from the original billing, *including* denied *claims*, zero *payments*, partial *payments*, reduced *payments*, *applied penalties*, additional *payments*, and supplemental *payments*.

Claim Adjustment Reason Codes and RA Remark Codes are two important non-medical code sets *that* communicate *adjustments* and *explain* why *MACs paid* a claim or service line differently than the provider billed. *The official ASC X12 website provides descriptions* for *both* code sets.

When CMS *doesn't* instruct MACs to use specific Claim Adjustment Reason Codes and RA Remark Codes to communicate claim payment and adjustment information, and *when* a code would help reduce provider inquiries, MACs shall use appropriate codes. MAC provider inquiry, POE, and systems staff shall *collaborate* to identify Claim Adjustment Reason Codes and RA Remark Codes *that* help communicate *adjustments* 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). MREP software *provides several benefits*:

- *Saves* time and money by printing remittance information directly on the day the Health Insurance Portability and Accountability Act (HIPAA) 835 *becomes* available without waiting for the mail
- *Creates and prints* special reports
- *Creates documents* that *providers* can *include* with claim submissions to secondary/tertiary payers.

CMS prefers the ERA for claims payment communication. When new versions of MREP software become available, MACs shall post *notifications* on their provider education websites and communicate this information to their MREP contact list and provider electronic mailing *lists*.

If a provider elects to receive the Standard Paper Remit (SPR), MACs shall use the SPR provider messaging properties, when available, to convey Medicare programmatic information including, *promoting* their provider education websites, *announcing* changes in policies and programs, and *promoting* their upcoming POE activities.

20.3.7- Web-based Provider Educational Offerings

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MACs shall offer web-based training and educational resources as self-help tools *for* Medicare Program *information*. MACs shall *actively* encourage providers to use the CMS website and *the MAC's provider education* website *to access* these *educational* offerings. *Additionally, MACs*

shall promote provider subscription to their electronic mailing lists to receive notifications about new and upcoming training opportunities.

To ensure accessibility for all providers, MACs must archive materials from all webcasts and make them available upon request to providers who couldn't attend the live sessions. This approach ensures that valuable educational content remains accessible to the provider community regardless of their ability to participate in real-time events. MACs have discretion to determine the appropriate length of time that archived webcast materials need to remain available to providers to ensure content is current.

20.4- POE Materials

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MACs shall develop clear, concise and accurate POE materials *that comply with Section 508 requirements and follow* the Plain Language Act of 2010 guidelines. MACs shall use CMS-developed materials, including relevant MLN products or content *when applicable*. See section 20.3.1 of this chapter. MACs shall include *the month and year they were produced* or re-issued *materials* within *each* publication. MACs shall disseminate POE materials timely, efficiently, and cost-effectively.

CMS owns all MAC-developed materials and *MACs* shall *make these materials* available to CMS upon request. If a MAC reproduces or uses material, in whole or in part, *that another MAC* originally developed, the MAC shall acknowledge the other MAC either within the material, or on its cover, case or container.

20.5- Regular Meetings

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MACs must establish and maintain regular meeting schedules with providers and their staff to support ongoing education, communication and relationship building. MACs can use these meetings to disseminate Medicare program information, address provider concerns and gather feedback that helps them improve service delivery.

20.5.1– POE Advisory Groups

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

Each MAC shall establish and maintain a POE Advisory Group (POE AG) *whose* primary function *involves helping* 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 contract year. *MACs shall provide teleconference/video conference capabilities for POE AG members who can't physically attend in-person meetings.*

The MAC shall maintain the POE AG and *designate* the main point of contact for all POE AG within the MACs POE area. The MAC shall not allow outside organizations to operate the POE AG. 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*
- *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 *serve on* other advisory committees, *most* POE AG members shall not be current members of any other MAC advisory group. After soliciting suggestions from the provider community, the MAC shall select the appropriate *people* and organizations *for* POE AG *inclusion*. 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. *The POE AG shall represent providers from different geographic areas, as well as from urban and rural locales.*

MACs shall consider having more than one POE AG if the size of *their* jurisdiction or diversity of providers within the jurisdiction affects the effectiveness of having a single POE AG (for example HH+H). MACs may choose to have a single POE AG for all contracts *they oversee* or have separate *groups* for each of *their* jurisdictions.

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

MACs shall consider the suggestions and recommendations of *their* POE AG and implement those *they deem* feasible and in the best interest of an effective PCSP. *To maintain* working *relationships*, the MAC shall explain to the POE AG *their* reasons for not implementing or adopting any POE AG suggestions or recommendations.

MACs shall distribute meeting times and agendas, which include discussion topics *suggested by* POE AG members, to all *POE AG* members and to CMS Central and Regional Office staff *before* any meeting.

20.5.2– "Ask-the-Contractor" Meetings

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

“Ask-the-Contractor” Meetings (ACMs) provide 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 ACMs.

MACs have the option to hold ACMs to complement, but not replace, the work of the POE AG. See section *20.5.1* of this chapter. MACs can offer ACMs as frequently as necessary. In designing ACMs, MACs shall consider all technological approaches, such as teleconferences and webinars. MACs may invite CMS Central and Regional Office staff to listen to ACMs. MACs shall update their provider education website to reflect what was discussed on the ACM. MACs are encouraged to post event information on their provider education website following the meeting.

MACs can use their POE AG to assist with *determining* the timing, frequency, size, topics, and provider *types to include* in ACMs. MACs should use methods *like* inquiry analysis, claims submission error analysis, MR data analysis, input from PCC staff, and information gathered through partnerships *to identify ACM topics*.

20.6- POE Reporting

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MACs shall report POE activities in PCID in accordance with section *80.3.2.3* of this chapter.

MACs shall prepare and submit the PCSP documents described in sections *20.6.1* and *20.6.2* of this chapter and submit updates as necessary.

Additional reporting may be required. See section *20.6.3* of this chapter.

20.6.1 – Provider Service Plan

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

Each MAC shall prepare and submit to CMS a one-time Provider Service Plan (PSP) that outlines the strategies, projected activities, efforts, and approaches the MAC will use throughout *its contract* duration 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, 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, *MACs* shall *submit the PSP* by close of business *on* 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, *MACs* shall *submit the PSP* 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, *MACs shall submit* the PSP by close of business on the next business day.

CMS requires a PSP for each new MAC contract, even if the incumbent *wins* the new contract *award*.

MACs shall use the PSP template and instructions *that CMS provides* in the Documentation section of PCID. CMS will notify MACs about updated templates *through* the PCUG electronic mailing list described in section 10.1 of this chapter.

20.6.2 – Provider Customer Service Program Activity Report *(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)*

Each MAC shall prepare an annual Provider Customer Service Program Activity Report (PAR) *that* summarizes and recounts the MAC's POE activities. *The PAR* 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 analysis* and follow-up actions
- *Materials* development and dissemination
- *ACM* and POE AG meetings

MACs shall use the PAR *to* report any changes to information contained in the PSP. HH+H MACs shall prepare *a* separate PAR for their corresponding HH+H work. MACs *aren't* required to include a listing of POE events because *they* shall *report that information* to PCID in accordance with section *80.3.2.3* 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, *MACs shall submit* the report by close of business on the next business day. MACs shall send all PARs electronically in MS Word to the provider services mailbox and to the appropriate COR or designee.

MACs shall use the PAR template and instructions *that CMS provides* in the Documentation section of PCID. MACs shall ensure *they're* using the most recent version of the PAR template. CMS will notify MACs about updated templates *through* the PCUG electronic mailing list described in section 10.1 of this chapter.

20.6.3 – Discretionary Reporting

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

CMS emphasizes the importance of *integrating* data analysis across all business functions within the MAC, as the MAC continuously assesses *how* its outreach and education efforts *affect* the error rate. MACs shall work to maintain or improve their CERT scores. At its discretion, CMS may require MACs who *don't* maintain or improve their scores from their *previous* year to submit additional reporting related to *how* they use outreach and education to achieve a reduction.

20.7- Charging Fees to Providers for Medicare Education and Training

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

Typically, MACs shall not charge for developing, reproducing, or presenting provider education and training materials.

However, MACs may charge “fair and reasonable” fees in some circumstances to offset or recover costs associated with education and training. MACs may not profit from or use fees to supplement MAC activities in other functional areas.

20.7.1– No Charge

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MACs shall not charge providers who are attending or participating in an education or training activity (that is, a non-conference outreach program) based upon *an* MR identified need for education. See sections *20.2.6* and *20.3.6.2* of this chapter.

20.7.2– Fair and Reasonable Fees

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MACs may charge “fair and reasonable” fees to cover the cost of certain POE materials and activities. “Fair and reasonable” means *MACs charge fees that align* with *their* actual *costs* and *remain* within the *financial* means of likely participants in the activity or recipients of materials.

20.7.2.1– Fees for Materials Available on MACs’ Provider Education Websites

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MACs may charge a fair and reasonable fee for duplicating and shipping materials directly to providers when the materials are available on their provider education website (including duplication in paper or in other formats).

20.7.2.2- Fees for Education and Training Activities

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MACs may charge fair and reasonable fees for education and training activities when those fees will offset or recover the costs associated with the following: travel, facility rental and set-up (see section *20.7.3* of this chapter for additional information), equipment rental and set-up, and development and reproduction of materials expressly developed for and disseminated at an education or training activity.

MACs may not use fees to supplement MAC activities in other functional areas.

20.7.2.3- Fees for Videotapes or Recordings of Education and Training Activities *(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)*

Entities not employed by CMS or not under contractual arrangement with CMS *can't* videotape or otherwise record education and training activities for profit-making purposes unless *they receive* prior approval from the COR. If a MAC records an education or training activity, the MAC may charge a fair and reasonable fee to duplicate and mail the recording to providers upon request.

20.7.3– Prohibitions *(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)*

MACs shall not offer providers light food or refreshments at education or training *activities* unless the facility rental *includes light food or refreshments*. If *they're* part of the facility rental, MACs shall not include the costs of those items in any fees they may charge providers for the education or training activity. MACs shall not advertise the availability of light food or refreshments.

MACs may request COR approval *when* they wish to invite CMS employees to participate in or attend *an education or training event*.

20.7.4– Reimbursement from Providers for POE Staff Attendance at Provider Meetings *(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)*

Providers, provider societies, *or* associations *may* offer to pay travel costs for a MAC's POE staff *to* attend and participate in provider meetings. In most instances, MAC staff may accept travel reimbursement if a provider society *or* association *sponsors the event*. However, if a single provider *sponsors the event*, the MAC shall not accept travel reimbursement.

If a MAC *wants* to accept a society or *association's offer*, the MAC shall send its *COR* and Contract Specialist a copy of the event invitation letter, proposed agenda, and, as applicable, issues the MAC's staff *will present* or discuss as part of a panel or general question *and* answer discussion.

In all cases, MACs shall not accept speakers' fees, but they may accept small gifts such as pens engraved with the *host's* logo, coffee mugs, plaques, flowers, *and similar items*. MACs *aren't* permitted to accept or use substantive gifts or donations associated with participation in education and training activities *without* specific authority from CMS.

20.7.5– Excess Revenues from Provider Participant Fees *(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)*

When MACs collect fees *that exceed their* allowable costs *for provider education and training activity*, *they shall* handle excess revenues *using one of two methodologies*:

1. Per Activity Methodology

MACs shall ensure the total fees collected for any education or training activity *don't* exceed actual

costs by more than 10%.

- If *excess* is 10% or less: *The* MAC may incorporate the excess revenue into its POE program.
- If *excess* exceeds 10%: *The* MAC shall refund the entire excess amount *equally* to all registrants who paid *fees* for the activity.

For example, a MAC *charges* 250 participants \$50 *each* for an activity *costing* \$10,000 (meeting facility *and* equipment rental). *The MAC collects \$12,500, which exceeds costs* by \$2,500 (25%). *Since this exceeds the 10% threshold, the MAC shall distribute the entire \$2,500 excess* equally *among* all paying registrants.

2. Per Year Methodology:

At the end of the 9th month of the contract year, the MAC shall:

- *Total all* fees collected *from* completed fee-associated provider education and training activities
- *Add* estimated fees from remaining scheduled activities *for the year*.
- *Subtract* the total actual and anticipated costs for all fee-associated education and training activities
- *Ensure the* remaining *amount doesn't* exceed actual and expected by more than 25%

If *excess* is 25% or less: *The* MAC shall note that amount in its PAR and incorporate the excess revenue into its POE program.

If *excess* exceeds 25%: *By* the end of the 10th month, *the MAC shall send a message* to the provider services mailbox detailing the excess revenue *amount its* plan to equally refund the entire excess *equally* to all provider registrants who attended fee-based activities *during that contract year*.

20.7.6– Refunds or Credits for Cancellation of Education and Training Activities ***(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)***

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

CMS understands that *MACs may need to make contractual commitments to* secure accommodations and services for planned provider education and training activities, *which could result in unavoidable* expenses. MACs may *consider these contractual obligations* when determining their refund *and* credit *policies*.

The policy must adhere to *these* guidelines *at minimum*:

- *Provider-initiated cancellations* - MACs shall *provide* full or partial refunds *or* credits to providers who pay a fee to attend an activity but who cancel before the activity date
- *MAC-initiated cancellations* - MACs shall *provide* full refunds *when they* cancel activities for which provider registrants *have already* paid fees
- *This policy framework allows MACs flexibility to account for their contractual commitments while ensuring fair treatment of providers who cannot attend scheduled activities.*

20.7.7– Considerations and Recordkeeping for Fee Collection

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

For each contract year, MACs shall keep *detailed* records of the actual costs *they incur* for each education or training activity *they hold*. *These* records shall *document* actual costs *for* the following *categories where applicable*:

- *Travel expenses*
- *Facility* rental and set-up *costs*
- *Equipment* rental and set-up *costs*
- *Development* and reproduction of materials *that MACs specifically create* for and *distribute* at education or training *activities*

MACs shall *also* keep *comprehensive* records of all fees *they charge* and *collect* from, provider registrants. *These records serve as documentation to support the fees charged for each activity.*

MACs shall keep these records for at least 1 year from the date of the education or training *activity*. *The records* shall *clearly* document *the* actual costs used to *justify* the fees charged *to participants*.

This record-keeping system ensures transparency and accountability in MAC fee structures while providing the necessary documentation to support cost-based pricing for provider education and training activities.

30 - PCC

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

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's 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.

MAC PCCs play a vital role in ensuring providers receive accurate, timely, and consistent Medicare information across all communication channels. As the primary point of contact between Medicare and health care providers, PCCs are essential for maintaining high-quality customer service and supporting effective program administration.

Your PCC shall include:

- *Provider telephone inquiries staff*
- *General written inquiries staff*
- *Provider Relations Research Specialists (PRRS)*
- *Walk-in inquiries staff*

Except for technologies discussed in sections 30.6.2 and 50 of this chapter and in chapter 2 of this manual, CMS does not require the use of any specific technologies, *if* 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 *understand both* telephone and written *provider* inquiries. MACs shall *enter the following for each contact in PCID:*

- *Full name*
- *Business telephone number*
- *Business email address*
- *Type of contact type (telephone, written, technical, etc.)*

See section 80.3.1 of this chapter for PCID reporting and data certification requirements.

30.1 – PCC Contractor Alerts

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MACs *shall email the service reports mailbox with the subject "Contractor Alert" as soon as they're aware of factors having an adverse effect on the PCC performance or operations.* The email shall describe the change or event, explain the impact on the PCC, and describe *what's* needed, internally or from CMS, to resolve the matter. Changes or events that may produce adverse effects on the PCCs include, but *aren't* limited to, the following:

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

- Unexpected increase in call volume or written *provider inquiries* 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
 - *Issues with* other MAC functional *areas*
 - *Unavailability* of data from any source used by the PCC
 - *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 *doesn't* eliminate the requirements to report *service interruptions (sections 30.6.4 and 80.3.2.6)* and *daily exception reports (sections 70.1.1 and 70.1.2)*.

30.2 – PCC Closures

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MACs shall analyze call patterns and consult their POE AG to determine optimal PCC closure times that will minimize impact on their ability to meet CMS performance requirements. Planned closures, including those used to train staff, shall not be the justification for missing PCSP performance requirements.

30.2.1 – Notifying Providers About PCC Closures

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MACs shall notify providers about planned PCC closures at least 2 weeks before their PCC will be closed. At a minimum, MACs shall post a PCC closure announcement on their provider education website and send a message through their electronic mailing list(s). MACs may also play an announcement on their IVR system. MACs with separate IVR and CSR lines should post a PCC closure notification for providers on both lines.

MACs shall monitor provider complaints about PCC closures and take action to resolve them and decrease the volume of complaints. Reports about provider complaints and their resolution shall be kept on site and available to CMS upon request.

30.2.2 Planned PCC Closures

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MACs shall submit planned PCC closure requests through PCID at least 30 days before each contract year begins. These requests typically cover closures for federal holidays, MAC-specific holidays, corporate meetings, and systems transitions. This requirement doesn't apply to specifically

intended for PCC staff training, which are covered under separate guidelines in section 30.2.3.

MACs may close their PCCs on the pre-approved days listed below without seeking CMS permission. For all other closure dates, MACs should consider their request automatically approved if CMS doesn't respond within 5 business days.

Pre-Approved Closure Days

- New Year's Day
- Martin Luther King, Jr. Day
- Presidents' Day
- Good Friday
- Memorial Day
- Juneteenth
- Independence Day
- Labor Day
- Columbus Day
- Veterans Day
- Thanksgiving Day
- Day After Thanksgiving
- Christmas Eve
- Christmas Day
- Day After Christmas

See section *80.3.1* of this chapter for the PCID reporting requirements.

30.2.3–PCC Training Closures

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MACs may close one or more locations of their PCCs to train their CSRs 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 8 hours per month shall only be used for training and not corporate meetings or other events. Unused hours can't be carried over to the next month.

For any training closures that fall outside the pre-approved days listed in section 30.2.2, MACs shall submit their requests through PCID. MACs shall consider these PCC closures approved unless CMS objects within 5 business days after the PCID reporting deadline.

See section *80.3.2.2* of this chapter for the monthly PCID reporting requirements.

30.2.4-Emergency PCC Closures

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MACs may occasionally need to close their PCCs to ensure staff safety and operational security. These closures may affect one or all PCC locations within a jurisdiction. Emergency closures typically result from severe weather conditions, building related problems such as utility failures, health and safety concerns requiring immediate action, or security issues including required emergency drills. During

such closures, MACs must follow specific reporting procedures to ensure CMS remains informed of operational status.

MACs shall report all emergency PCC closures to CMS, even when they have backup plans for handling calls since an emergency closure can affect call volume and service quality, regardless of contingency plans.

MACs shall use the PCID Service Interruptions module to report incidents to CMS (see section 80.3.2.6 for more information).

30.3 – Disaster Recovery Plan

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

When a PCC is faced with a situation that results in a major disruption of service, the PCC shall:

- *Take immediate* action to *notify* providers of the situation
- *Activate* emergency messages *and re-route* calls *whenever possible (Contact the Provider Network Support (PNS) contractor if unable to reroute calls and providers can't reach the PCC switch)*
- *Follow normal procedures for* all other telecommunications support requests

MACs shall develop and maintain an annual telecommunications Disaster Recovery Plan *that describes* how the Medicare provider telecommunications operations will be maintained or continued in the event of manmade or natural disasters. The Disaster Recovery Plan shall cover, at a minimum, all items outlined in the Disaster Recovery Plan Checklist located in the Documentation section of PCID. The Disaster Recovery Plan shall also contain a Compliance Matrix that identifies where each item in the checklist can be found in the MAC's Disaster Recovery Plan. The Disaster Recovery Plan may include arrangements with one or more other MACs to assist in telephone workload management *when* the PCC is unable to receive provider telephone calls.

MACs shall submit the Disaster Recovery Plan to the service reports mailbox and *the COR or designee* by the end of the third month of the contract year. *Newly* awarded MAC contracts *shall submit the Disaster Recovery Plan according to following schedule:*

- If the contract award date was between the 1st and the 14th of a month, the initial Disaster Recovery Plan is due the last day of the second month that follows the month of the contract award.
- If the contract award date was between the 15th and the last day of a month, the Disaster Recovery Plan is due the last day of the third month that follows the month of the contract award.

If the due date falls on a weekend or holiday, the Disaster Recovery Plan is due by close of business on the next business day.

The Disaster Recovery Plan is a separate deliverable, however instead of developing a stand-alone telecommunications Disaster Recovery Plan, MACs may choose to submit the telecommunications portion of their overall MAC contingency plan developed in accordance with the requirements found in Pub. 100-17, Centers for Medicare & Medicaid Services (CMS) Business Partners Systems Security Manual.

30.4 CSR Equipment Requirements

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MACs shall provide each CSR with the following:

- *A computer terminal with online access at their desk*
- Access to the MAC's provider education website
- Access to CMS's website
- An outgoing line for callbacks

30.5 – Inquiry Triage Process

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MACs shall use a triage system to route general telephone inquiries to the most appropriate resource. This tiered approach ensures inquiries are handled by staff with the right expertise, minimizing transfers and improving efficiency. The system matches inquiry complexity with appropriate expertise, optimizing both provider satisfaction and operational efficiency.

MAC's may also use a similar approach to triage general written inquiries. MACs shall develop mechanisms to quickly identify complex or sensitive written inquiries needing referral to the PRRS. The figure below 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:

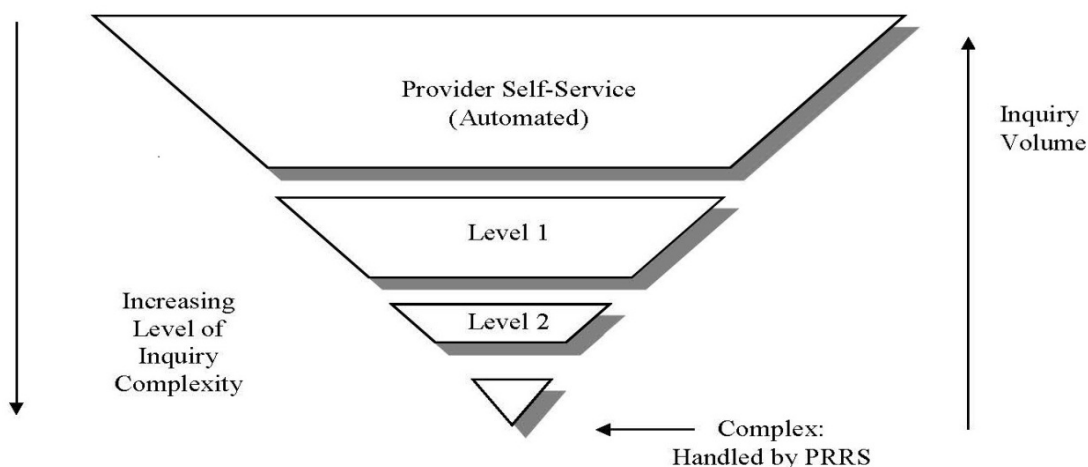
- First-level telephone CSRs, *at a minimum*, answer a wide range of basic questions that self-service *options can't address. These representatives*
 - *Answer inquiries that don't* require substantial research and can easily be answered during the initial call
 - *Have* the authority to refer more complex questions to second-level telephone CSRs
- Second-level CSRs have more experience and expertise *and may:*
 - *Answer* more complex questions requiring a higher level of research
 - *Serve* as consultant subject matter experts for first-level CSRs *without* always *speaking* directly to a provider
 - *Answer* first-level CSR questions *when* workload demands

- *Handle* callbacks

CSRs shall refer the most complex questions or sensitive issues to the PRRS, as discussed in section 30.9.

MACs can enhance their provider inquiry triage systems by specializing their telephone CSRs within skillset or across multiple PCC locations. This specialization allows MACs to leverage skills-based routing, ensuring that provider inquiries reach the most appropriately skilled staff. Additionally, MACs can implement technology solutions that automatically route callers based on the nature and complexity of their inquiry, improving efficiency and first-call resolution rates.

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



Figure

30.5.1- Responding to Coding Questions

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

Providers are responsible for determining the correct diagnostic and procedural coding for the services they *provide* to Medicare beneficiaries. CSRs shall not make determinations about the proper use of codes for the provider.

30.6- Provider Telephone Inquiries

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

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 *calls are* handled by the GSA's designated contractor *working* 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.

This centralized approach ensures consistent service quality and compliance with federal telecommunications requirements across all MACs.

30.6.1 Provider Inquiries Line(s)

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

At a minimum, MACs shall use the provider toll-free line(s) to handle questions related to billing, claims, payment, appeals, EDI, and PE. MACs may configure their PCC lines in the most effective way to meet the call handling and quality standards including:

- *A single toll-free number with internal routing*
- *Multiple dedicated toll-free numbers connecting callers directly to specific areas*
- *A combination of both approaches*

CMS encourages MACs to use the fewest numbers possible to meet performance standards. However, CMS will consider all requests for additional toll-free numbers if MACs need new service to handle additional Medicare applications.

When MAC's use multiple queues (for example, A/B, HH+H, DME, appeals, EDI, PE), the statistics from each queue combine into a single data set that determines whether the PCC met required standards. If any individual queue fails to meet the call handling and quality standards, it could cause the entire PCC to fail those standards. MACs shall report all applicable data (for example, quality call monitoring, telephone inquiry tracking, and telephone inquiry reporting) for each queue. This comprehensive reporting approach ensures accountability across all service areas and provides CMS with visibility into PCC performance.

MACs may require callers *without* 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. *However, PCCs must respond to at least three inquiries in a single call before requesting the provider to call back. MACs may require that these three inquiries relate to the same NPI/PTAN.*

30.6.1.1- Emergency Toll-Free Line

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MACs shall maintain a dedicated toll-free line that can be activated within 48 hours in the event of a disaster or national emergency. MACs who have more than one contract may choose to have a line for each jurisdiction or one consolidated line.

The MACs shall include audio and *screen* recording capabilities. MACs shall retain recordings for a period of at least one year.

30.6.2 PCC Accessibility Requirements

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MACs shall provide communications options for deaf, hard-of-hearing, or speech-impaired providers as required by section 504 of the Rehabilitation Act of 1973 and the Workforce Investment Act of 1998,

MACs must offer either:

- Teletypewriter (TTY) equipment – *A special device that allows people with hearing or speech disabilities to type messages instead of speaking and listening.*
- 711 Telecommunications Relay Service - *A service that helps people with hearing or speech disabilities to communicate through the telephone*

MACs shall *include information about their TTY line or 711 service* on their provider education websites. *MACs shall ensure their chosen option (TTY or 711) is* also available for complex beneficiary inquiries.

MACs using 711 shall:

- *Report* zeros (0) in the “Number of Attempts (TTY/TDD)” and “Number of Failed Attempts (TTY/TDD)” fields in *Provider Inquiries Evaluation System (PIES)*
- *Include 711 calls in the report for the toll-free line through which the call came*

30.6.3 Inbound Calls

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

CMS *pays* for the *installation and monthly fees* of inbound lines and all connect time charges for toll-free provider services. *MACs shall not include these costs* in their budget requests.

However, MACs shall remain responsible for all other internal telecommunications costs and devices, *including:*

- *Agent consoles and headsets*
- *Internal wiring*
- *Equipment like Automatic Call Distributors, IVR systems, and Private Branch Exchange (PBX)*
- *Local* or outbound telephone services and line charges

Since these costs *aren't* specifically identified in any cost reports, MACs shall maintain records for all costs associated with providing telephone service to providers (for example, costs for headsets) and shall provide this information *to CMS* upon request.

30.6.4– Reporting PCC Service Interruptions

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MACs shall monitor their PCC operations to identify and quickly fix any service interruptions. This includes monitoring all phone services (IVR-only, CSR-only, and combined lines), telecommunications systems, self-service portal, websites, and data systems functionality. When problems occur, MACs must identify and fix them immediately to maintain service for providers.

A service interruption occurs when any service is partially or fully unavailable, preventing:

- *Providers from accessing the PCC*
- *The PCC from answering inquiries*
- *The PCC from retrieving data*

MACs shall use the PCID Service Interruptions module to report incidents to CMS (see section 80.3.2.6 for more information).

MAC are responsible for monitoring their equipment and troubleshooting issues, but the PNS contractor is available for additional support. Contact the PNS contractor for questions, issue escalation, or help with toll-free carrier discussions. Use the toll-free carrier's online system to review documents and track trouble tickets.

30.6.5- Requesting Changes to Telephone Configurations *(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)*

CMS and MACs both play roles in managing the provider toll-free system. The PNS contractor processes all change requests for the toll-free network, including adding or removing channels, office moves, and routing changes. CMS may initiate changes based on telephone performance data and traffic reports and reserves the right to make changes based on this information.

When a MAC needs to request a change to their telephone configuration they shall:

- *Send change requests to the service reports mailbox at least 60 calendar days before the requested effective date*
- *Include an analysis of its current telephone environment with detailed traffic reports specific to the requested service*
- *Provide justification showing the need for the change for example, additional lines, trunk group reconfiguration*

MACs shall gather this information through its switch and toll-free carrier's reports.

CMS will review the recommendation based on technical merit and availability of funds. If approved, CMS will forward the approved requests to the designated agency representative for order issuance.

Even when circumstances don't require immediate resolution, MACs shall submit change requests timely. The 60-calendar day advance notice ensures all involved parties can review the request, ask questions and receive answers, and resolve issues before implementation.

30.6.6- Hours of Operation *(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)*

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 Monday through Friday, 8:00 am through 4:00 pm for all time zones of the geographical area serviced.

MACs may shift the normal business hours for all time zones where provider call volume supports an alternate schedule. MACs shall request approval for *an* alternate schedule by emailing the service reports mailbox 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 *don't* need annual approvals for previously approved alternate schedules if there are no additional changes *to* the hours of operation.

30.6.7- Providing Busy Signals

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MACs shall not configure or program PCC customer premise equipment to return “soft busies.” PCCs shall only provide “hard” busy signals to the toll-free network. All system components-including software, gates, vectors, applications, IVR systems and ACD/PBX equipment-shall not provide answer supervision followed by busy signals or call drops. MACs shall maintain optimal inbound toll-free circuit capacity based on their CSR staffing levels.

30.6.8 Directing Non-Compliant Callers to a Custom Network Message

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MACs shall monitor their incoming calls for non-compliant callers who refuse to use self-service resources, who repeatedly ask same or similar questions despite educational efforts, or who are disrespectful to CSRs.

MACs shall work with CMS to create a custom network message in the GSA designated contractor's network for the purpose of redirecting these non-compliant callers before they reach the PCC's premise-based equipment. The custom network message shall provide a MAC *email* address for the caller to contact before their calls are allowed to connect to the PCC.

Once identified, MACs shall send the incoming telephone number of non-compliant callers to the service reports mailbox with a copy to the PNS contractor, requesting calls from this number be sent to the custom network message. We'll work with the GSA designated contractor to add the incoming telephone number to the custom network message. MACs shall send a follow-up email when you're ready to redirect the telephone number from the custom network message back to your PCC.

30.6.9- Queue Message

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MACs shall provide recorded *messages with the following information for providers waiting in queue to speak to an available telephone CSR:*

- *Wait Time: Provide an anticipated* time until the call will be answered, including any temporary delays the provider may experience while waiting in queue
- *Preparation Guidance: Tell providers what information they* should have before speaking with a telephone CSR
- *Educational Content: Include educational* information on issues identified by the MAC.
(See section 20 of this chapter)

30.6.10-Provider Telephone Line Staffing

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

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. PCCs *may allow callers to place CSRs on hold during a call, but only when they aren't experiencing high call volumes or performance issues. When holds are permitted, CSRs should warn providers that they may disconnect if the hold exceeds 2 minutes and should inform providers about the best time to call back with all required information ready. MACs shall not disconnect calls before the 2-minute threshold. However, during periods of high call volume, CSRs should politely advise providers that they cannot be placed on hold due to current PCC conditions, and at a minimum, should suggest optimal times for the provider to call back with all necessary information prepared.*

30.6.10.1– CSR Sign-in Policy

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MACs shall establish and follow a standard telephone CSR sign-in policy that *includes these requirements:*

- CSRs available to answer telephone inquiries shall sign in to the telephone system to *start* data collection.
- CSRs shall sign off the telephone system for breaks, lunch, training, and when performing any other non-telephone inquiry workload. (Note: If the telephone system supports an additional CSR category that accumulates this non-telephone inquiry performance data so it can be separated and not have any impact on the measurements CMS wants to collect, this category may be utilized in lieu of CSRs *signing off* the system).
- CSRs shall sign off the telephone system at the end of their workday.

30.6.10.2- CSR Identification to Callers

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

Telephone CSRs shall identify themselves when answering calls. MACs may allow CSRs to use aliases such as Operator IDs or telephone extensions instead of their real names. These aliases serve as unique identifiers for each CSR, ensuring accountability while safeguarding personal information. MACs must maintain records of these aliases and provide them to CMS for monitoring purposes.

30.6.11- Guidelines for High Quality Responses to Provider Telephone Inquiries
(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

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. MACs shall monitor, measure, and report the quality of service continuously by employing CMS's quality call monitoring (QCM) process.

30.6.11.1- Telephone Response Quality Monitoring Program
(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MACs shall have a monitoring program in place to ensure the quality of telephone inquiry responses on the provider inquiry line(s). *Monitoring the accuracy, completeness, adherence to the Privacy Act, and professionalism of telephone CSR-handled calls leads to improved customer satisfaction and reduce the number of calls to the PCCs. MACs shall provide CMS with access to their quality monitoring systems (such as NICE, QFiniti and Verint) and notify us by emailing the provider services mailbox within 2 business days about any changes that will require us to update that access.*

MACs shall use the information from their quality monitoring program to improve telephone inquiry responses within the PCC, including individual PCC staff. MACs shall document their monitoring efforts and corrective action plans as applicable and make them available to CMS upon request.

CMS will provide MACs with feedback about monitoring and information about the evaluation processes used through the PCUG electronic mailing list and regularly scheduled meetings.

30.6.11.2- QCM Program Minimum Requirements
(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

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. A MAC's telephone inquiries monitoring program shall ensure:

1. *Reviewers evaluate all* MAC staff handling provider calls 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. *Reviewers select calls* from providers and are of the type the telephone CSR's typically handles (for example, Level 1, Level 2, PRRS).
4. *Reviewers randomly sample responses to* be representative of varying days of the week, weeks of the month, and monitors/auditors.
5. *Reviewers use* the official QCM scorecard and Scoring Chart and *record results* in the QCM database.

6. *Reviewers enter all* scores into the QCM database by the 10th day of the following month (*for* example, responses scored in December shall be entered by January 10th).
7. *Reviewers adequately monitor telephone* CSR trainees and new telephone CSRs. *MACs are encouraged to heavily monitor telephone CSR trainees who have just completed classroom instruction before they start handling calls without the assistance of a “mentor.” The program excludes* telephone CSR trainee *scores* 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’s* conducive to the success of the monitoring program.
9. *MACs provide timely* to those monitored.
10. *MACs educate* PCC staff *on* the program and its use.
11. All telephone CSRs, *reviewers*, and *supervisors* have copies of the official QCM scorecard, Scoring Chart, and Handbook.
12. *MAC staff follow the* QCM Handbook and User.

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.

30.6.11.3 – Recording Calls

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MACs shall record *all* incoming CSR-handled calls (while working in the PCC or remotely) to ensure the quality of telephone inquiries. MACs shall *announce at the start of the call* that the call may be monitored or recorded for training purposes. If a provider objects to *the recording*, the CSR *shall explain that calls are recorded solely for* quality assurance and training *purposes* and *that* individual *CSRs can’t stop the recording*. If the provider still objects and *doesn’t* want to continue with the recorded call, the CSR *shall* inform *them of available self-service options or advise them to send the* inquiry in writing.

For QCM purposes, MACs shall maintain recordings for *a rolling* 90-calendar-day period during the year *with all* recordings *dated* and filed for easy selection *during reviews*. MACs shall dispose of any recordings no longer used in a *way* that *prevents* someone from *accessing* personally identifiable information (PII) or protected health information (PHI) from the recordings.

30.6.11.4– QCM Calibration

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

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 national QCM calibration sessions organized by CMS. *These national sessions may be held quarterly, with meeting appointments distributed through the PCUG electronic mailing list as referenced in section 10.1. When examples of calls are needed for calibration meetings, CMS will issue a Technical Direction Letter (TDL) that provides comprehensive instructions on how to format and submit the calls.*

Beyond national requirements, MACs shall conduct their own monthly internal calibration sessions. For MACs with reviewers at multiple call center locations, all reviewers shall participate in these monthly calibration sessions to ensure consistency across all sites. PCCs shall maintain detailed written records of all internal calibration activities for documentation and reference purposes.

30.7- Provider Written Inquiries

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MACs shall handle written inquiries received by postal mail, email, fax or secure internet portal consistently to ensure accuracy, professionalism and timeliness. Each inquiry requires a final response in the language of the incoming inquiry that accurately and completely addresses all issues raised in the incoming inquiry. For inquiries that could be resolved through self-service options (such as claim status and eligibility inquiries), MACs shall direct providers to the appropriate self-service resources.

MACs *should* encourage providers to use *their* MAC *secure internet portal when such* functionality exists. Additionally, responses should include information about relevant *educational opportunities* on the MAC's provider education website, *when* appropriate to the *inquiry* topic.

MACs handle the following three types of provider written inquiries:

1. General – *Provider* written inquiries handled within the PCC that *don't* require extra research. They *shall meet* the performance standards in this section *and the timeliness* standards defined in section *70.2.2.1* of this chapter.
2. PRRS – *Provider* written inquiries handled within the PCC that require extra research, *can't* be handled by the general inquiries staff, *or are sensitive or complex in nature, excluding Congressionals*. 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 *shall meet* the performance standards in this section *and the timeliness* standards defined in section *70.2.2.2* of this chapter.

3. Congressional – *Provider* written inquiries the MAC receives either directly from a Congressional office *through* CMS Central Office or a CMS Regional Office. Congressional provider written inquiries *shall meet* the performance standards in this section *and the timeliness* standards defined in section 70.2.2.4 of this chapter.

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 30.7.4.3 of this chapter regarding specific requirements for electronic responses to provider inquiries.

30.7.1- Controlling Provider Written Inquiries

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MACs shall control all provider written inquiries until *they're* closed by the written inquiry unit.

Consider a written inquiry closed upon

- *Release* of the final response
- *Transfer* of the inquiry to another department within the MAC
- *Rerouting* of the inquiry to the appropriate external entity

The corporate mailroom shall forward provider written inquiries, except for misrouted inquiries, to the PCC's written inquiry unit for processing and control. MACs shall stamp the cover page of all provider written inquiries and the top page of all attachments with the date of receipt in the corporate mailroom. Electronic inquiries with system-generated date stamps don't require an additional corporate date stamp. However, electronic inquiries received after the close of a MAC's normal business day shall be date-stamped the next business day. For provider inquiry timeliness purposes, count the date of receipt as day one.

MACs *aren't* required to keep the incoming envelope *but those who do shall ensure* the envelope, incoming correspondence, and the top page of all attachments *are* date-stamped in the corporate mailroom.

30.7.1.1– Handling Transferred or Misrouted Written Inquiries

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MACs shall follow the instructions below when handling transferred or misrouted provider written inquiries:

A transferred inquiry is correspondence received in the written inquiry unit that should be handled by another department within the MAC.

Upon receipt the MAC shall:

- *Transfer the inquiry to the proper department within the MAC*
- *Close the inquiry in the written inquiry unit*
- *Include the transferred inquiry in monthly reporting in PIES and the Inquiry Tracking module in PCID.*

A misrouted inquiry is correspondence received either in the corporate mailroom or in the written inquiry unit that wasn't intended for the MAC.

Upon receipt, the corporate mailroom or the written inquiry unit shall:

- *Reroute it to the proper external entity using one of the following options:*
 - *Option 1*
 - *Contact the provider to inform them the correspondence was misrouted and is being rerouted to the appropriate external entity*
 - *Inform the provider of the name and mailing address of the appropriate external entity for future reference*
 - *Reroute the correspondence to the appropriate external entity*
 - *Option 2*
 - *Contact the provider to inform them the correspondence was misrouted and is being returned to them*
 - *Give the provider the name and mailing address of the appropriate external entity*
- *Close the inquiry in the written inquiry unit*
- *Include the misrouted inquiry in monthly reporting in PIES and the Inquiry Tracking module in PCID.*

The above definitions and handling instructions also apply to Congressional provider written inquiries. Be mindful that the timeliness standards for responses to Congressional inquiries are more stringent than the standards for other responses.

30.7.2– Storing Provider Written Inquiries ***(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)***

MACs shall allow CMS access to all provider written inquiries stored off site within 24 hours of notification to the MAC. All provider written inquiries, whether maintained on site or off site, shall be clearly identified and filed for easy selection *during reviews*.

MACs shall enter in PCID the physical address where they store their provider written inquiries. MACs shall enter changes to this information in PCID within 14 calendar days of the change.

See section *80.3.1* of this chapter for the PCID reporting and data certification requirements.

30.7.3– Duplicate Inquiries ***(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)***

If a MAC identifies that a provider submitted a duplicate written inquiry, the MAC may verify whether the provider received a response to the initial inquiry through either telephone contact or letter. If the MAC chooses to send a verification letter, this communication counts as an interim response. After confirming the provider received a response to their initial inquiry, the MAC shall close the duplicate inquiry and exclude it from workload reporting. However, if the MAC finds that the provider didn't receive a response to the initial inquiry, the MAC shall send a response to the duplicate inquiry and include it in their monthly workload reporting. If the MAC doesn't receive a response from the provider

within 14 business days after attempting to verify receipt of *the initial* response, the MAC shall *send* a response to the duplicate inquiry and include it in *their monthly* workload reporting.

30.7.4– Responding to Written Inquiries

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MACs may use the following methods to respond to provider written inquiries:

- 1. Postal – hardcopy letters sent through USPS*
- 2. Telephone – outbound calls to providers*
- 3. Electronic – electronic responses sent through email, fax, MAC secure internet portal or other approved electronic mechanisms*

30.7.4.1- Postal Responses to Provider Written Inquiries

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MACs may respond to provider written inquiries with hard-copy letters sent through postal mail within 45 business days of receipt. For inquiries requiring additional research or coordination, MACs shall send an interim response that acknowledges receipt and, when possible, informs the provider how long they will wait to receive the final response. MACs shall send the final response within 5 business days after receiving the needed information.

Responses must be accurate, complete and written in plain language.

30.7.4.2- Telephone Responses to Provider Written Inquiries

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MACs may respond to general provider and PRRS provider written inquiries by telephone within 45 business days of receipt. 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, MACs shall develop a report of contact for each telephone response to a provider written inquiry and retain these reports in the same manner and time frame as written responses. All reports of contact shall contain the following information:

- Provider name (including the representative or billing company name when applicable)*
- Provider telephone number*
- Provider number (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*

When a 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. If the provider requests an email or fax response, MACs shall follow the requirements in section 30.6 of this chapter when the response contains protected or sensitive information like PII Or PHI. Sending the report of contact isn’t acceptable. All timeliness and quality guidelines for a written response apply to the response sent.

If the MAC can’t reach the provider by telephone, the MAC shall develop a written response within 45 business days of receipt of the incoming inquiry. Leaving a message/response on the provider’s voicemail isn’t acceptable.

30.7.4.3- Electronic Responses to Provider Written Inquiries ***(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)***

MACs may receive and respond to provider written inquiries by email, fax, MAC secure internet portal or through other approved electronic mechanisms within 45 business days of receipt.

When sending electronic responses containing protected or sensitive information, MACs shall comply with CMS Acceptable Risk Safeguard controls and other CMS directives for secure communications.

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

All electronic responses shall meet the same timeliness and quality guidelines that apply to all written responses and electronic content, including attachments, must be section 508 compliant.

30.7.5- Check Off Letters ***(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)***

MACs may use check-off letters to respond to routine provider written inquiries like claim status, eligibility inquiries, or non-appealable claims. MACs shall not use check-off letters to address more complex inquiries. All check-off letters shall be personalized and meet the same timeliness and quality guidelines that apply to all written responses to provider inquiries.

30.7.6- Guidelines for High Quality Responses to Provider Written Inquiries ***(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)***

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 possible. *This law* 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 Plain Language Website *for guidance on meeting these* requirements.

Additionally, MACs shall use the National Provider Communication Standards and the CMS Writing Guide *when preparing* written responses to provider inquiries. The *writing guide is available* in the Documentation *section* of the QWCM database.

MACs may also use other resources (for example, grammar guides) to supplement their writing process.

30.7.7– Stock Language/Form Letters

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

CMS may request *that* MACs submit their most frequently used stock language or form letters *sent* to providers. CMS will review *these materials* and provide suggestions to improve the language. If CMS *identifies* errors or issues affecting the readability or meaning of the response, MACs shall make *the necessary* revisions within 60 business days from CMS *notification*.

30.7.8- Provider Written Response Quality Monitoring Program

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MACs shall maintain a monitoring program for all written provider inquiry responses *including* general, Congressional, and PRRS. *Quality Written Correspondence Monitoring (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. These* quality monitoring standards shall not apply to responses handled by departments *outside the PCC*.

MACs shall use *findings* from their quality monitoring program to improve written responses within the PCC, including *providing feedback to* individual PCC staff. MACs shall document their monitoring efforts and corrective action plans, as applicable, and make them available to CMS upon request.

30.7.8.1- QWCM Program Minimum Requirements

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

The MAC's written response quality monitoring program shall, at a minimum, follow the requirements and performance standards as *established* in the QWCM program.

A MAC's provider written inquiries monitoring program shall ensure that:

1. *Reviewers evaluate all* MAC staff responding to provider general, PRRS or Congressional written inquiries throughout the month. This includes temporary employees and part-time employees.
2. Each PCC *monitors 5* written responses per written CSR per month per jurisdiction.
3. *Reviewers select responses* prepared for providers *that match* the type the written CSR

typically handles (general, PRRS, Congressional.)

4. *Reviewers* randomly *sample responses that represent* varying days of the week, weeks of the month, and *different* monitors.
5. *Reviewers use* the official QWCM scorecards and Scoring Charts and *record results* in the QWCM database.
6. *Reviewers enter all* scores into the QWCM database by the 10th day of the following month (*for example, monitors shall enter* December *scores* by January 10).
7. *Reviewers adequately monitor written* CSR trainees and new written CSRs. *The program excludes trainee scores* from QWCM performance for one 30-calendar-day period following the end of their formal classroom training.
8. *MACs provide timely* feedback to those monitored.
9. *MACs educate PCC staff on* the program and its use.
10. All written CSRs, reviewers, and supervisors have copies of the official QWCM scorecards, Scoring Charts, Handbook, and Writing Guide.
11. *MAC staff follow the* QWCM Handbook and User Guide.

Official QWCM scorecards, Scoring Charts, Handbook, and User Guide are available in the QWCM database. Detailed descriptions of all evaluation criteria can be found in the official QWCM Scoring Charts and Handbook.

30.7.8.2- QWCM Calibration

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

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. *These national sessions may be held quarterly, with meeting appointments distributed through* the PCUG electronic mailing list *as referenced in* section 10.1. *When cases are needed for calibration meetings, CMS will issue a TDL that provides comprehensive instructions on how to format and submit.*

All reviewers *shall* participate in the monthly calibration sessions *to ensure consistency across sites*. PCCs shall keep *detailed* written records of *all* internal calibration *activities for documentation and reference purposes*.

30.7.9- Replying to Correspondence from Members of Congress *(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)*

In addition to the guidelines outlined above, MACs shall use the following instructions to respond to Members of Congress:

A – Sending the Response

Generally, *MACs send* the original and the courtesy copy of the reply to the Washington, D.C. office of the Member of Congress. However, if the inquiry *came* from a home office, *MACs direct* the original and the courtesy copy there.

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

When replying to a letter signed by more than one Member of Congress, *MACs prepare* a reply for each Member and *enclose* a courtesy copy with each. *MACs release* the replies to each Member of Congress at the same time.

MACs state in the opening paragraph that *they are sending* the same reply to each person who signed the letter and *make* an official file copy for each Member of Congress. *MACs* may use the following in *their* final reply:

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

C - Replying to a Letter Signed by an Employee in a Congressional Office

MACs address replies to the Members of Congress even when staff members *sign the inquiries*.

D - Replying Directly to a Constituent at the Request of a Member of Congress

When addressing a reply to a constituent, *MACs send* a courtesy letterhead copy to the Member of Congress, along with a copy of the constituent’s letter.

E - Replying to an Inquiry from Former Members of Congress

Unless the former Member of Congress requests otherwise, *MACs address* the reply to the constituent. The MAC shall send a courtesy copy to the former Member of Congress.

F – Addressing the response

30.8- Provider Walk-In Inquiries

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

If a provider makes an in-person inquiry at the MAC's office, staff shall give the provider an opportunity to meet with a representative in a private area to address the provider's concerns.

Whenever possible, inquiries shall be handled completely during the initial meeting.

MACs shall count a walk-in inquiry as a provider written inquiry for workload and reporting purposes.

The MAC shall maintain a log of walk-in inquiries. The log, at a minimum, shall include the following:

- *Provider name*
- Date and time of arrival
- Time service was provided
- Name of the person handling the inquiry
- *Summary of the issue including how it was resolved*
- *Date resolved*

30.9- PRRS Operations

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MACs shall maintain PRRS operations as a *collaborative* effort between the PCC and POE units. *This partnership ensures providers receive* consistent, accurate, and timely information regarding complex inquiries that *can't* be answered by the MAC's telephone or written inquiries or staff *that* require significant research. MACs shall design and staff the PRRS component *to efficiently address more complex provider questions including those related to coverage policy, coding and payment policy. This structure allows for adequate research time to answer complex inquiries in a timely and efficient manner.*

PRRS staff shall also identify *potential* provider education topics based on complex inquiries received. *When* the MAC determines *that* general provider education on specific topics would be *beneficial* to the provider community and *help to* reduce inquiries, *these topics shall be developed into educational resources.*

The PRRS shall also handle complex beneficiary inquiries that *can't* be resolved by CCO.

30.9.1- Complex Provider Inquiries

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

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, *though this staff member doesn't* have to be assigned exclusively to the PRRS. DME MACs are exempt from the requirement since the *Pricing, Data Analysis and Coding (PDAC) handles* DME coding questions.

PRRS staff shall address coding questions that relate to underlying Medicare payment or coverage policy. PRRS shall refer pure coding questions unrelated to a Medicare payment or coverage policy to the correct organizations such as the American Medical Association and the American Hospital Association's Coding Clinic. For more information, see section 30.5.1 of this chapter.

30.9.2- Complex Beneficiary Inquiries

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

CCO or the CMS Regional Office staff will identify and refer complex beneficiary inquiries to the PRRS via Next Generation Desktop (NGD). These inquiries may include telephone calls, written correspondence, and emails. See chapter 2 of this manual for information about handling, controlling, and responding to beneficiary inquiries.

30.9.3– PRRS Workload Reporting

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

PRRS staff shall take ownership of referred inquiries and assume responsibility for research and resolution.

For workload reporting purposes, when staff refer a provider telephone inquiry to the PRRS, they shall close the telephone inquiry and open a written inquiry. If staff refer a written inquiry originally classified as general to the PRRS, they shall transfer the original general inquiry and count the original as a PRRS inquiry. The MAC shall only count the written inquiry once as a PRRS Inquiry.

30.10 - Provider Inquiry Tracking

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MACs shall track and report telephone and written inquiry reasons using categories and subcategories from the CMS Standardized Provider Inquiry Chart. The Documentation section of PCID contains the latest version of the chart. MACs may add contractor-specific subcategories to track provider inquiries within their jurisdiction (see section 30.10.D).

MACs shall apply inquiry logging, tracking and reporting across:

- All PCC call center locations (for MAC with multiple call center locations)
- All PCC triage levels (Level 1, Level 2, PRRS)
- All provider inquiries the PCC handles including general inquiries, escalated inquiries within CSR levels, Congressional inquiries, PE, Appeals, EDI, Reopening, MR, Audits and Reimbursement

A. Inquiry Tracking Requirements

MACs shall maintain an Inquiry Tracking System for all provider inquiries. *The system shall identify* at a minimum:

1. *Inquiry Type* (telephone, written, walk-in).
 2. Person responsible for answering the inquiry
 3. *Inquirer information* (name, NPI and PTAN).
 4. *Inquiry nature* (*using* the categories and subcategories *from* the CMS Standardized Provider Inquiry Chart and contractor-specific subcategories when appropriate). *This identifies* the reason or issue that caused the provider *to* contact the PCC.
 5. *Inquiry disposition*, including referral to other PCSP areas or areas elsewhere at the MAC (for example, MR, MSP) and *contact* information *for follow-up or clarification*.
 6. *Response timeliness*
- B. Inquiry Tracking Data Use

MACs shall use inquiry tracking data to enhance and improve their PCSP *by*:

1. *Developing* 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. *Identifying* areas for broader provider and CSR education
3. *Conducting* analysis of the *inquiry numbers* and types to develop *self-service education*
4. *Assessing and monitoring Medicare and MAC internal and external policy, process, and procedure* effectiveness and efficiency
5. *Conducting* analysis of the *inquiry numbers* and types to develop *self-service education*
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7. *Conducting* analysis of the *inquiry numbers* and types to develop *self-service education*

8. *Conducting* analysis of the *inquiry numbers* and types to develop *self-service education*
9. *Assessing and monitoring Medicare and MAC internal and external policy, process, and procedure* effectiveness and efficiency
10. *Documenting* enhancements and innovations to improve the Medicare provider customer service experience, *operational effectiveness, and efficiency* (for example, provider self-service technology, POE website content)
11. *Assessing* PCC staff skill level needs based on frequency, complexity *and* trends
12. *Identifying organizational* areas or processes within the MAC’s organization that *require* follow-up to maintain *or* reduce provider inquiries, meet response and processing targets, meet POE targets, *and* reduce provider burden

C. Requirements for Classifying the Nature of Inquiries

MACs shall follow these requirements when classifying provider inquiries:

1. Use *standardized* categories and subcategories *from* the CMS Standardized Provider Inquiry Chart to classify and log all written and telephone inquiries. *Develop* contractor-specific subcategories to capture an additional *detail* level to support CMS in developing new inquiry types and *identifying* provider education or CSR training needs.
2. *Capture the inquiry reason*, not the status, disposition (for example, *referrals* to the IVR), or action taken. PCC staff shall exercise best judgement *to identify* the true issue *behind each* provider contact.
3. Track multiple issues raised by a provider during a single call or written inquiry, *provided* MACs *can* identify the *required* information (See *section 30.10.A*) and comply with the reporting requirements.
4. Report *unclassified* inquiries using the “Not Classified” field for the appropriate category (*except* “General Information” *which* uses “Other Issues” subcategory instead of “Not Classified”). *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 30.10.D*).

D. Guidance for Creating Contractor-Specific Subcategories

MACs shall adhere to *these* requirements when creating contractor-specific subcategories:

1. *Maintain* a dynamic process to identify and create contractor-specific subcategories that could lead to new or enhanced inquiry. *Create* contractor-specific subcategories to continuously reduce inquiries that *don't fit* existing standardized inquiry subcategories. CMS will monitor *these* subcategories to assess trends and determine future developments.
2. *Avoid creating duplicate* contractor-specific subcategories when the CMS Standardized Provider Inquiry Chart provides existing standard subcategories. *Don't create* "HCPCS" under "Coding" *when* "Procedure Codes" *already exists* under "Coding."
3. *Assign* descriptive *names* and *definitions* to each contractor-specific subcategory. *Don't* use *generic names like* "Subcategory 1" or "Contractor-Specific." *Consider* using the following when creating contractor-specific subcategories:
 - MLN Matters Article *numbers describing* the nature of the inquiry
 - RARC *and* CARC code combinations *from* CRs
 - Shared Systems edits codes with definitions
 - Specific claim improper payment issues (for example, coding *errors*, missing *medical necessity* information)
 - Specific claim submission errors (for example, missing documentation, lack of signature)
4. *Create* contractor-specific subcategories for issues *with* significant *operational* impact *or high-volume inquiries*.
5. *Regularly* review contractor-specific subcategories and deactivate *those with* low inquiry volume (*fewer* than 10 inquiries *for 3 consecutive months*). This *excludes* Program Integrity or POE *specific subcategories*.
6. *Avoid creating* contractor-specific subcategories under "Temporary Issues" that *belong in more relevant categories*. Example: *Create* "HMO Refunds" under "*Financial Information*" *not* "Temporary Issues.
7. *Avoid* provider types *and* specialties as contractor-specific *subcategory* names since reports can *filter by these categories*. However, use POE training *topics* as contractor-specific subcategory *names when appropriate*.
8. *Add CMS-directed* contractor-specific *subcategories when requested*. CMS may add contractor-specific *subcategories* in the PCID Contractor-Specific Subcategories Module *for immediate assessment needs*.

30.10.1– Updates to the CMS Standardized Provider Inquiry Chart *(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)*

CMS *updates* the chart as needed, including adding subcategories under the Temporary Issues category to track *short-lived* inquiries. CMS *issues changes to the CMS* Standardized Provider Inquiry Tracking Chart, including reporting timeframes, through CRs or TDLs. Upon issuance MACs shall update their MAC Inquiry Tracking Systems with any updates or additions. See *section 30.10.A*.

Between updates, MACs may create contractor-specific temporary subcategories for their jurisdiction(s) if call volume dictates. Per section *30.10.D*, 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 available in* the Documentation section of PCID.

MACs shall recommend changes to the CMS Standardized Provider Inquiry Chart *when necessary*, including:

- *Modifications* to existing categories and subcategories
- *Addition* of new inquiry categories and subcategories

MACs shall submit changes or comments via the provider services mailbox. Suggested changes shall include:

- *Category or subcategory name* - Name of the proposed category or subcategory
- *Definition – Clear definition* of the proposed inquiry category or subcategory
- *Examples - Sample* questions where the proposed inquiry category *applies*
- *Volume data - Number* of inquiries the MAC received *related to* the proposed category or subcategory

30.10.2 – MAC Inquiry Tracking Self-Data Review and Self-Validation Process *(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)*

MACs shall document inquiry tracking data review activities and validation procedures, including:

- *Major process* components (for example, analyzing inquiry trends)
- *Developments* and enhancements (for example, Inquiry Tracking System, inquiry types, CSR desk procedures *for logging* inquiries, resources *for* inquiry analysis)
- *Identification* and mitigation for *error-prone* areas

MACs shall analyze their PCSP inquiry data *at least monthly examining* changes in inquiry volume, proportion, trends, and provider specialty *patterns*.

CMS encourages MACs to explore additional resources to adopt focused, effective, and efficient analyses practices, *including* collaborating with other MACs.

1. Monitoring of “Not Classified” Inquiries

MACs shall regularly analyze “Not Classified” subcategories to ensure CSRs *don't* report a high number of similar inquires when the MAC should create a contractor-specific subcategory instead.

2. Provider Inquiry Proportional Changes

MACs shall monitor their inquiry tracking volume to determine proportional changes over the previous month and *compare them to* the same period last year to identify the following:

- *Correct categorization of* inquiry data
- New patterns, “spikes” and *inquiry type* trends

3. Inquiry Tracking Rate

MACs shall monitor *and compare* their Inquiry Tracking *Rates*:

- Telephone Inquiries *Rate* - (Total Telephone Inquiries in the Inquiry Tracking System/ Total PCC Calls Answered by CSRs) *X* 100
- Written Inquiries *Rate* - (Total Written Inquiries in the Inquiry Tracking System/ Total Provider Written Correspondence Received) *X* 100

CMS encourages each MAC to increase *these rates*.

4. MAC Provider Inquiry Tracking Updates

MACs shall send Provider Inquiry Tracking Updates to provider services mailbox with the subject line "MAC Provider Inquiry Update," when *they find*:

- Root causes for abrupt changes or “*spikes*” *during* the month and any *related actions taken*
- Root causes for inquiry trends *lasting* two or more consecutive months and *related* actions taken

5. Inquiry Tracking Report Review and Validation

MACs shall *follow section 80.3.2.1* to review Inquiry Tracking Report *accuracy* before submission. This includes ensuring *proper documentation of all new contractor-specific subcategories* before submitting data to CMS.

30.11- Fraud and Abuse

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MACs shall immediately send any provider inquiry or complaint about fraud and abuse *to the Unified Program Integrity Contractor (UPIC)*, along with a referral package (*see Pub. 100-08, Chapter 4, section 4.3.2.4*). 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. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MACs *are* fully responsible for *educating, developing, evaluating,* and *managing* PCSP staff. MACs *shall provide* initial and ongoing education and training *for* all PCSP staff. Training should vary due to the wide spectrum of subjects, resources and tasks *that* the PCSP *handles, as well as* the complexity and nature of the workload *that* PCSP staff *manages.* *Additionally,* MACs shall *create and document* an education and development plan for each staff member that addresses the education of new staff and the continued education *for* existing staff. *MACs shall make education* and reference materials and tools, *and* policy manuals readily available and accessible to all staff. MACs shall ensure *all staff have* educational opportunities and promotion pathways through the design and implementation of the PCC and POE functions.

40.2- PCC Staff Development and Training

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MACs shall provide training for all new PCC personnel and refresher training updates for existing personnel. 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.

MACs shall use ongoing data analysis 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 *developing* training materials for the general inquiries staff. *MACs shall tailor training* to the level *and* 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 *have* 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 ensure these materials will be implemented for *future hires.* Since *CMS develops* these materials, there *won't* be any costs to the MACs to use *them.* MACs may supplement the CMS-developed materials with their own materials *if there's* no contradiction of policy or procedures.

40.2.1- Required Training for PCC Staff

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

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 and other self-service tools, *including* the IVR system and the MAC *secure internet portal*.
2. How to find, navigate and use the CMS website. This includes all online education resources provided through the MLN.
3. How to find, navigate, and use the PCSP website. This website strengthens MACs' PCSPs by providing support information, CERT Resources and feedback mechanisms.
4. The MLN (See section *20.3.1* 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.

The PRRS will need specialized training in the use of the CMS Internet-Only Manuals, the CMS website, the Medicare.gov website, the MAC's provider education website, regulations, laws, and other information tools to *respond* accurately and completely to complex provider inquiries. (PRRS also handle complex beneficiary inquiries. See chapter 2 of this manual for information about complex beneficiary inquiries.)

See section *80.3.2* of this chapter for the monthly PCID reporting requirements.

40.2.2- PCC Staff Feedback and MAC Evaluation of PCC Training (Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MACs shall ensure CSRs and PRRS *receive* the maximum benefit *from* the training program, *through monthly evaluations of staff* progress *and periodic assessments of how well staff retain* training information. MACs shall *also* use pre-and post-training evaluation results *along with* staff feedback to *continuously* improve their training program.

40.2.3- PCC Training Documentation (Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MACs shall provide copies of their PCC staff training schedule, training plan, training materials, training assessments, training feedback and PCC staff attendance sheets to CMS when requested.

50 - PSS Technology

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

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

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

- IVR system for telephone inquiries
- Provider education website
- Web-based provider educational offerings
- Electronic mailing lists
- Social media (*optional, at the MACs discretion*)
- MAC *secure internet portal* (see the "Medicare Administrative Contractor Provider Portal Handbook")

MACs *can require* providers (and their representatives) to use their IVR, *secure internet portal*, public website and other self-service tools to obtain *readily available* information.

MACs shall expand the use of their self-service options and offerings, as appropriate, and shall routinely analyze the options *and their* utilization to *determine* whether and how to expand *these* offerings.

50.1 - IVR System

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MACs shall provide automated "self-help" tools, *like* IVR systems to *handle provider* inquiries, *while still allowing* providers *to speak with CSRs during normal PCC operating hours.*

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 isn't available to IVR system users, MACs shall post a message alerting providers on the IVR system.

MACs shall report their IVR system type and options in PCID, following the requirements outlined in section 80.3.1 of this chapter.

50.1.1- Provider Authentication Requirements

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MACs shall program their IVR systems to adhere to the requirements in the Privacy Act of 1974 and HIPAA Privacy Rule. Before releasing PII and PHI MAC IVR systems shall authenticate providers using the procedures outlined in the DDR as referenced in Section 90.

50.1.2– IVR System Minimum Requirements

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

At a minimum, the IVR shall include the following:

1. MAC *Hours of Operation: Provide* telephone CSR service *hours*.
2. After- *Hours Message: Provide* normal business hours. (*unless already provided before reaching the IVR*)
3. General Medicare Program *Information: Keep* individual *messages* under 30 seconds. *Maintain* technical capability to either require callers to listen *to messages* or allow them to bypass *them per CMS direction. Use discretion when CMS provides no instruction.*
4. *Claims Information: Provide details* about claims in process and *completed* claims.
5. *Remittance Code Definitions: Provide official* definitions for *at least* the 100 most frequently used Remittance Codes as determined by each MAC. MACs may add more if their IVR system has the capability. *MACs may satisfy this* requirement by providing official Remittance Code definitions for specific provider IVR system claim status inquiries.

At a minimum, the MACs shall require providers to use the IVR system to access claim status. MACs *can* also require providers to use any other functionality available through the IVR *at their discretion*. Telephone CSRs shall refer providers to the IVR system for applicable questions. Telephone CSRs may give the information if *it's* clear the IVR system *isn't* functioning, and the provider *can't* access the information. *MACs* shall update the IVR systems *at least once every 6 months based on* provider needs *identified* through the MACs' PCSP inquiry analysis.

NOTE: *MACs may also* require providers to use the MAC *secure internet portal* for existing IVR functionality if the portal *offers* the same *capabilities*.

50.1.3– IVR Operating Guide

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MACs shall *develop and post* a clear IVR system operating guide *on the MAC's provider education website*. The guide shall detail how callers can bypass the IVR and speak with a CSR for general questions that *don't* require authentication *or* when the caller *doesn't* have the required authentication elements (for example, consultants, attorneys, enrolling providers, etc.). However, if required and the caller *doesn't* authenticate before reaching a CSR, MACs *may* transfer the caller back to the IVR to complete authentication. *MACs shall update and repost the guide promptly whenever their* IVR system functionality changes.

50.2 - Provider Education Website

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MACs shall offer a provider education website as a PSS technology help providers *gain* timely, accessible, and understandable Medicare Program information.

MACs shall *provide the ability for a* provider *to clearly find information specific to their jurisdiction*. See section 20.3 of this chapter for the requirements to include relevant MLN or CMS products or content.

50.2.1 – Provider Education Website Promotion

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

The information contained on the MAC's provider education website shall be structured in such MACs shall actively promote, market, and explain their Medicare provider education website *along with all its* information and features, including the MLN resources discussed in section 20.3.1 of this chapter. *MACs shall include information* about *their* provider education website *in* all MAC POE workshops, seminars, training sessions with individual providers, and all other provider education activities *they arrange or participate in*. *Additionally*, MACs shall *evaluate whether* their PCC *could* also *effectively* promote their provider education website.

50.2.2 Website Organization and Design

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MACs are responsible for their provider education website *structure and* shall *design it so it's clear to providers they're accessing the provider education website for their jurisdiction(s)*.

MACs shall organize their provider education website to be easily found and searchable, *reducing* the number of pages users *navigate to find* information. *When* designing websites, MACs shall *follow these* basic, research-based usability guidelines:

- *Accessibility - Follow Section 508 standards to assist users with disabilities*
- *Consistency - Maintain a uniform appearance in each section*

- *Clarity - Use plain language for all content without redundancy*
- *Searchability - Include an easy-to-find search function*
- *Security - Maintain a safe, secure connection*
- *User-Centered Design - Meet user needs with data-driven analysis*

MACs shall adhere to federal website best practices found at www.digital.gov.

50.2.3 – Website Content Requirements

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MACs shall ensure that their provider education website includes all the required information and meets CMS standards to ensure consistent, accurate and accessible information delivery to Medicare providers.

MACs shall review its monthly WebScan report to continuously improve the content of its provider education website (see Section 50.2.7)

50.2.3.1– Minimum Content Requirements

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

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.*
2. *FAQs (see section 50.2.3.3 of this chapter for more information)*
3. *A schedule of upcoming POE activities (for example, seminars, workshops, fairs).*
4. *Registration capability for MAC-sponsored education and outreach activities.*
5. *Search engine functionality.*
6. *A “What’s New” or similarly titled section that presents important immediate or time sensitive information.*
7. *A site map that shows simple text headings of the major website components and allows users direct access through selecting and clicking titles. MACs shall make this feature accessible from the home 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 if the “help” feature is accessible from the home page.*

9. *Information for providers on electronic claims submission.*
10. *Information about the MAC, including at a minimum telephone number(s) for provider inquiries, a fax number for provider inquiries, and a mailing address or secure internet portal link for provider written inquiries.*
11. *An IVR system operating guide.*
12. *CMS products posted or linked, as directed.*
13. *CMS regional office resource mailbox for feedback (see “How Can I Give Feedback About My MAC?” for mailbox addresses)*
14. *Relevant content from the MLN Connects newsletter as mentioned in section 50.3.3 of this chapter.*
15. *Relevant MLN products or content links.*
16. *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 50.2.3.4 of this chapter)*

50.2.3.2– Required Links

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

Additionally, MACs shall include the following links on their provider education website:

1. *CMS website*
2. *Medicare.gov (If a prominent part of the MAC’s provider education website or a landing page references individuals entitled to Medicare benefits, MACs shall use the term “person(s) with Medicare” to describe those individuals).*
3. *MLN*
4. *CMS’s manuals and transmittals web pages*
5. *CMS’s HIPAA web page*
6. *CMS’s central provider web page*
7. *CMS’s ICD-10 web page*
8. *CMS’s MREP Software information*
9. *ASC X12 web page containing descriptions for RA reason codes and remark codes.*

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

50.2.3.3– FAQs

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

All MACs shall maintain regularly updated local FAQs on their provider education website. *Providers use these FAQs as an important tool to get answers without contacting the PCC. The MACs’ FAQs shall be developed and updated for accuracy and relevance. MACs shall develop local FAQs based upon the data analyses described in section 20.2 of this chapter.*

50.2.3.4– Provider Claims Payment Alerts

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MACs shall develop and regularly update a dedicated webpage that alerts providers *about* 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 *about* claims processing issues that are currently active *and* provide an archive of resolved issues. *The alert webpage should use clear, concise language that avoids technical jargon when possible. MACs should organize issues in a logical manner, such as by recency, impact severity, or provider type, to help providers quickly locate relevant information.*

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 (*for example* 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 *to help providers better understand each issue. This supplementary information may include:*

- *Regional processing variations that affect the issue*
- *Contact information for specialized assistance*
- *Estimated timeframes for resolution when available*
- *Links to related resources or guidance documents*
- *Frequently asked questions specific to common issues*
- *Notification options for providers to receive updates about issue status changes*

50.2.4– Website Content Management

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MACs shall address outdated and inaccurate content promptly. When removing content, where appropriate, MACs should create redirects (for example, an HTTP 301) to direct the public and search engines to new or more accurate content. MACs shall correct or remove specific information or links from their provider education websites when directed to do so by CMS.

MACs shall establish processes to review and eliminate content with errors, outdated content, and duplicate content across websites within their organizations and CMS whenever possible. Similar content on multiple websites may be appropriate when those websites serve different audiences or user needs. However, duplication creates confusion when information is inconsistent and imposes extra maintenance costs.

MACs may post LCD information *from* the Medicare Coverage Database *on their provider education website*. See Pub.100-08, Medicare Program Integrity Manual, *for* LCD provider education website posting requirements.

MACs shall *continuously improve* and ensure the integrity of their provider education website (for example, by ensuring section 508 compliance and correcting broken links).

50.2.5 Website Analytics and Reporting ***(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)***

MACs shall capture and report *analytical data* to CMS by jurisdiction for their provider education website. *This data includes* statistics on website visits, page views, and on-site search queries. See PCID documentation for definitions and more information. This requirement *doesn't apply to the MAC secure internet portal*.

See section *80.3.2.9* of this chapter for monthly PCID provider education website analytic data reporting requirements.

50.2.6– Webmaster and Attestation Requirements ***(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)***

MACs shall assign a Webmaster *who periodically reviews* the provider education website *to ensure compliance with CMS requirements, including:*

- *CMS's Contractor Website Guidelines*
- Section 508 of the Rehabilitation Act of 1973 (*see CMS.gov Accessibility and Compliance with Section 508 for more information*)
- Requirements stated in Pub. 100-04, Medicare Claims Processing Manual, chapter 23, section 20.7 regarding the use of CPT¹ codes and descriptions

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

MACs *must attest their compliance using the PCID module (see section 80.3.2.12).*

If a Webmaster *identifies non-compliance* with any CMS requirements, the MAC shall *document specific steps they will take to achieve compliance and include this* information with *their* attestation statement.

50.2.7– Website Scans

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

CMS and its *third-party* contractor will conduct scans *of* MAC websites *for Section 508 compliance and customer analysis. The scans identify:*

- *Accessibility errors that violate World Wide Web Consortium (W3C) and government regulations, particularly guidelines under Section 508 of the Rehabilitation Act of 1973 as amended, 29 U.S.C. § 794(d) (Section 508)*
- *Areas where MAC websites aren't following CMS policies for branding, design, compliance, or other requirements outlined in the CMS Brand Strategy and Graphic Standards Guide*
- *Website responsiveness issues requiring troubleshooting (for example, website issues, syntax errors, and broken or dead URLs)*
- *Content that doesn't comply with Federal Plain Language standards*
- *Sections that don't comply with CMS MAC National Provider Communication Standards*

The *primary* goal is to give MACs *tools* to improve their individual MAC websites, *ultimately increasing* provider satisfaction.

MACs shall use the scan results to improve their websites. MACs can run scans more *often* to test web updates or to *verify* resolution of *issues identified in* monthly scans.

50.3- Electronic Mailing Lists

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MACs shall offer electronic mailing lists to *help* Medicare providers *get* information about *important, time-sensitive Medicare Program information, upcoming provider communications events, and announcements requiring immediate attention. Each MAC's electronic mailing list shall accommodate all providers in its jurisdiction.*

CMS recommends MACs use electronic mailing *lists* for only one-way communication (from MACs to subscribers). MAC electronic mailing *lists*, including information about subscribers (for example, email addresses) are the property of CMS and *MACs* shall *share this information* with CMS *when requested.*

50.3.1- Targeted Electronic Mailing Lists

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MACs may create and use targeted electronic mailing lists to send *relevant* Medicare Program *information* to specific provider audiences. MACs *should try to identify* provider types *of electronic mailing list registrants in the instance a targeted message is required. MACs may use the list of provider types* on the Medicare PE application to determine appropriate audiences.

50.3.2– Promotion of Electronic Mailing Lists

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MACs shall actively promote the benefits of *subscribing* to the electronic mailing *lists using* all regular provider communications tools and channels (for example, workshops, education events, POE AG meetings, ACMs, PCCs, and written materials). *Providers shall be able to subscribe or unsubscribe to the electronic mailing lists through their MAC’s provider education website.*

MACs *may have* telephone CSRs *offer to* subscribe providers to the electronic mailing *lists* during calls if the providers *aren’t* currently subscribed. MACs shall coordinate internally with other MAC departments to encourage electronic mailing list subscription.

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

50.3.3– Sharing the MLN Connects Newsletter

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

When MACs get the MLN Connects newsletter described in section 10.1 of this chapter, *it* contains 2 parts:

1. Instructions to MACs - Follow these instructions, but don’t send them to providers
2. CMS Provider Education Message – Send this content to providers

When MACs send the MLN Connects newsletter to providers via their electronic mailing list they shall:

- Send the newsletter exactly as CMS provided within 1 business day
- Supplement it with localized information for their jurisdiction that will help their providers bill and administer the Medicare Program correctly.

Email questions about the MLN Connects newsletter to the [MLN Connects mailbox](#).

MACs *can* include relevant MLN Connects newsletter content in their POE activities.

50.3.4– Electronic Mailing List Record Retention

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MACs shall maintain usage records of their electronic mailing lists for 1 year from the date of usage. These records shall include:

- *When they used the electronic mailing list(s)*
- *The text of the messages sent*

- *The number of subscribers to whom messages were sent (per message)*
- *The message authors*
- *Any transference or sharing that may have occurred*

50.3.5– Electronic Mailing List Data Protection

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MACs shall protect electronic mailing list addresses from unauthorized access or inappropriate usage. MACs shall not sell or transfer any electronic mailing list information to other organizations or entities. In special circumstances where sharing information might benefit CMS or the Medicare Program, MACs shall first obtain express written permission from their COR.

During jurisdiction transitions, MACs shall transfer electronic mailing lists, and related information to incoming contractors.

50.4 – Social Media

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MACs may use social media in their PCSP. Social *media includes web* or cellular phone-based technologies that allow information *sharing, such as* Facebook, YouTube, *X (formerly* 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 80.3.2.9* of this chapter for the monthly PCID reporting requirements.

50.5 – MAC Secure Internet Portals

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MACs shall follow the guiding principles outlined in the Medicare Administrative Contractor Provider Portal Handbook when redesigning or modifying their Secure Internet Portal. CMS will notify MACs of updates to the Handbook *through* TDLs.

60 - Surveys

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

CMS manages a survey program to measure provider satisfaction through experiences with their MAC. These surveys evaluate business functions, such as PCSP, Redeterminations and Audit and Reimbursement, to ensure MACs deliver quality service to providers. MACs use these surveys to understand provider experiences and identify improvement opportunities.

60.1 - Provider Satisfaction Survey

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

Executive Order (EO) 12862 requires *federal agencies* to be customer-driven by providing customer service *that equals* the best in business. The EO *directs* Agencies to survey *their* customers to *learn what* services they want and *how good those services should be, and how satisfied they are* with existing

services.

CMS complies with this EO by *using surveys to measure how satisfied providers are* with the *MACs services*. MACs shall assist CMS in *developing and implementing* these tools to meet this requirement.

CMS *currently* uses the MAC Customer Experience (MCE) to survey providers. *This program helps CMS improve how both MACs and CMS handle their processes* based on the *feedback they receive*. The MCE program *doesn't replace* the MACs' existing inquiry handling processes. *When survey respondents leave their contact information*, MACs may *direct them* to the *proper* inquiry channels.

MACs shall email the MCE mailbox with *general* questions *about the MCE Program*. *MACs shall work with their division admins to contact the survey vendor*.

60.1.1 – MAC Survey Participation Requirements

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

When CMS requests it, MACs shall administer provider satisfaction surveys and *complete these tasks*:

- *Survey Team, Setup – MACs shall assign up to four* points of contact *from each company* to serve as liaisons between CMS and the MAC. *These contacts will 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.
- *Survey Development – MACs shall help develop and refine* survey tools by:
 - Providing insight on what information is important to collect.
 - Testing and piloting new survey tools.
 - Suggesting innovative survey tool strategies and technologies.
- *MACs shall develop MAC-specific* questions for satisfaction *surveys*, as CMS *instructs*.
- *Technical Implementation – MACs shall add* code from the Survey Contractor to *their websites* and *portals* and activate the code as CMS *instructs*. *MACs shall use the third-party platform that CMS provides*.
- *Making surveys available – MACs shall make surveys available* to *their* 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.
 - *Offering a survey to providers calling the PCC*.

- *Ongoing Survey Management – MACs shall review survey results regularly and perform ongoing marketing and outreach for surveys by:*
 - *Sharing information about surveys on electronic mailing lists and other provider communications channels, as appropriate.*
 - *Posting survey information on provider education websites, MAC secure internet portals, social media channels, and IVR messaging.*
- *Survey Participation Standards – MACs shall encourage survey participation for all business functions but shall not request or pressure participants to give the MAC high scores.*

60.1.2 – Continuous Improvement

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

Survey Data Access and Analysis - MAC POCs shall maintain access to the Survey Contractor’s portal to view survey results regularly and analyze the data to ensure provider satisfaction.

Improvement Planning and Implementation - Based on this analysis, MACs shall develop and implement plans to improve providers’ overall customer experience. *MACs shall post these changes to their websites at least every 6 months, and through a link found in the MCE User Guide’s MAC Reporting section.*

60.1.3 – Closed-Loop Ticketing

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

Closed-Loop Ticketing allows 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 that CMS provides.

The system automatically generates a ticket when someone submits a survey response and that meets certain criteria based on each survey. MACs don’t need to provide a personalized response to every ticket, even when respondents leave their contact information.

MACs can choose how to close a ticket using several approaches:

- *Send* a personalized email to close the ticket or initiate a discussion with the respondent
- *Send* a canned response explaining available resources to resolve the respondent’s issue (for example, directing them to specific website resources)
- *Send* a canned response directing the respondent to the appropriate inquiry mechanism (for example, directing them to the PCC or Portal Help Desk)
- *Send* a canned response thanking the respondent for their feedback when contact information is provided but no response is needed
- *Close* the ticket without a response when no response is needed and no contact information is provided

60.1.4 – Survey Response Prohibition

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

At the *start* of each calendar year, MACs shall send written communication to employees and subcontractors *clearly* stating *that MAC employees and subcontractor employees* are prohibited from taking *their own* MAC's satisfaction survey or any other *MACs satisfaction survey*. *When CMS requests it*, each MAC shall *provide* documentation of *these* written communications *to demonstrate compliance with the prohibition policy*.

60.1.5 – MCE User Guide

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MACs shall follow the MCE User Guide. The MCE User Guide serves as a reference to help MACs implement and administer their MCE programs. *The MCE User Guide includes platform access instructions, reporting instructions and system support information, along with other essential resources for program administration. MACs can access the MCE User Guide in the MAC Division Admin Library on the MCE survey platform. Ensure all relevant team members have access to and understand how to use the guide effectively.*

60.1.6 - Third-Party Contractor Platform System Users

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

Each MAC shall identify *up to four* staff who will serve as *MAC Division* Administrators. These *administrators* will have the highest level of access *to* the Survey Contractor's online platform and will *oversee* staff access to the platform. *MAC Division Administrator responsibilities include:*

- *Assigning* user accounts
- Deactivating users who no longer need access
- Maintaining signed and dated copies of the survey contractor's FedRAMP Rules of Behavior. *Note:* MACs may *store these documents* electronically or in hard copy and shall make *them* available to CMS upon request.

Before CMS assigns someone as a *MAC Division* Administrator, each *administrator* shall sign and date the survey contractor's FedRAMP Rules of Behavior and forward a copy to the MCE mailbox. MACs shall notify CMS about changes to *administrators* and submit signed *agreements* for new *administrators* within five days of the change.

60.1.7– Survey Data Review

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MACs shall implement procedures to verify data accuracy and completeness before uploading into the third-party contractor's survey analysis platform. MACs shall identify and resolve any identified issues and document correction procedures. MACs shall document and maintain their review procedures and provide them to CMS when requested.

MACs can find the metadata term definitions to upload into the system in the MCE User guide.

60.1.8– Survey Data Retention

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MACs shall keep a copy of all production data transferred to the third-party platform for a minimum of 30 calendar days after transmission. You will use this data if there's a failed transfer or if you need to

update and resubmit any information.

60.2– MAC Satisfaction Score

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

CMS monitors satisfaction with MAC services throughout the contract year for each jurisdiction using results from the MCE survey. The MCE survey measures satisfaction with individual MAC functions (for example, POE, digital services, PE) and provides a MAC business function satisfaction score per jurisdiction.

60.3 – MAC Created Surveys

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MACs shall use the third-party contractor’s analysis survey platform that CMS provides. MACs must get CMS approval for any survey that will be sent to Medicare providers. CMS will determine whether proposed surveys require approval from the Office of Management and Budget (OMB). If so, CMS will secure approval through the Paperwork Reduction Act process.

For MAC internal surveys, MACs shall notify CMS to publish. For more information, see the MCE user guide.

70 - PCSP Performance Management

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MACs must deliver consistent, high-quality customer service to providers. To ensure that providers receive service that supports Medicare integrity and supports provider satisfaction, MACs must meet the performance requirements in section 70.1 – 70.3.

70.1 - Telephone Standards

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

CMS holds each MAC’s PCC accountable for meeting call handling and quality standards, such as call completion rates, average speed of answer, and quality call monitoring. All calls handled by a MAC’s PCC contribute to that MAC’s success or failure in meeting the standards described in sections 70.2.1 – 70.2.4 of this chapter.

70.1.1- Call Completion

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

The call completion rate is the percentage of all toll-free attempts successfully delivered to the PCC’s equipment. The PCC shall meet the following standards:

- Each CSR/IVR combined line shall have a completion rate of no less than 80%
- Each CSR-only line shall have a completion rate of no less than 80%
- Each IVR-only line shall have a completion rate of no less than 95%

The standards are measured quarterly and are cumulative for the quarter.

MACs shall email the service reports mailbox by 11:00 *am* ET *when* 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."

70.1.2- Call Acknowledgment

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

Calls shall be acknowledged within 20 seconds by telephone CSR, IVR, or ACD prompt.

70.1.3– Average Speed of Answer

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

The average speed of answer (ASA) is the average time callers spend *waiting* in the telephone CSR queue *before connecting* to a telephone CSR. When determining the ASA, the wait time *starts* 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 email the service reports mailbox by 11:00 *am* ET *when* the ASA on the PCC line(s) *exceeds* the applicable quarterly standard for the previous business day. The email shall specify the *daily, month to date and quarter to date* 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."

70.1.4– Callbacks

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MACs shall ensure telephone CSRs collect necessary information from *callers* to perform research and respond. For callback completion and closeout, MACs shall make one attempt to reach a provider *and* may leave a message requesting a return call *that includes* the reference number and beneficiary's name if appropriate, but *they must not include any* other PHI or PII. MACs shall not leave responses on provider voicemail systems. If the MAC *can't* leave a *message*, then *they* 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 *resolving* their inquiry. Once the MAC has attempted to reach the provider, *through* either phone *contact* or written response, the callback is considered *complete* and closed.

MACs shall complete and close all callbacks within 10 business days of receipt of the original inquiry and *document them* in the inquiry tracking system, discussed in section *30.10* 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.

70.1.5– QCM Performance Standards

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MACs shall monitor a minimum of five telephone calls per telephone CSR per month per jurisdiction. *The PCC shall document any deviation from this requirement and maintain documentation* in the event the number of calls monitored is questioned. MACs shall meet the following standard:

- For all calls monitored for the quarter, the percent scoring as “Yes” for Knowledge Skills, Customer Skills and Adherence to Privacy Act shall be no less than 93%. This standard is measured quarterly and is cumulative for the quarter.

70.2 – Standards for Written Responses to Provider Inquiries

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

CMS requires MACs to maintain high standards when responding to provider inquiries in writing. The standards ensure providers receive accurate, timely and comprehensive information to support their Medicare billing and administrative needs. MACs must respond to provider inquiries within established timeframes.

MACs shall evaluate the responses to written provider inquiries by employing CMS’s QWCM process.

70.2.1- QWCM Performance Standards

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MACs shall evaluate and enter into the QWCM *database* a minimum of five provider responses per written CSR per month per jurisdiction or the entire universe available for monitoring, whichever is less, regardless of the different addresses to which inquiries may be sent. *If a written CSR responds to types of inquiries that aren’t handled by the PCC, those responses shall not be included in the required minimum number of responses evaluated and entered in the QWCM database. The PCC must document any deviation from this requirement and maintain documentation* in the event the number of responses monitored is questioned. MACs shall meet the following standard:

- For all written provider responses monitored for the quarter, the percent scoring as “Yes” for Knowledge Skills, Customer Skills and Adherence to Privacy Act shall be no less than 93%. This standard is measured quarterly and is cumulative for the quarter.

70.2.2– Timeliness of Responses to Written Provider Inquiries

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

Standards for responding timely to provider written inquiries (general, PRRS and Congressional) are calculated using business days. See the chart below for assistance with converting calendar days to

business days. This chart is provided as a guide only and *isn't* definitive. The chart assumes the MAC was open for business every day during the reporting period. Days where the MAC is closed for business shall not count as business days.

Business Days	Calendar Days
5	7
10	14
15	21
20	28
25	35
30	42
35	49
40	56
45	63

70.2.2.1- Timeliness of Responses to General Provider Inquiries
(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

All general written provider inquiries (including those received electronically) shall be responded to in writing or by telephone within 45 business days of receipt.

This timeframe *starts* the day *MAC* originally *receives and date-stamps the inquiry* and ends the day the MAC sends the final response. For those general inquiries that *can't* be answered in final within 45 business days of receipt, MACs shall issue an interim response acknowledging receipt of the inquiry and explaining the reason for the delay. When possible, inform the provider about how long it will be until a final response will be sent. Sending an interim There may be instances when an inquiry is mistakenly sent to another address used by the MAC. The 45-business-day timeframe *starts* once the inquiry is received in the MAC mailroom where written inquiries are routinely sent. This *doesn't* apply to MACs who choose to have all their mail sent to a separate location and then forwarded to the proper location. For these MACs, the 45-business-day timeframe starts the day that the mail is received at the initial location.

The 45-business day timeframe *applies* to inquiries that require a response related to any claim type for which the MAC is responsible (A/B, HH+H, DME). Therefore, if applicable, the MAC shall ensure that inquiries are provided to more than one responding department as quickly as possible. The response to these inquiries may be combined or separate, depending on which procedure is most efficient for the MAC. If the MAC departments respond separately, each response shall refer to the fact that the other department is also sending a response.

70.2.2.2- Timeliness of Responses to Complex Provider Inquiries
(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

The PRRS staff shall provide clear and accurate answers to provider inquiries within 45 business days of receipt.

This timeframe *starts* the day the *MAC* originally *receives and date-stamps the inquiry* and ends the day the *MAC* sends the final response. For those PRRS inquiries that *can't* be answered in final within 45 business days of receipt, *MACs* shall issue an interim response acknowledging receipt of the inquiry and explaining the reason for the delay. When possible, inform the provider about how long it will be until a final response will be sent. Sending an interim response *doesn't* resolve the issue and the inquiry *isn't* considered closed until the *MAC sends the* final response. The final response shall be sent within 5 business days after receipt of the *needed information*. Any interim responses sent to PRRS inquiries will count toward the *MAC's* overall allowance of no more than 5 percent of interim responses for the universe of written responses to provider inquiries.

70.2.2.3- Timeliness of Responses to Complex Beneficiary Inquiries
(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

Refer to chapter 2 of this manual for information about the timeliness of responses to complex beneficiary inquiries.

70.2.2.4- Timeliness of Responses to Congressional Inquiries
(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

All Congressional written inquiries shall be responded to in writing within 10 business days of receipt.

This timeframe *starts* the day the *MAC* originally *receives and date-stamps the inquiry* and ends the day the *MAC* sends the final response. For Congressional inquiries that *can't* be answered in final within 10 business days of receipt, *MACs* shall issue an interim response within 10 business days of receipt explaining the reason for the delay and *indicate* how the Congressional office can contact the *MAC* to check on the status. When possible, inform the Congressional office about how long it will take *to send* a final response. Sending an interim response *doesn't* resolve the issue and the inquiry *isn't* considered closed until the final response is sent. The final response shall be sent within 5 business days after receipt of the needed information. Any interim responses sent to Congressional inquiries will count toward the *MAC's* overall allowance of no more than 5 percent of interim responses for the universe of written responses to provider inquiries.

70.3– MAC Satisfaction Score
(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MCE helps MACs understand providers satisfaction with their services. MACs should deliver quality service to providers and understand and identify improvement opportunities.

Each MAC jurisdiction shall achieve an average score of 3.6 out of 5.0 for each evaluated business function during their contract year. MACs shall collect a minimum of 50 survey responses for each business function.

The MAC satisfaction scores can be seen on the Shared Dashboard within the Survey Contractor Platform and measures the average score for each business function for the entire contract year.

70.4 – POE Measurement

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

Providers rely on POE education to be presented with clarity by knowledgeable staff. MACs should offer education that providers consistently value and would recommend to their colleagues as their first choice to get reliable information.

POE provided by MACs shall be reviewed throughout the contract year for each jurisdiction. Scores are assessed during the evaluation period using results from the MCE survey. For the evaluation period, MACs shall maintain a

- POE Net Promoter Score (NPS) of 65
- Likelihood to Return score of 4.7

NPS is a nationally *recognized tool that measures* customer experience and *predicts* growth. The Likelihood to Return *score* evaluates the confidence providers have in the delivery of the education and its beneficial content.

All scores are derived from the Shared Dashboard within the Survey Contractor Platform.

80- PCSP System

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

The PCSP System is *comprised of four* interactive web-based *databases that support the oversight of the PCSP at the MACs. Each database* is password protected and accessible only to authorized users. The system includes

- PIES
- PCID
- QCM
- QWCM

When a MAC develops a new reporting category that doesn't fit into any existing categories in the databases, email the [service reports mailbox](#) for guidance.

80.1- PCSP System Access

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

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 *they are* 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 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 *using* the provider services mailbox, with the subject: "PCSP System Access Form." Once the form is returned and *CMS approves* the request, the Database Supervisors and alternate will have access to the requested PCSP System database(s) and shall begin assuming PCSP System database access responsibility for other MAC staff.

MAC staff who need access shall submit the request by filling out the PCSP System User Access Request Form and submitting to the Database Supervisor or alternate. The PCSP User Access Request Form can be found in the documentation section of each of the PCSP System databases. The Database Supervisor or alternate shall either grant or deny access to the requested database(s). The Database Supervisor or alternate may grant access to the database(s) to the same person for more than one contract. The Database or alternate shall keep a copy of all completed access forms and provide them to CMS upon request.

When MAC staff no longer need access to the database(s), the Database Supervisor or alternate shall archive those users within 7 calendar days. The Database Supervisor or alternate should review the database(s) monthly to identify and archive staff who no longer need access.

80.2- PIES

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MACs report PCC performance data *monthly in* PIES. Definitions, calculations and additional information for each of the required data elements as well as associated standards are *available in* PIES. 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 *30.6.1* of this chapter.)

80.2.1- Due Date for Data Submission to PIES

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

Each PCC shall enter required PCC data elements into PIES monthly 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, *CMS will consider* any missing data late and will need to be entered into PIES by CMS staff. *CMS does not consider callback* data 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.

If a MAC entered data timely but, after the PIES reporting due date, determined that the data *needs* to be changed, the MAC will not be able to change the data; *CMS staff will need to enter* the *changes*. In this situation, MACs shall *send* CMS the data to be changed, the reason(s) for the change(s), and the field(s) to be changed *to* the PIES mailbox.

80.2.2- Data to be Reported Monthly in PIES

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MACs shall capture and report in PIES the following data elements:

- Telephone inquiries data: appropriate for their MAC profile (CSR- and IVR-only lines or a combined CSR/IVR line).
- Written inquiries data: specified in the PIES database related to their general, PRRS, and Congressional written inquiries.
- MAC Secure Internet Portal data: specified in the PIES database related to their MAC Secure Internet Portal services.

80.1 - PCID

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

PCID *serves* as a central place to capture and store information about MACs' PCSP activities as well as provide an online reporting mechanism for the MACs' inquiry tracking reports.

MACs with more than one jurisdiction shall have the ability to separately identify provider data for each jurisdiction to accurately report this information in PCID.

80.3.1- MAC Contract and PCSP Data

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

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 newsletter Contact
 - MAC Liaisons (for MAC-to-MAC collaboration)
- ***Planned*** PCC Closures – MACs shall report PCC closures that fall on CMS pre-approved days and any other planned PCC closure dates ***and*** 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 ***becomes*** 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.

80.3.2– Additional Data to be Reported and Reporting Due Dates

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MACs shall report in PCID the data described in sections ***80.3.2.1 – 80.3.2.13*** of this chapter monthly between the 1st and the 10th of each month for the previous month's data and, for certain data required by section ***80.3.2.2*** 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 ***and*** 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.

If the MAC entered data timely but, after the PCID reporting due date, determined the data ***needs*** to be changed, the MAC will not be able to change the data; ***CMS staff will need to enter*** the changed data. In this situation, MACs shall ***send*** CMS the data to be changed, the reason(s) for the change(s), and the field(s) to be changed to the PCID mailbox

80.3.2.1- Inquiry Tracking Data
(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MACs shall log all PCSP inquiries in their Inquiry Tracking System and enter them in the PCID Inquiry Tracking module.

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 30.10.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 30.10.2* 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 *ensure* minimum procedures have been completed before submitting the Inquiry Tracking Report to CMS).

80.3.2.2– PCC Training Closure Information
(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MACs shall report PCC training closure information in PCID monthly 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 email the provider services mailbox 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 *CMS* Standardized Provider Inquiry 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.

80.3.2.3– POE Data

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

POE event and self-paced *education definitions*, additional instructions, and the POE Topic/Subtopic listing are available in the Documentation section of PCID.

MACs with multiple jurisdictions shall report POE event data and self-paced education data by jurisdiction. More information on reporting POE *events* and self-paced education data and their definitions can be found in the PCID Quick Start Guide. The PCID Quick Start Guide is available in the Documentation *section* of PCID.

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.

80.3.2.4– Provider Electronic Mailing List Subscriber Data

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MACs shall report the number of unique subscribers, *avoiding duplicate counts whenever possible*. 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.

80.3.2.5– Special Initiatives Activities

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

CMS issues a CR or TDL when MACS are required to report on activities related to special initiatives. Special initiatives activities may include direct mailings, electronic mailing list messages, POE events, website postings, or IVR system messages.

80.3.2.6– Emergency PCC Closures and Service Interruptions

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

If an emergency PCC closure or service interruption occurs (see section 30.2.4 or 30.6.4 of this chapter), MACs shall enter that closure in PCID Service Interruption module within 1 hour during normal business hours or by 9 am ET the next business day for after hours problems.

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

- Date and time of day (local time) the issue began*
- Date and time of day (local time) the issue was resolved*
- Line of Business affected -- A, B, HH+H, DME*
- Channel Impacted – IVR-only, CSR-only, combined IVR/CSR portal, website*
- Source – Internal, External, Not sure yet*
- Description -- A description of the problem*
- Resolution -- How the interruption was resolved*

Until resolved, each submission shall be updated, at a minimum at the end of each business day and by 10am ET the next day. CMS may request more frequent updates depending on the severity of the interruption.

80.3.2.7– MAC Secure Internet Portal Functionality

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MACs shall report *secure internet portal* functionality in the Portal Functionality module by selecting the available functionalities from a list. MACs shall also report additional functionalities available but are not in the list *to the provider services mailbox*.

Additional information is available in PCID documentation.

80.3.2.8– Provider Education Website Analytic Data
(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MACs shall report provider education website analytic data in the Website Analytics module using the definitions provided by CMS.

Definitions and additional information are available in *the PCID Quick Start Guide found in the Documentation section of PCID*.

80.3.2.9– Social Media Analytic Data
(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MACs shall report their social media data in the Social Media module using the definitions provided by CMS.

MACs shall enter their social media channels in PCID under “Administration” before reporting monthly data.

Definitions and additional information are available in the PCID Quick Start Guide found in the Documentation section of PCID.

80.3.2.10– Direct Mailing Information
(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

Contractors shall report the following information about Direct Mailings into the Special Initiatives *module in accordance with the instructions provided in the TDL*.

If MACs need to change the numbers reported in PCID, corrections shall be *emailed* to the PCID mailbox. MACs shall not make multiple entries into PCID regarding direct mailings.

80.3.2.11– Inquiry Capability Reporting
(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

Inquiry Capability Reporting includes IVR and Secure Internet Portal self-service technology capabilities. MACs shall:

- *Select* the jurisdiction inquiry capabilities from a list based on the applicable CMS standardized provider inquiry capabilities chart (IVR or Portal). After the initial entry, MACs only need to verify the data each month and make any changes
- *Use* the applicable glossary link in the module to review definitions from the related CMS standardized provider inquiry capabilities chart when necessary

- *Select* the “Not Classified” subcategory when the MACs capability handles inquiries only at the category level or cannot breakdown the nature or the transaction issues into an existing subcategory or into a new one
- *Use* the report’s comment field to inform CMS about relevant IVR or Secure Internet Portal inquiry capability reporting information
- *Report* capabilities by MAC jurisdiction if multiple jurisdictions apply
- *Email* the provider services mailbox at least 30 days before the MAC adds an inquiry capability. When adding a capability MACs shall include a brief IVR or Secure Internet Portal inquiry capability description and its requested effective date

Additional information is available in PCID documentation.

80.3.2.12– Website Attestation and Accessibility

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

MACs shall attest that their provider education website complies with CMS requirements within 30 calendar days following the cutover of a new contract (or the earliest cutover date if multiple exist) and thereafter, by the end of the sixth month of their contract (see section 50.2.6).

MACs shall use the most recent monthly CMS accessibility scan report to enter their accessibility score.

80.4– QCM

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

QCM is a web-based database that’s used to collect consistent and comparable data on the quality of the PCC telephone customer service delivered to Medicare providers.

MACs shall complete scorecards and enter data into QCM by the 10th of each month for the previous month. See section 30.6.11.2 of this chapter for additional information.

80.5–QWCM

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

QWCM is a web-based database that’s used to collect consistent and comparable data on the quality for PCC written responses to provider written inquiries.

MACs shall complete scorecards and enter data into QWCM by the 10th of the month for the previous month. See section 30.7.8.1 of this chapter for additional information.

90 - Disclosure of Information

(Rev. 13683; Issued: 04-08-26; Effective: 05-08-26; Implementation: 05-08-26)

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 DDR is available in the Documentation Section of PCID

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
<u>R13683COM</u>	04/08/2026	Updates to Pub. 100-09, Chapter 6 Beneficiary and Provider Communications Manual, Chapter 6, Provider Customer Service Program (PCSP)	05/08/2026	14379
<u>R13683COM</u>	04/08/2026	Updates to Pub. 100-09, Chapter 6 Beneficiary and Provider Communications Manual, Chapter 6, Provider Customer Service Program (PCSP)	05/08/2026	14379
<u>R12172COM</u>	08/03/2023	Updates to Pub. 100-09, Chapter 6 Beneficiary and Provider Communications Manual, Chapter 6, Provider Customer Service Program	09/04/2023	13293
<u>R11956COM</u>	04/202023	Updates to Pub. 100-09, Chapter 6 Beneficiary and Provider Communications Manual, Chapter 6, Provider Customer Service Program	05/22/2023	13158
<u>R10900COM</u>	08/11/2021	Updates to Pub. 100-09, Chapter 6 Beneficiary and Provider Communications Manual, Chapter 6, Provider Customer Service Program	09/14/2021	12374
<u>R10772COM</u>	04/30/2021	Updates to Pub. 100-09, Chapter 6 Beneficiary and Provider Communications Manual, Chapter 6, Provider Customer Service Program	12/16/2020	11918
<u>R10519COM</u>	12/15/2020	Updates to Pub. 100-09, Chapter 6 Beneficiary and Provider Communications Manual, Chapter 6, Provider Customer Service Program- Rescinded and replaced by Transmittal10772	12/16/2020	11918
<u>R10455COM</u>	11/13/2020	Updates to Pub. 100-09, Chapter 6 Beneficiary and Provider Communications Manual, Chapter 6, Provider Customer Service Program- Rescinded and replaced by Transmittal 10519	12/16/2020	11918
<u>R41COM</u>	02/08/2019	Update to Publication (Pub.) 100-09 to Provide Language-Only Changes for the New Medicare Card Project	03/12/2019	11059
<u>R39COM</u>	10/22/2017	Updates to Pub. 100-09, Chapter 6 Beneficiary and Provider Communications Manual, Chapter 6, Provider Customer Service Program	10/23/2017	10258
<u>R36COM</u>	07/21/2017	Updates to Pub. 100-09, Chapter 6 Beneficiary and Provider Communications Manual, Chapter 6, Provider Customer Service Program	08/22/2017	10168

<u>R35COM</u>	10/07/2016	Updates to Pub. 100-09, Beneficiary and Provider Communications Manual, Chapter 6, Provider Customer Service Program	11/08/2016	9682
<u>R31COM</u>	02/13/2015	Update of IOM Pub. 100-09, Chapter 6, section 30.2.11 to include the requirements for implementing Quality Assurance Monitoring at the Medicare Administrative Contractors	02/20/2015	8995
<u>R30COM</u>	12/19/2014	Revision of Pub. 100-06 - Medicare Financial Management Manual, Chapter 6 - Intermediary and Carrier Financial Reports, and Pub. 100-09 - Medicare Contractor Beneficiary and Provider Communications, Chapter 6 - Provider Customer Service Program	01/23/2015	8906
<u>R29COM</u>	06/27/2014	Revision of Pub. 100-09, Chapter 6, Medicare Contractor Beneficiary and Provider Communications Manual; Clearance of MAC Internet-Based Provider Portal Handbook; and Deletion of IOM Pub. 100-09, Chapter 3, Provider Inquiries	07/02/2014	8491
<u>R28COM</u>	05/02/2014	Revision of Pub. 100-09, Chapter 6, Medicare Contractor Beneficiary and Provider Communications Manual; Clearance of MAC Internet-Based Provider Portal Handbook; and Deletion of IOM Pub. 100-09, Chapter 3, Provider Inquiries – Rescinded and replaced by Transmittal 29	07/02/2014	8491
<u>R27COM</u>	03/12/2010	Change in Provider Customer Service Program Requirements	04/12/2010	6817
<u>R26COM</u>	08/07/2009	Provider Customer Service Program Updates	09/08/2009	6482
<u>R25COM</u>	03/04/2009	Implementation of the New Provider Authentication Requirements for Medicare Contractor Provider Telephone and Written Inquiries	01/05/2009	6139
<u>R24COM</u>	02/25/2009	Implementation of the New Provider Authentication Requirements for Medicare Contractor Provider Telephone and Written Inquiries - Rescinded and replaced by Transmittal 25	01/05/2009	6139
<u>R23COM</u>	02/10/2009	Implementation of the New Provider Authentication Requirements for Medicare Contractor Provider Telephone and Written Inquiries - Rescinded and replaced by Transmittal 24	04/06/2009	6139

<u>R22COM</u>	08/08/2008	Implementation of the New Provider Authentication Requirements for Medicare Contractor Provider Telephone and Written Inquiries – Rescinded and replaced by Transmittal 23	01/05/2009	6139
<u>R21COM</u>	01/11/2008	Instructions Related to the CMS Standardized Provider Inquiry Chart for FY2008	02/11/2008	5848
<u>R20COM</u>	07/13/2007	IOM Pub. 100-09, Chapters 3- Provider Inquiries and Chapter 6- Provider Customer Service Program Updates	07/30/2007	5597
<u>R19COM</u>	06/29/2007	IOM Pub. 100-09, Chapters 3- Provider Inquiries and Chapter 6- Provider Customer Service Program Updates - Replaced by Transmittal 20	07/30/2007	5597
<u>R18COM</u>	09/08/2006	Provider Customer Service Program	10/02/2006	5277
<u>R16COM</u>	07/21/2006	Disclosure Desk Reference for Provider Contact Centers	10/02/2006	5089
<u>R15COM</u>	11/18/2005	Initial Issuance of Chapter	12/19/2005	4137

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