CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-09 Medicare Contractor Beneficiary and Provider Communications	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 11956	**Date April 20, 2023**
	Change Request 13158

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

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to revise Chapter 6 to remove duplicate sections, update references, revise language and add new reporting requirements.

EFFECTIVE DATE: May 22, 2023
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: May 22, 2023

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	6/Table of Contents
R	6/10.1/PCSP Electronic Mailing Lists
R	6/10.2/PCUG Call
R	6/10.3 Integration of POE, PCC and PSS Activities in the PCSP
R	6/20 Provider Outreach and Education
R	6/20.1/Internal Development of Provider Issues
R	6/20.2 Partnering with External Entities and with Other MACs
R	6/20.3.2/Analysis of Error Rate Reduction Data
R	6/20.3.6/Analysis of MR Referrals
R	6/20.4 Provider Education
R	6/20.4.1 - Provider Bulletins/Newsletters
R	6/20.4.2/Direct Mailings for the PCSP
R	6/20.4.3 Training for New Medicare Providers
R	6/20.4.4 Training Tailored for Small Medicare Providers
R	6/20.4.5/Educational Topics
R	6/20.4.5.3/Medicare Preventive Service Benefits
R	6/20.4.5.5/Remittance Advice
R	6/20.5/POE Materials
R	6/20.6.1/POE AG's
R	6/20.6.2/Ask-the-Contractor Meetings
R	6/20.7/POE Reporting
R	6/20.7.1/Provider Service Plan
R	6/20.7.2/Provider Customer Service Program Activity Report
R	6/20.8/Charging Fees to Providers for Medicare Education and Training
R	6/20.8.1/No Charge
R	6/20.8.2/Fair and Reasonable Fees
R	6/20.8.2.1/Fees for Materials Available on MACs' Provider Education website
R	6/20.8.5/Excess Revenues from Provider Participant Fees
R	6/30/Provider Contact Center (PCC)
R	6/30.1.1/Pre-Approved PCC Closures
R	6/30.1.2/Planned PCC Training Closures not Pre-Approved PCC Closures
R	6/30.1.3/Emergency and Similar PCC Closures

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	6/30.3.1/Responding to Coding Questions
D	6/30.3.8.1/Written Responses to Provider Inquiries -- Quality Written Correspondence Monitoring (QWCM) Program Minimum Requirements
D	6/30.3.8.2/QWCM Calibration
D	6/30.3.9/Replying to Correspondence from Members of Congress
R	6/30.4.2/Teletypewriter Lines
R	6/30.4.4/Troubleshooting PCC Service Interruptions
R	6/30.4.5/Requesting Changes to Telephone Configurations
R	6/30.4.6/Hours of Operation
N	6/30.4.8/Directing Non-Compliant Callers to a Custom Network Message
N	6/30.4.9/Queue Message
N	6/30.4.10/Provider Telephone Line Staffing
N	6/30.4.10.1/CSR Sign-in Policy
N	6/30.4.10.2/CSR Identification to Callers
N	6/30.4.11/Monitoring CSR Calls
N	6/30.4.11.1/Quality Call Monitoring
N	6/30.4.11.2/Quality Assurance Monitoring
N	6/30.4.11.3/Remote Monitoring
N	6/30.4.12/Disaster Recovery Plan
N	6/30.4.13/Guidelines for High Quality Responses to Provider Telephone Inquiries
N	6/30.4.13.1/Telephone Response Quality Monitoring Program
N	6/30.4.13.2/Telephone Responses to Provider Inquiries
N	6/30.4.13.3/Recording Calls
N	6/30.4.13.4/QCM Calibration
R	6/30.5/Provider Written Inquiries
R	6/30.5.5/Electronic Responses to Provider Written Inquiries
R	6/30.5.6/Check Off Letters
R	6/30.5.7/Guidelines for High Quality Responses to Provider Written Inquiries
R	6/30.7/PRRS Operations
R	6/30.8/Provider Inquiry Tracking
R	6/30.8.1/Updates to the CMS Standardized Provider Inquiry Chart
R	6/30.8.2/MAC Inquiry Tracking Self-Data Review and Self-Validation Process

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	6/30.9/Fraud and Abuse
R	6/40.2.1/Required Training for PCC Staff
R	6/50/Provider Self Service Technology
R	6/50.1/Interactive Voice Response System
R	6/50.2/Provider Education Website
R	6/50.2.1/General Requirements
R	6/50.2.2/Webmaster and Attestation Requirements
R	6/50.2.2.1/Website Scans
R	6/50.2.3/CMS Feedback
R	6/50.2.4/Contents
R	6/50.2.4.1/Dissemination of Information from CMS to Providers
R	6/50.2.4.2/Frequently Asked Questions (FAQs)
D	6/50.2.4.3/Quarterly Provider Update
N	6/50.2.4.3/Web-based Provider Educational Offerings
N	6/50.2.4.4/Provider Claims Payment Alerts
R	6/50.3.1/Targeted Electronic Mailing Lists
R	6/50.3.2/Electronic Mailing List Promotion
R	6/50.5/MAC Secure Internet Portals
R	6/50.5.1/MAC Secure Internet Portal Service Interruptions
R	6/60.1/Provider Satisfaction Survey
R	6/60.1.1/MAC Survey Participation Requirements
R	6/60.1.6/Third-Party Contractor Platform System Users
R	6/70.2.1/Call Completion
R	6/70.2.3/Average Speed of Answer
R	6/70.2.5/QCM Performance Standards
R	6/70.2.6/QAM (Telephone) Performance Standard
R	6/70.3.1/QWCM Performance Standards
R	6/80/PCSP Data Reporting
R	6/80.1.2/Due Date for Data Submission to PIES
R	6/80.1.3/Data to be Reported Monthly in PIES
R	6/80.2.2/MAC Contract and PCSP Data to be Reported in PCID

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	6/80.2.3/Additional Data to be Reported Monthly in PCID and Reporting Due Dates
R	6/80.2.3.2/PCC Training Closure Information to be Reported in PCID
R	6/80.2.3.8/MAC Secure Internet Portal Service Interruptions to be Reported in PCID
R	6/80.2.3.9/MAC Secure Internet Portal Functionality to be Reported in PCID
R	6/80.2.3.11/Social Media Analytic Data to be Reported in PCID
R	6/80.2.3.12/Direct Mailing Information to be Reported in PCID
N	6/80.2.3.13/Inquiry Capability Reporting in PCID
R	6/80.3/QCM

III. FUNDING:

For Medicare Administrative Contractors (MACs):

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

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-09	Transmittal: 11956	Date: April 20, 2023	Change Request: 13158

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

EFFECTIVE DATE: May 22, 2023

**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: May 22, 2023

I. GENERAL INFORMATION

A. Background: The purpose of this Change Request (CR) is to revise Chapter 6 to remove duplicate sections that were moved in the previous revision. It also updates references, revises language and adds new reporting requirements for the Medicare Administrative Contractors (MACs).

B. Policy: MAC Provider Customer Service Program established by the MMA.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
13158.1	MACs shall implement all requirements contained within Pub. 100-09, Chapter 6 Medicare Contractor Beneficiary and Provider Communications Manual.	X	X	X	X					
13158.2	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 disrepectful to CSRs. (Section 30.4.8)	X	X	X	X					
13158.2.1	MACs shall work with CMS to create a custom network message in the GSA designated contractor's network for the purpose of redirecting	X	X	X	X					

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	these non-compliant callers before they reach the PCC's premise-based equipment. (Section 30.4.8)									
13158.2.2	Once identified, MACs shall send the incoming telephone number of non-compliant callers to the service reports mailbox with a copy to the Provider Network Support (PNS) contractor, requesting calls from this number be sent to the custom network message. (Section 30.4.8)	X	X	X	X					
13158.3	MACs shall attest to compliance with CMS requirements for QAM as stated in this chapter at the start of each contract year. (Section 30.4.11.2)	X	X	X	X					
13158.3.1	MACs shall submit the Annual MAC QAM Attestation within 15 business days after the start of each contract year. (Section 30.4.11.2)	X	X	X	X					
13158.3.2	To attest, go to the Attestation page in CRAD. Select the MAC, jurisdiction, and program which will auto populate the contract year. The MAC shall read and check the box for the following statement: This attestation certifies that we have a quality monitoring system in place that meets the requirements of IOM Publication 100-09, Chapter 6. *(Section 30.4.11.2)*	X	X	X	X					
13158.3.3	MACs shall enter the name and title for the manager of the PCC who is attesting	X	X	X	X					

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	for the MAC. (Section 30.4.11.2)									
13158.4	For workload reporting purposes, if an inquiry originally classified as general is referred to the PRRS, the MAC shall transfer the original general inquiry as a PRRS (written or telephone). (Section 30.7)	X	X	X	X					
13158.4.1	The MAC shall only count the inquiry once as a PRRS Inquiry. (Section 30.7)	X	X	X	X					
13158.5	If required and the caller does not authenticate before reaching a CSR, MACs should transfer the caller back to the IVR to complete authentication. (Section 50.1)	X	X	X	X					
13158.6	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. (Section 50.2.4.1)	X	X	X	X					
13158.6.1	MACs shall have discretion to include relevant MLN Connects newsletter content in their POE	X	X	X	X					

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	activities. (Section 50.2.4.1)									
13158.7	MACs shall email the MCE mailbox with questions or technical issues about the MCE program. (Section 60.1)	X	X	X	X					
13158.8	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. (Section 70.2.5)	X	X	X	X					
13158.9	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. (Section 70.3.1)	X	X	X	X					
13158.10	MACs shall enter its inquiry capabilities in PCID's Inquiry Capability	X	X	X	X					

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	Module, between the 1st and the 10th of each month for the previous month. (Section 80.2.3.13)									
13158.10.1	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. (Section 80.2.3.13)	X	X	X	X					
13158.10.2	MACs shall use the applicable glossary link in the module to review definitions from the related CMS standardized provider inquiry capabilities chart when necessary. (Section 80.2.3.13)	X	X	X	X					
13158.10.3	MACs shall: 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. (Section 80.2.3.13)	X	X	X	X					
13158.10.4	MACs shall use the report's comment field to inform CMS about relevant IVR or Secure Internet Portal inquiry capability reporting information. (Section 80.2.3.13)	X	X	X	X					
13158.10.5	MACs shall report capabilities by MAC jurisdiction if multiple jurisdictions apply.	X	X	X	X					

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	(Section 80.2.3.13)									
13158.10.6	MACs shall email the provider services mailbox at least 30 days before the MAC adds an inquiry capability. (Section 80.2.3.13)	X	X	X	X					
13158.10.6.1	When adding a capability, MACs shall include a brief IVR or Secure Internet Portal inquiry capability description and its requested effective date.(Section 80.2.3.13)	X	X	X	X					

III. PROVIDER EDUCATION TABLE

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

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
	N/A

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

V. CONTACTS

Pre-Implementation Contact(s): Kimberly Anthony, 410-786-2746 or kimberly.anthony@cms.hhs.gov

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

VI. FUNDING

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

ATTACHMENTS: 0

Medicare Administrative Contractor (MAC) Beneficiary and Provider Communications Manual

Chapter 6 - Provider Customer Service Program

Table of Contents
(Rev.11956, Issued 04-20-23)

Transmittals for Chapter 6

50.5 - *MAC Secure Internet Portals*

50.5.1 – *MACs Secure Internet Portal Service Interruptions*

70.2.3 - *Average Speed of Answer*

80.2.3.8 – *MAC Secure Internet Portal Service Interruptions to be Reported in PCID*

80.2.3.9 – *MAC Secure Internet Portal Functionality to be Reported in PCID*

80.2.3.13 – Inquiry Capability Reporting in PCID

10.1 –*Electronic Mailing Lists for Medicare Administrative Contractors*

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

1. Provider Customer Service Program Contractor User Group (PCUG) electronic mailing list – *CMS uses this* electronic mailing list to *send* important and timely information from CMS related to the PCSP, including CSR training materials and quality assurance program updates. 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 individuals who wish to subscribe or unsubscribe to the electronic mailing list *to the provider services mailbox*. There is no *limit* on the number of subscribers for any MAC, *but at a minimum, the following staff shall subscribe:*
   - *MAC POE manager*
   - *MAC PCC manage*
   - *Those managing PSS technology*
   - *Quality analysts*

2. MLN Connects® *newsletter* – CMS *uses this* electronic mailing list to send MACs important and timely information to share with their provider community. MACs shall subscribe to *the MAC-specific version of the* MLN Connects *newsletter within 30 business days after a new MAC contract award date by emailing the MLN Connects mailbox:*

   - *Names* and email addresses of the *staff MACs want* to subscribe. There is no *limit* on the number of subscribers.
   - *Permanent MAC component/resource box that will get the newsletter*

Email MAC subscriber changes to the MLN Connects mailbox. For staff departures, MAC shall email the change before they depart.

10.2 –Provider Customer Service Program User Group (PCUG) Call

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

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

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

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

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

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

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

20 –*POE*

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

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

MACs shall disseminate information to their providers through outreach, education, training, technical assistance, or other activities to help reduce improper payments. Each MAC shall establish an improper payment outreach and education program that will expand and enhance

efforts to reduce improper payments in accordance with guidance from CMS. In particular, MACs shall analyze data in accordance with sections 20.3 of this chapter when developing their outreach and education program.

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

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

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

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

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

20.1 - Internal Development of Provider Issues

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

The POE staff may send a representative to the MAC's Contractor Advisory Committee (CAC) as part of its identification and development of provider issues. See Pub. 100-08, Medicare Program Integrity Manual, Chapter 13.

20.2 - Partnering with External Entities and with Other MACs

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

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

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

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

1. Including information from partners in newsletters or publications.

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

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

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

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

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

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

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

MACs shall report information about their partnerships with external entities, specifically on partnerships related to education on items or services with the highest improper payment rate, in Provider Customer Service Program Customer Information Database (PCID) on a monthly basis. See section 80.2.3.3 of this chapter for more information on reporting requirements.

MACs shall work with each other to establish and maintain, on a regular basis, collaborative relationships with other MACs for the purposes of developing and implementing outreach and education offerings to providers on Medicare Program requirements that cross their lines of business (Part A, Part B, HH+H, and DME). The requirements for ordering home health services and DMEPOS are prime examples of two such collaborative efforts. MACs shall

ensure their outreach and education plans include efforts related to: (1) educating physicians about the Medicare requirement when ordering home health services for people with Medicare and about the specific documentation requirements of those orders, and (2) educating physicians and clinicians who are permitted to order DMEPOS about the Medicare requirement when ordering DMEPOS for people with Medicare and about the specific documentation requirements of those orders.

MACs shall report information about their collaborations with other MACs, specifically about their collaborations related to education on items or services with the highest improper payment rate, in PCID on a monthly basis.

20.3.2 - Analysis of Error Rate Reduction Data

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

MACs shall implement a provider education plan that focuses on reducing the CERT error rate. MACs shall focus on data from the CERT and RAC programs, as appropriate. Additionally, MACs shall use other data sources, such as provider inquiry tracking data and claims submission error data, as part of the analysis in developing their error rate reduction plan.

CERT data, including the inpatient claims error rate, are primary sources of information to target education activities. MACs shall utilize the reports accessible from these programs, using national data where available. Local data shall be compiled in a way to identify which providers in a MAC's jurisdiction may be driving any unusual patterns. MACs shall consider other sources of data when evaluating the CERT findings in order to develop an educational plan.

MACs shall ensure their CERT educational activities focus on existing CMS products and publications, including MLN products or content. MACs shall be aware of the CERT materials available from CMS and suggest topics to CMS for MLN products or content. See section 20.4 of this chapter.

20.3.6 – Analysis of MR Referrals

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

In accordance with Pub. 100-08, Medicare Program Integrity Manual, Chapters 1 and 3, POE staff is responsible for providing education as a result of referrals from MR. As part of this process, POE staff shall maintain information about referrals from MR, requests for education from providers, follow-up communication with MR, and disposition of problems referred from MR, including the type of education given. *See section 20.4.5.2 of this chapter.*

20.4 - Provider Education

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

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.

Medicare Learning Network® (MLN), MLN Connects® and MLN Matters® are registered trademarks of the U.S. Department of Health and Human Services (HHS) and brand names for official CMS provider educational products, outreach activities, and information resources designed to promote national consistency of Medicare provider information. MLN products include:

- Publications (*fact* sheets, *educational tools* and *booklets*)
- MLN Matters Articles
- MLN Connects *newsletter*
- Web-*based training*
- *Multimedia*

MACs shall use these MLN products and content to deliver a planned and coordinated provider education program that *accommodates* health care professionals' busy schedules with the least amount of disruption to their normal business operations. MACs shall use MLN products or content for all educational topics and for specialty provider groups *like* new Medicare providers and small Medicare providers. MACs shall supplement MLN products or content and other CMS materials with specific information unique to their jurisdictions.

MACs shall include or link to *relevant* MLN products *at https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlngeninfo*.

MACs shall train their CSRs at least once per contract year on:

- the MLN webpage
- how to access and use MLN products or content
- the MLN Connects newsletter

If MACs identify a lack of information about specific topics, they shall suggest topics *by emailing* the *MLN mailbox*.

20.4.1 - Provider Bulletins/Newsletters

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

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

20.4.2 – Direct Mailings for the PCSP

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

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

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

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

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

20.4.3 - Training for New Medicare Providers

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

MACs shall offer training tailored to the needs of new Medicare providers and billing staff. MACs shall use CMS-developed materials, including *relevant* MLN products or content. See section 20.4 of this chapter. This training shall include fundamental Medicare policies, programs, and procedures and shall concentrate on and feature information on billing Medicare.

20.4.4 - Training Tailored for Small Medicare Providers

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

MACs shall tailor education to the needs of their small Medicare providers. Small providers are defined by law as providers with fewer than 25 full-time equivalent employees or suppliers with fewer than 10 full-time equivalent employees. This training may involve interactive communication such as face-to-face trainings or web-based tutorials or instruction. CMS does not require MACs to identify or validate providers who meet the definition of small provider.

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

- *Reviewing* of billing systems and internal controls to determine program compliance and to suggest more efficient and effective means of achieving such compliance
- *Holding* educational seminars for groups of providers identified as having similar *issues providing technical* assistance from EDI support staff

20.4.5 – Educational Topics

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

MACs shall use their discretion to determine the educational topics most relevant to their provider population. MACs shall use various sources of information, including provider feedback, policy and procedure changes, and MAC data analysis to determine these topics; however, at a minimum, MACs shall educate providers on the topics outlined in this section. MACs shall use CMS-developed materials, including *relevant* MLN products or content. See section 20.4 of this chapter.

20.4.5.3 - Medicare Preventive Service Benefits

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

MACs shall promote the use of preventive services and other benefits provided by the Medicare program to beneficiaries. *For more information see the Preventative Services website*.

20.4.5.5 - Remittance Advice

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

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

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

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

MACs shall also promote the use of the free *Medicare Remit Easy Print* (MREP) software to obtain Electronic Remittance Advice (ERA). The benefits of using MREP software include saving time and money by printing remittance information directly on the day the Health Insurance Portability and Accountability Act (HIPAA) 835 is available without waiting for the mail, the ability to create and print special reports, and the ability to create document(s) that can be included with claim submissions to secondary/tertiary payers. *CMS prefers the* ERA for claims payment communication. When new versions of MREP software become available, MACs shall post this notification on their provider education websites and communicate this information to their MREP contact list and provider electronic mailing list(s).

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

20.5 - POE Materials

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

MACs shall develop clear, concise and accurate POE materials, following the Plain Language Act of 2010 *guidelines*. MACs shall use CMS-developed materials, including *relevant* MLN products or content. See section 20.4 of this chapter. MACs shall include production or re-issued month and year for POE materials *within the publication*. MACs shall disseminate POE materials timely, efficiently, and cost-effectively. MACs shall follow IOM Pub. 100-04 Claims Processing Manual, Chapter 23 requirements and guidelines for any new or revised website and electronic media material. MACs shall make all documents section 508 compliant.

All MAC-developed materials *are* the property of CMS, and shall *be made* available to CMS upon request. If a MAC reproduces or uses material, in whole or in part, originally developed by another MAC, the MAC shall acknowledge the other MAC either within the material, or on its cover, case or container.

20.6.1 – *POE Advisory Groups*

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

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

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

The MAC shall maintain the POE AG *and the main point of contact for all POE AG communication shall be 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 be members of other advisory committees, the majority of 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 individuals and organizations to be included in the POE AG.* MACs shall strive to maintain professional

and geographic diversity within the POE AG and have representatives of the major provider specialties or provider institutions they serve. Providers from different geographic areas, as well as from urban and rural locales, shall be represented in the POE AG.

MACs shall consider having more than one POE AG *if the size of the jurisdiction or diversity of the 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 *it* oversees *or have a separate group for each of its 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 its provider education website that allows providers to access information about the POE AG. This information shall include, at a minimum, minutes from meetings, upcoming meeting dates and locations, list of organizations or entities comprising the POE AG, and an email address for a contact point for further information on the POE AG.

MACs shall consider the suggestions and recommendations of its POE AG and implement those deemed feasible and in the best interest of an effective PCSP. In the interest of maintaining a working relationship, the MAC shall explain to the POE AG reasons for not implementing or adopting any POE AG suggestions or recommendations.

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

20.6.2 – *"Ask-the-Contractor" Meetings*

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

"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 20.6.1 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 the FAQs on 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 the timing, frequency, size, topics, and provider type(s) included in *ACMs*. MACs *should* also use other methods for *ACM* topic identification, such as inquiry analysis, claims submission error analysis, MR data analysis, input from PCC staff, and information gathered through partnerships.

20.7 - POE Reporting

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

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

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

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

20.7.1 - *Provider Service Plan*

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

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 the duration of its contract to support provider education and communications. The PSP shall address and support all the implementation strategies and activities stated in this chapter, as well as all required activities stated in the MAC's SOW. An HH+H MAC shall prepare a separate PSP for its corresponding HH+H work.

Each MAC shall send the PSP electronically in MS Word to the *provider services mailbox,* and to the appropriate Contracting Officer Representative (COR) or designee, according to the following schedule:

- If the implementation start date is between the 1st and the 14th of the month, the PSP shall be due by close of business the last day of the month following the start of the implementation period.
- If the implementation start date is between the 15th and the last day of the month, the PSP shall be due by close of business the last day of the second month following the start of the implementation period.
- If the due date falls on a weekend or holiday, the PSP is due by close of business on the next business day. The PSP is required for each new MAC contract, even if the incumbent is awarded the new contract.

MACs shall use the PSP *template* and instructions located *in the Documentation section of PCID. CMS will notify* MACs *about* updated templates via the CMS PCUG electronic mailing list described in section10.1 of this chapter.

20.7.2 – *Provider Customer Service Program Activity Report*

(Rev.11956; Issued 04-20-23; Effective: 05-22-23 ; Implementation: 05-22-23)

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

The PAR is due to CMS on the 30th calendar day after the last day of the contract year. If the 30th calendar day falls on a weekend or holiday, the report is due by close of business on the

next business day. MACs shall send all PARs electronically in MS Word to the *provider services mailbox* and to the appropriate COR or designee.

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

20.8 - Charging Fees to Providers for Medicare Education and Training

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

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

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

20.8.1 – No Charge

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

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 a MR identified need for education. *See sections 20.3.6 and 20.4.5.2 of this chapter.*

20.8.2 – Fair and Reasonable Fees

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

MACs may charge "fair and reasonable" *fees* to cover the cost of certain POE materials and activities. "Fair and reasonable" means the fee charged is in line with the actual cost to the MAC and is within the means of likely participants in the activity or recipients of materials.

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

20.8.2.1 – Fees for Materials Available on MACs' Provider Education Websites

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

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).

20.8.5 – Excess Revenues from Provider Participant Fees

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

Excess revenues from participant fees may occur when the total of the fees collected exceeds the total of the allowable costs. MACs may use one of the following methodologies to determine how to handle any excess revenues collected from fee-associated provider education and training activities:

Per activity: The total fees collected for any education or training activity should not exceed the actual costs incurred for the activity by more than 10 percent. If the total collected is less than 10 percent, the MAC may incorporate the excess revenue into its POE program. If the total collected exceeds 10 percent, the MAC shall evenly refund the entire excess amount collected to all registrants who paid a fee for attending the activity. For example, the MAC charged 250 participants a $50 registration fee for an activity that cost the MAC $10,000 (for meeting facility, equipment rental). Therefore, the MAC collects $12,500. Since the amount collected exceeds the cost of the activity by more than 10 percent, the entire excess amount collected ($2,500) shall be equally disbursed back to all paying registrants.

Per year: At the end of the 9th month of the contract year, the MAC shall total the fees collected to attend completed fee-associated provider education and training activities for that year. To that amount, the MAC shall add the estimated fees the MAC anticipates collecting from all remaining scheduled fee-associated education and training activities. The MAC shall subtract from this amount the total actual and anticipated costs for all past and future fee-associated education and training activities for the contract year. The total remaining should not exceed the actual and expected costs incurred for the year by more than 25 percent. If the amount collected is 25 percent or less of total costs, the MAC shall note that amount in its PAR, and incorporate the excess revenue into its POE program. If the amount collected exceeds 25 percent of the total costs, the MAC shall send a message by the end of the 10th month of its contract year to the *service reports mailbox* listing the amount of excess revenue collected and the MAC's plan to equally refund the entire excess revenue to all provider registrants who attended any of the MAC's fee-based education or training activities.

30 - Provider Contact Center (PCC)

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

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

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

MACs shall identify at least two points of contact for each PCC. The contacts should have knowledge of provider telephone and written inquiries. MACs shall enter each contact's

name, business telephone number, business email address and point of contact type (telephone, written, technical, etc.) in PCID. See section 80.2.2 of this chapter for PCID reporting and data certification requirements.

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

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

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

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

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

30.1.1 - Pre-Approved PCC Closures

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

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

- New Year's Day
- Martin Luther King, Jr. Day
- Presidents' Day

- Good Friday
- Memorial Day
- *Juneteenth*
- Independence Day
- Labor Day
- Columbus Day
- Veterans Day
- Thanksgiving Day
- Day After Thanksgiving
- Christmas Eve
- Christmas Day
- Day After Christmas

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

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

30.1.2 – Planned PCC Training Closures not Pre-Approved PCC Closures

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

MACs shall request permission to close one or more locations of a jurisdiction's PCC for PCC training on days other than those referenced in section *30.1.1* of this chapter by reporting these planned PCC closures in PCID on a monthly basis. MACs shall consider these PCC closures approved unless they hear otherwise from CMS within 5 business days after the PCID reporting deadline.

See section 80.2.3.2 of this chapter for the monthly PCID reporting requirements.

30.1.3 – Emergency and Similar PCC Closures

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

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

business hours the night before or before business hours that day. The email shall explain the reason for the PCC closure and, if known at the time, indicate when the PCC will reopen.

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

30.3.1 - Responding to Coding Questions

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

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

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

2. The American Hospital Association (AHA) *website has* many resources for answers to coding questions. The website also has a direct link to the *AHA Coding Clinic* whereby coding questions may be submitted and tracked.

3. Level II Healthcare Common Procedure Coding System (HCPCS) codes related to durable medical equipment or prosthetics, orthotics, and supplies are answered by the Pricing, Data Analysis and Coding (PDAC) Contractor. Information about the PDAC Contractor and the services it provides can be found *on their website*.

4. *Additional HCPCS information*

30.4.2 - *Teletypewriter Lines*

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

In accordance with Section *504* of the Rehabilitation Act of 1973 and the Workforce Investment Act of 1998, all PCCs shall provide the ability for deaf, hard-of-hearing, or speech-impaired providers to communicate via *Teletypewriter (TTY)* equipment. A TTY is a special device permitting deaf, hard-of-hearing, or speech-impaired individuals to use the telephone by allowing them to type messages back and forth to one another instead of talking and listening. A TTY is required at both ends of the conversation in order to communicate. MACs shall publicize the TTY line on their provider education websites. This TTY shall also be available for complex beneficiary inquiries.

30.4.4 – Troubleshooting PCC Service Interruptions

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

---

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

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

1. *Email* the *service reports mailbox* with a copy to the Provider Network Support (PNS) contractor to notify CMS of a service interruption. The email shall be sent within 1 hour of the start of the service interruption if it began during normal business hours, or by 9:00 a.m. ET the next business day if the interruption began after business hours the night before or before business hours that day. The email shall summarize the problem and the steps taken to restore full service.

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

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

2. *Send* at least one daily follow-up email to the *service reports mailbox* by 12:00 p.m. ET providing a status until the problem has been resolved.

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

    - Internal customer premise equipment or network service.

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

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

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

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

4. *Email* the *service reports mailbox within 1 hour after resolution*.

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

30.4.5 - Requesting Changes to Telephone Configurations

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

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

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

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

30.4.6 - Hours of Operation

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

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

Normal business hours for live telephone service are 8:00 a.m. through 4:00 p.m. for all time zones of the geographical area serviced, Monday through Friday. Where provider call volume supports it, the normal business hours may be shifted for all time zones. MACs adopting alternate hours shall request approval for this alternate schedule by *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 do not need annual approvals for previously approved alternate schedules if there are no additional changes/updates for the hours of operation.

30.4.8 – *Directing Non-Compliant Callers to a Custom Network Message*

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

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 e-mail 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 Provider Network Support (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.

30.4.9- Queue Message

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

MACs shall provide a recorded message that provides the following information while providers are waiting in queue to speak to an available telephone CSR:

- Anticipated time until the call will be answered including any temporary delays the provider may experience while waiting in queue.
- Non-peak times for providers to call back when the PCC is less busy.
- Information the provider should have available before speaking with a telephone CSR.
- Educational information on issues identified by the MAC. (See section 20 of this chapter).

30.4.10 – Provider Telephone Line Staffing

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

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

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

30.4.10.1 – CSR Sign-in Policy

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

MACs shall establish and follow a standard telephone CSR sign-in policy that contains the following:

- CSRs available to answer telephone inquiries shall sign in to the telephone system to begin 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.

30.4.10.2 - CSR Identification to Callers

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

The telephone CSRs shall identify themselves when answering calls. In order to provide a unique identity for each telephone CSR for accountability purposes and to protect the privacy of a telephone CSR if an inquiring provider asks the telephone CSR for his/her name, PCC management may permit each telephone CSR to use an alias, such as an Operator ID or a telephone extension. This alias shall be known by the MAC and provided to CMS for monitoring purposes.

30.4.11 - Monitoring CSR Calls

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

CMS has three monitoring programs to ensure quality responses to calls from providers: (1) *Quality Call Monitoring (*QCM*)*, (2) *Quality Assurance Monitoring (*QAM*)*, and (3) remote monitoring. 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.

As MACs are ultimately responsible for their responses to provider telephone inquiries, MACs shall use monitoring results to identify and act upon areas of needed improvement, both for the PCC as a whole and for individual telephone CSRs. MACs shall document the actions, to include corrective action plans, as applicable, they take to improve CSR-handled calls if CMS monitoring, or their own monitoring, indicates improvements are recommended or required. MACs shall provide such information 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.

30.4.11.1 – Quality Call Monitoring (QCM)

(Rev.11956; Issued 04-20-23; Effective: 05-22-23 ; Implementation: 05-22-23)

See section *30.4.13.2* of this chapter for the guidelines and requirements of quality call monitoring.

30.4.11.2 – Quality Assurance Monitoring (QAM)

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

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

CMS *maintains* a *Communications Relational Assurance Database* (CRAD) *for* CMS and MAC staff to review QAM Scores, Issues, Rebuttals, and Reports.

MACs shall attest *to* compliance with CMS requirements for QAM as stated in this chapter *at the start of each contract year*. *MACs shall submit the Annual MAC QAM Attestation within 15 business days after the start of each contract year.* To attest, *go to the Attestation page in CRAD. Select the MAC, jurisdiction, and program which will auto populate the contract year. The MAC shall read and check the box for the following statement: This attestation certifies that we have a quality monitoring system in place that meets the requirements of IOM Publication 100-09, Chapter 6. MACs shall enter the name and title for the manager of the PCC who is attesting for the MAC. Once all selections have been made, the manager shall submit the attestation*

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

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

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

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

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

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

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

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

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

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

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

- Retaining audio and video recordings for all calls for a period of *90* calendar days from the date of the calls.

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

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

30.4.11.3 – Remote Monitoring

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

MACs shall maintain the ability for CMS to remotely monitor live provider calls in their entirety by specific workstation (CSR), next call from the network or next call from the telephone CSR queue, or specific business line. MACs shall make remote monitoring instructions, access codes, and telephone CSR IDs available to CMS upon request. CMS will take reasonable measures to ensure the security of this access (for example, passwords will be controlled by one person).

30.4.12 – Disaster Recovery Plan

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

When a PCC is faced with a situation that results in a major disruption of service, the PCC shall take the necessary action to ensure providers are made aware of the situation. Whenever possible, the PCC is responsible for activating its own emergency messages or re-routing calls. However, when this is not possible and providers are unable to reach the PCC switch, the PCC shall contact the PNS contractor. For all other telecommunications support requests, PCCs shall follow their normal procedures.

The annual telecommunications Disaster Recovery Plan shall describe 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 during the time the PCC is unable to receive provider telephone calls.

MACs shall submit the Disaster Recovery Plan electronically in MS Word to the *service reports mailbox* and to the appropriate Deliverables mailbox by the end of the third month of the contract year. For newly awarded MAC contracts: 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.

30.4.13 - Guidelines for High Quality Responses to Provider Telephone Inquiries

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

MACs shall monitor, measure, and report the quality of service continuously by employing CMS's QCM process. MACs are encouraged to heavily monitor telephone CSR trainees who have just completed classroom instruction before they begin to handle calls without assistance of a "mentor."

30.4.13.1 – Telephone Response Quality Monitoring Program

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

MACs shall have a monitoring program in place to ensure the quality of telephone inquiry responses. The monitoring program is applicable to MACs' provider inquiry line(s).

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.

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

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

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. Copies of the official QCM scorecard, User Guide, Handbook, and Scoring Chart can be obtained through the QCM database. A detailed description of the evaluation criteria can be found on the official QCM Scoring Chart and Handbook. In addition, a MAC's telephone inquiries monitoring program shall ensure:

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

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

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

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

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

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

7. Telephone CSR trainees and new telephone CSRs are adequately monitored. However, scores for telephone CSR trainees will be excluded from QCM

performance for one 30-calendar-day period following the end of their formal classroom training.

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

9. Timely feedback is provided to those monitored.

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

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

12. The QCM Handbook and User Guide are followed.

30.4.13.3 – Recording Calls

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

MACs shall record incoming CSR-handled calls (while working in the PCC or remotely) as part of their contract with CMS to ensure the quality of telephone inquiries. MACs shall provide verbal notification at the beginning of the call announcing that the call may be monitored or recorded for training purposes. If a provider objects to having the conversation recorded, the telephone CSR will inform the provider the MAC records calls for the sole purpose of quality assurance and training and the recording system cannot be stopped by an individual telephone CSR. If the provider still objects and does not want to continue with the recorded call, the telephone CSR will inform the provider that they may send the inquiry in writing. The telephone CSR shall then provide the appropriate address for written correspondence.

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

30.4.13.4 – QCM Calibration

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

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

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

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

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

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

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

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

30.5 - Provider Written Inquiries

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

All provider written inquiries, shall be handled consistently for accuracy, professionalism and timeliness. Every provider written inquiry shall receive a final response that accurately and completely addresses the issue(s) contained in the incoming inquiry. For provider written inquiries received that could be handled by *a self-service option*, such as claim status and eligibility inquiries, MACs shall *refer the provider to the location for their answer*. See section 50.1 of this chapter.

MACs also have the discretion to encourage providers to use the *MAC Secure Internet Portal* if the functionality exists. Additionally, responses should include information about relevant training seminars or computer-based training on the MAC's provider education website if that is appropriate to the topic of the inquiry.

MACs handle the following three types of provider written inquiries:

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

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

section. Timeliness standards for PRRS provider written inquiries are defined in section 70.3.2.2 of this chapter.

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

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

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

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

1. Postal - hardcopy letters sent through the USPS

2. Telephone – outbound calls to providers

3. Electronic – electronic responses sent through email, fax, *MAC Secure Internet Portal* or other approved electronic mechanisms

30.5.5 – Electronic Responses to Provider Written Inquiries

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

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

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

Email content, including attachments, must be section *508 compliant*.

30.5.6 - Check Off Letters

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

Check-off letters are appropriate for responding to routine provider written inquiries like claim status, eligibility inquiries, *or non-appealable claims*. Check-off letters shall not be

used to address more complex inquiries. Each check-off letter shall be personalized and follow the same timeliness and quality guidelines that pertain to all written responses to provider inquiries.

30.5.7 - Guidelines for High Quality Responses to Provider Written Inquiries

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

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*. The Plain Writing Act of 2010 requires all federal agencies and, by extension, their contractors to use plain writing in any document that (1) is necessary to obtain a federal benefit or service, (2) gives information about a federal benefit or service, or (3) explains how to comply with federal requirements. MACs shall refer to *the Plain Language Website to help meet the requirements of the Plain Writing Act of 2010. We also encourage you to reference the National Provider Communication Standards.*

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

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

30.7 - PRRS Operations

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

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

For workload reporting purposes, upon referral of a provider telephone inquiry to the PRRS, the telephone inquiry shall be closed and a written inquiry shall be opened. *If a written inquiry originally classified as general is referred to* the PRRS, the *original general* inquiry shall be *transferred* and *counted as a PRRS. The MAC shall only count the written inquiry once as a PRRS Inquiry.*

30.8 - Provider Inquiry Tracking

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

CMS requires MACs to track and report the reason for telephone and written inquiries using categories and subcategories found in the CMS Standardized Provider Inquiry Chart. The chart can be found *in the Documentation section of PCID.* MACs also have the flexibility to add contractor-specific subcategories to track provider inquiries that may arise within its jurisdiction See Section 30.8.D.

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

A. Inquiry Tracking Requirements

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

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

2. Person responsible for answering the provider inquiry

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

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

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

6. Timeliness of the response.

B. Inquiry Tracking Data Use

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

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

2. Identify areas for broader provider and CSR education.

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

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

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

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

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

C. Requirements for Classifying the Nature of Inquiries

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

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

2. Use categories and subcategories in the CMS Standardized Provider Inquiry Chart to capture the reason/issue for the inquiry, not the status, the disposition (for example, Referrals to the IVR), or the action taken. To capture the most relevant and accurate inquiry data when logging a provider inquiry in the MAC Inquiry Tracking System, all PCC staff shall exercise best judgement in identifying the true issue of the provider contact to the PCC.

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

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

D. Guidance for Creating Contractor-Specific Subcategories

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

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

2. MACs shall not create contractor-specific subcategories when the CMS Standardized Provider Inquiry Chart provides existing standard existing subcategories that can be used to log and report those inquiries. Example: A MAC should not create a contractor-specific subcategory called "HCPCS" under the "Coding" category because the chart already provides "Procedure Codes" as one of the standard subcategories under "Coding."
3. MACs shall assign a specific descriptive name and a descriptive definition to each contractor-specific subcategory they create and report to CMS. This is essential to identify what is being reported. Do not use "Subcategory 1" or "Subcategory 2" or "Contractor-Specific" as the descriptive names. CMS encourages the MACs to consider using the following when creating contractor-specific subcategories:

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

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

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

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

Issues" category because a subcategory of "HMO Refunds" would more appropriately belong under the "Financial Information" category.

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

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

30.8.1 – Updates to the CMS Standardized Provider Inquiry Chart

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

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

The latest version of the CMS Standardized Provider Inquiry Tracking Chart is located *in the Documentation section of PCID.*

As necessary, MACs shall recommend changes to the CMS Standardized Provider Inquiry Chart, including modifications to existing categories and subcategories and the addition of new inquiry categories and subcategories. MACs shall submit changes or comments related to the CMS Standardized Provider Inquiry Chart via the *provider services mailbox*. Suggested changes shall include the following information:

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

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

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

MACs shall document inquiry tracking data review activities and validation procedures, including major components of the process (for example, analyzing inquiry trends),

developments and/or enhancements (for example, Inquiry Tracking System, inquiry types, CSR desk procedures to log inquiries, resources to complement inquiry analysis), and identification and mitigation for areas vulnerable to errors.

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

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

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

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

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

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

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

   CMS encourages each MAC to increase their rate.

4. MAC Provider Inquiry Tracking Updates
   MACs shall send CMS Provider Inquiry Tracking Updates to *provider services mailbox* with the subject line "MAC Provider Inquiry Update," when the MAC finds:

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

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

30.9 - Fraud and Abuse

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

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

1. Provider/Supplier name, NPI, provider/supplier number, and address.
2. Type of provider involved in the allegation and the perpetrator, if an employee of the provider/supplier.
3. Type of service involved in the allegation.
4. Place of service.
5. Nature of the allegation(s).
6. Timeframe of the allegation(s).
7. Narration of the steps taken and results found during the MAC's screening process (discussion of beneficiary contact, if applicable, information determined from reviewing internal data, etc.).
8. Date of service, procedure code(s).
9. Beneficiary name, Medicare Beneficiary Identifier (MBI), telephone number.
10. Name and telephone number of the MAC employee who received the complaint.

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

The MAC shall maintain a copy of all referral packages.

40.2.1 - Required Training for PCC Staff

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

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

1. How to find, navigate and use their provider education website (including the MAC's FAQs, the schedule of upcoming outreach and education events, and all available online education) and other self-service tools, to include the IVR system and the *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 20.4 of this chapter.)

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

6. The Privacy Act of 1974 and HIPAA

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

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

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

50 - *PSS Technology*

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

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

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

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

- *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 information readily available within these tools.

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

50.1 – Interactive Voice Response (IVR) System

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

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

1. MAC hours of operation for telephone CSR service.

2. After-hours message indicating normal business hours. (It is not necessary to duplicate this message if the caller is informed of the normal business hours via the telephone system prior to being delivered to the IVR system.)

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

4. Specific information about claims in process and claims completed. (For claims status inquiries handled in the IVR system, all PCCs shall adhere to the Privacy Act of 1974 and HIPAA Privacy Rule by authenticating providers as required by the Disclosure Desk Reference (DDR), which is referenced in section *90* of this chapter and is available in the Documentation Section of PCID.

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

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

At a minimum, the MACs shall require providers to use the IVR system to access claim status and beneficiary eligibility information; however, MACs have discretion to also require

providers to use any other functionality available through the IVR. Telephone CSRs shall refer providers to the IVR system for applicable questions. Telephone CSRs may give the information if it is clear the IVR system is not functioning and the provider cannot access the information. Each MAC shall update the IVR systems to address provider needs as determined through the MACs' PCSP inquiry analysis at least once every 6 months.

NOTE: Each MAC has the discretion to also require providers to use the *MAC Secure Internet Portal* for existing IVR functionality if the portal also has the same functionality.

The IVR system shall be available to providers 24 hours a day, 7 days a week with allowances for normal claims processing and system mainframe availability, as well as normal IVR system maintenance. When information is not available to IVR system users, MACs shall post a message alerting providers on the IVR system.

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

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

50.2 - Provider Education Website

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

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

MACs shall consider the use of their provider education website for every educational offering they provide to Medicare providers, including approaches such as web-based conferencing and trainings and computer-based training. See section 20.4 of this chapter for the requirements to include *relevant* MLN *or CMS* products or content.

50.2.1 – General Requirements

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

The information contained on the MAC's provider education website shall be structured in such a way information is easily found and searchable, so as to reduce the number of pages users have to go through in order to gain access to the information they are seeking. In designing their websites, MACs shall adhere to basic, research-based website usability guidelines, including the use of plain language, a task-based design, and the elimination of

redundant, outdated, and trivial content detected in periodic content audits. MACs shall also be aware of and adhere to federal website best practices found at www.digital.gov.

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

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

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

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

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

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

50.2.2 – Webmaster and Attestation Requirements

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

MACs shall assign a Webmaster responsible for maintaining and updating relevant portions of the MAC's provider education website in a timely manner. The Webmaster shall ensure that the provider education website complies with *CMS's Contractor Website Guidelines*. Webmasters shall pay close attention to the requirements for compliance with the requirements outlined in Section 508 of the Rehabilitation Act of 1973. See *CMS.gov Accessibility and Compliance with Section 508*

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

MACs shall periodically review the CMS Contractor Website Guidelines to determine their continued compliance. Within 30 calendar days after a cutover (if more than one cutover date, within 30 calendar days of the earliest cutover date), and, thereafter, by the end of the

sixth month of a contract year, MACs shall send two statements from their Webmaster attesting their provider education website complies with:

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

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

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

50.2.2.1 – Website Scans
(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

CMS and its contractor will conduct scans to ensure MAC websites are compliant with Federal 504/508 policy as well as to search for dead URLs throughout the MAC webpages. The overarching goal is to give the MACs a tool to improve their individual MAC websites, which should translate into increased provider satisfaction.

MACs shall use the scan results as a tool to improve their individual MAC websites. MACs *can* run scans more frequently to test things like web updates or to test the resolution of any findings from the monthly scans.

50.2.3 – CMS Feedback
(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

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

MACs shall provide information about how providers can *provide feedback* to CMS about the MAC's performance. Each MAC shall provide the email address of the resource mailbox at the CMS regional office that has jurisdiction over the MAC. The *information is on the CMS external website under "How Can I Give Feedback About My MAC?"* Users shall be able to easily reach this information from the provider education website.

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

50.2.4 – Contents
(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

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:

---

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

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

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

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

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

5. Search engine functionality.

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

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

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

9. Information for providers on electronic claims submission.

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

11. An IVR system operating guide.

12. CMS products posted or linked, as directed.

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

14. *Relevant content from the* MLN Connects *newsletter* as mentioned in section 50.2.4.1 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 *50.2.4.5* of this chapter)

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

1. *CMS website*

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

3. *MLN*

4. Sites for downloading CMS *manuals* and *transmittals*

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

6. *CMS's HIPAA web page*

7. *CMS's central provider web page*

8. *CMS's ICD-10 web page*

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

10. *CMS's MREP Software information*

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

50.2.4.1 – *Emailing the MLN Connects Newsletter* to Providers

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

MACs shall *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 have discretion to include relevant MLN Connects newsletter content in their POE activities.

50.2.4.2 – Frequently Asked Questions (FAQs)

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

All MACs shall maintain regularly updated local FAQs on their provider education website. The FAQs are an important tool for the providers to use to get answers to their questions without contacting the PCC. The MACs' FAQs shall be updated for accuracy and relevance at least quarterly and the date an FAQ was last reviewed shall be noted on the provider education website. MACs shall develop local FAQs based upon their data analyses described in section 20.3 of this chapter. At a minimum, each MAC shall post FAQs based upon its jurisdiction's Top 10 telephone and Top 10 written provider inquiries, claims submission errors, and MR topics.

50.2.4.3 - Web-based Provider Educational Offerings
(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

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

50.2.4.4 – Provider Claims Payment Alerts
(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

MACs shall develop and regularly update a dedicated webpage that alerts providers of confirmed system-related claims processing issues that have been identified by CMS, the MAC or the Shared Systems Maintainer. The page shall provide information and educational announcements around claims processing issues that are currently active as well as provide an archive of resolved issues. At a minimum the page shall include the following information for each reported issue:

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

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

50.3.1 - Targeted Electronic Mailing Lists
(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

Targeted electronic mailing lists shall be used to send messages and information regarding the Medicare Program, policies, or procedures of relevance or interest to specific provider audiences. MACs shall use the list of provider types listed on the *Medicare PE application*

to determine applicable and appropriate audiences. MACs may combine provider types listed on the PE applications to create targeted electronic mailing lists.

50.3.2 – Electronic Mailing List Promotion

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

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

50.5 – *MAC Secure Internet Portals*

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

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 via TDLs.

50.5.1 – *MAC Secure Internet Portal Service Interruptions*

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

MACs shall report portal service interruptions to CMS as soon as they become aware of the issue. MACs shall email the *service reports mailbox* with the subject "Portal Interruption." The email shall describe the issue, the impact on service to providers and what is being done to resolve the issue. Updates shall continue to be sent daily until the issue is resolved.

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

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

60.1 - Provider Satisfaction Survey

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

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

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

MACs shall email the MCE mailbox with questions or technical issues about the MCE program.

60.1.1 – MAC Survey Participation Requirements

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

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

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

60.1.6 - Third-Party Contractor Platform System Users

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

Each MAC shall identify two staff who will serve as Administrators. These individuals will have the highest level of access in the Survey Contractor's online platform and will be responsible for overseeing staff access to the platform. This includes assigning user accounts, deactivating users who no longer need access and maintaining signed and dated

copies of the survey contractor's FedRAMP Rules of Behavior. MACs may maintain this document electronically or in hard copy and shall make it available to CMS upon request. Within five days of being assigned as a MAC 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 new signed agreements for new Administrators within five days of the change.

70.2.1 - Call Completion

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

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

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

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

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

70.2.3 – *Average Speed of Answer*

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

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

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

70.2.5 – QCM Performance Standards

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

MACs shall monitor a minimum of five telephone calls per telephone CSR per month per jurisdiction. Any deviation from this requirement shall be documented by the PCC. Documentation shall be maintained 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.

70.2.6 – QAM (Telephone) Performance Standard

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

The quality of telephone CSR responses to provider telephone calls shall be monitored throughout the contract year for each MAC jurisdiction using QAM (Telephone). The goal of QAM (Telephone) is to ensure the telephone CSRs provide accurate and complete information, in a courteous and professional manner, while ensuring that information is released to those authorized to receive it. As stated in section *30.4.11.2* of this chapter, QAM (Telephone) monitoring shall be conducted by the CMS independent monitoring contractor.

Each MAC jurisdiction shall achieve an average quality rate of at least 93% for the contract year.

The quality rate is determined by dividing the total number of QAM scorecards marked as "Passed" by the total number of QAM scorecards completed during the contract year. With respect to A/B MACs whose contracts include HH+H work, the CMS independent monitoring contractor shall generate separate scorecards and totals for A/B calls and for HH+H calls but these scorecards shall be combined to determine the total number of scorecards completed, the total number of scorecards passed, and the total number of scorecards failed for the jurisdiction.

70.3.1 - QWCM Performance Standards

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

MACs shall evaluate and enter into the QWCM application 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. Any deviation from this requirement shall be documented by the PCC. Documentation shall be maintained 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.

80 - PCSP Data Reporting

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

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

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

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

80.1.2 - Due Date for Data Submission to PIES

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

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

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

If a MAC did not report data timely, the MAC shall inform CMS of the data to be entered into PIES by submitting that information within 2 business days after it becomes available to the *PIES mailbox*.

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

80.1.3 - Data to be Reported Monthly in PIES

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

- Telephone inquiries data: MACs shall capture and report in PIES the data elements appropriate for their MAC profile (CSR- and IVR-only lines or a combined CSR/IVR line).

- Written inquiries data: MACs shall capture and report in PIES the data elements specified in the PIES database related to their general, PRRS, and Congressional written inquiries.

- *MAC Secure* Internet *Portal* data: MACs shall capture and report in PIES the data elements specified in the PIES database related to their *MAC Secure Internet Portal* services.

The list of data elements and their corresponding definitions are available in the PIES Database.

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

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

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)
- Pre-Approved PCC Closures – MACs shall report PCC closures that fall on CMS pre-approved days and any other planned PCC closure dates the reasons for the closures.

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

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

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

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

MACs shall report in PCID the data described below in sections *80.2.3.1 – 80.2.3.12* of this chapter on a monthly basis between the 1st and the 10th of each month for the previous month's data and, for certain data required by section *80.2.3.2* of this chapter, between the 1st and the 10th of the month for the upcoming month. After the 10th of the month, the data entry capability will no longer be available to the MACs. After the 10th of the month, any missing data will be considered late and will need to be entered into PCID by CMS staff. If a MAC did not report data timely, the MAC shall inform CMS of the data to be entered into PCID by submitting that information within 2 business days after it becomes available to the *PCID mailbox*.

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

80.2.3.2 – PCC Training Closure Information to be Reported in PCID

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

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

- Date, start and end times, and location of PCC training closures for the upcoming month if any such closures are planned. If no such closures are planned for the upcoming month, the MAC shall 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 Standardized Provider Inquiry Tracking Chart) that correspond to the CSR training that occurred in the previous month.

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

80.2.3.8 – *MAC Secure Internet Portal Service Interruptions to be Reported in PCID*

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

If *MAC Secure Internet Portal* service interruption occurred (for example, the portal was unexpectedly down or one or more portal functions were unexpectedly unavailable to portal

users), the MAC shall enter that interruption into PCID between the 1st and the 10th of the previous month's data, using the Telecommunications Service Interruptions data entry screen. No reporting is necessary for months in which there were no such interruptions. (See section 30 of this chapter, which requires MACs to report a Contractor Alert at the time of an unexpected portal downtime or the unexpected unavailability of a portal function(s) that creates an adverse effect on the PCC.)

The data to be entered in PCID to report *MAC Secure Internet Portal* service interruptions are as follows:

Date the *MAC Secure Internet Portal* service interruption occurred.
Time of day (local time) the *MAC Secure Internet Portal* service interruption occurred.
Date and time of day (local time) the *MAC Secure Internet Portal* issue was resolved.
HETS-related (check box)
Portal function(s) affected by the service interruption (for example, all functions, ability to submit claims, ability to submit an eligibility request and receive an eligibility response, etc.).
Impacted jurisdiction(s).
Source -- Internal or external problem.
Overview/Description -- A description of the problem.
Resolution -- How the service interruption was resolved.

80.2.3.9 – *MAC Secure Internet Portal Functionality to be Reported in PCID*

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

MACs shall enter *Secure Internet Portal* functionality in PCID on a monthly basis between the 1st and the 10th of each month for the previous month's data. MACs shall report 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.

Additional information is available in PCID documentation.

80.2.3.11 – Social Media Analytic Data to be Reported in PCID

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

MACs shall enter their social media data on a monthly basis between the 1st and the 10th of each month for the previous month's data. 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. MACs shall enter the following data to setup their social media channels in PCID:

- Channel – The type of social media channel: ex. Blog, Facebook, LinkedIn, Twitter, YouTube
- Name – The name of the channel: ex. JX Twitter
- URL – The URL of the social media channel

MACs shall report the following monthly social media data, by jurisdiction, into PCID:

- Number of Posts - The number of *new* posts
- Number of Comments to Posts - The number of comments received on posts
- Number of Followers - The number of followers to the social media channel
- Number of Likes - The number of likes to the social media channel
- Number of Shares/Retweets - The number of times posts were shared by followers
- Number of Mentions - The number of times the term or phrase you were tracking was used across social media

80.2.3.12 – Direct Mailing Information to be Reported in PCID

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

Contractors shall report the following information about Direct Mailings into the Special Initiatives portion of PCID between the 1st and 10th of the month, following the month of the actual completion date:

- Date completed
- Number of packages sent
- Number of providers covered by packages sent
- Number of packages returned
- Cost

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

MACs shall track and report undeliverable packages for two months after the packages are mailed.

80.2.3.13 – Inquiry Capability Reporting in PCID

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

MACs shall enter its inquiry capabilities in PCID's Inquiry Capability Module, between the 1st and the 10th of each month for the previous month. 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 –QCM

(Rev.11956; Issued 04-20-23; Effective: 05-22-23; Implementation: 05-22-23)

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

MACs shall complete scorecards and enter data into the QCM the 10th of each month. See section *30.4.13* of this chapter for additional information.