Medicare *Administrative* Contractor *(MAC)* Beneficiary and Provider Communications Manual

Chapter 6 - Provider Customer Service Program

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(Rev. 35, 10-07-16)

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Provider Customer Service Program

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

NOTES:

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

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

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

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

10 – Introduction to Provider Customer Service Program (PCSP)

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

CMS requires that all *Medicare Administrative Contractors (MACs)* have a Provider Customer Service Program (PCSP) to assist providers in understanding and complying with Medicare's operational processes, policies, new initiatives, and billing procedures. The PCSP serves to strengthen and enhance CMS's ongoing efforts associated with provider inquiries and education. The primary principle is to continuously improve Medicare provider satisfaction through the timely delivery of accurate and consistent information in a courteous and professional manner. These practices will enable providers to understand, manage, and bill the Medicare program correctly, with the goal being reductions in their Medicare paid claims error rate and in improper payments, both nationally and for individual *MACs*.

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

MACs shall report certain MAC contract and PCSP data to the Provider Customer Service Program Contractor Information Database (PCID). See section 70.2.2 of this chapter for PCID reporting and data certification requirements.

10.1 – PCSP Electronic Mailing Lists (Listservs)

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

1. Provider Customer Service Program User Group (PCUG) electronic mailing list - To receive important and timely information from CMS related to the PCSP, including Customer Service Representative (CSR) training materials and quality assurance program updates, *MACs* shall subscribe to the CMS PCUG electronic mailing list. To subscribe to this electronic mailing list, *MACs* shall send an e-mail to the Provider Services mailbox at providerservices@cms.hhs.gov. The e-mail shall include the names and e-mail addresses of the individuals who wish to subscribe to the electronic mailing list. At a minimum, the *MAC* POE manager, the *MAC* PCC managers, those managing PSS technology, and quality analysts shall subscribe to the electronic mailing list. Additional *MAC* staff may also subscribe. There is no limitation as to the number of subscribers for any *MAC*.

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

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

MACs shall ensure that staff who are subscribed to one or both of these electronic mailing lists who later depart or are terminated from MAC employment are unsubscribed to the appropriate electronic mailing list(s) before the time of departure or termination.

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

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

The PCUG conference call is held on a regularly scheduled basis with staff from CMS and the *MACs'* PCSP functions. 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 that staff from their PCC, POE, and PSS functions attend each monthly PCUG call. *MACs* may submit topics for consideration in agenda planning to the Provider Services mailbox

at providerservices@cms.hhs.gov. Further information about the PCUG can be found at http://www.cms.gov/Medicare/Medicare-Contracting/FFSProvCustSvcGen/index.html.

10.3 – PCSP *Blog Spot*

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

CMS established the PCSP *Blog Spot* in the Medicare Learning Network® (MLN) Learning Management System (LMS) to enable *MAC* staff to easily communicate with each other to share information and ideas about PCSP-related issues and concerns and to facilitate collaboration among *MACs*. *The* CMS does not provide guidance to *MACs* via the *PCSP Blog Spot*. *MAC* staff who are involved with the work of the PCSP may request access to the *PCSP Blog Spot* upon approval of their PCSP management staff. *MACs* can learn more about the *PCSP Blog Spot*, including the instructions for obtaining access to *it*, in the Provider Customer Service Program Contractor Information Database (PCID) documentation at *https://www.p-cid.com/*.

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

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

Since the PCSP is an integration of POE, PCC and PSS activities, *MACs* shall regularly review their operations for ways that these activities can be integrated and existing resources leveraged to provide a comprehensive PCSP to providers in their jurisdiction. *MACs* shall look at how POE activities can reduce the need for providers to call the PCC, how actions taken by Customer Service Representatives (CSRs) in the PCCs can incorporate education resources into a call or written response without adding significant time to the call length, and how the interactive voice response (IVR) system can be used to publicize the electronic mailing list or upcoming training, seminars, etc. Examples include providing upcoming education information to CSRs, so that if they receive a question on a particular topic for which provider training is scheduled or for which computer based-training is available, they can give the inquirer information about the training and/or instructions on how to sign up for it or access it. Another example is to have 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. *MACs* are also encouraged to give POE staff and PCC staff, including CSRs, avenues to provide feedback to each other with the goal of coming up with ways that assist both areas with accomplishing their respective tasks by working together. Such sessions could periodically be part of the regularly scheduled CSR training classes so that no additional time is taken from PCC operations.

MACs or even individual *MAC* staff may already be doing these types of activities. For example, individual CSRs may routinely guide an inquirer through the provider education website or suggest that a provider subscribe to the electronic mailing list. If so, *MACs* are encouraged to continue and increase these efforts. If these activities are not currently happening, then *MACs* shall implement these types of efforts.

20 – Provider Outreach and Education (POE)

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

The primary goal of the POE program is to reduce the Comprehensive Error Rate Testing (CERT) error rate by giving 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, medical review data, CERT data, and Recovery Auditor data.

In accordance with guidance from CMS, each MAC shall establish an improper payment outreach and education program that will expand and enhance efforts to reduce improper payments. In particular, MACs shall analyze data in accordance with sections 20.3, 20.3.1, 20.3.2, 20.3.4, and 20.3.5 of this chapter in developing this outreach and education program.

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

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

MACs shall utilize a variety of strategies and methods to offer Medicare providers a broad spectrum of information about the Medicare program through a variety of communication channels and mechanisms—including print, Internet, telephone, CD-ROM, educational messages on the general inquiries line and IVR, face-to-face instruction, web-based training, and presentations in classrooms and other settings. POE education may be delivered by clinical and non-clinical staff to groups or to individuals. The type and size of education delivered is at the discretion of the *MAC*, with the goal of effectively and efficiently using the POE funding to reduce the error rate, the number of provider inquiries, and the number of claims errors. *The* CMS encourages *MACs* to be innovative in their identification of provider educational priorities and the methods used to deliver this education, 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 that have been 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 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. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

MACs shall coordinate internally with staff in appropriate areas (including personnel responsible for medical review, provider enrollment, electronic data interchange (EDI)/systems, appeals, Medicare Secondary Payer (MSP), and program integrity) to ensure that issues identified by these other areas in the organization are communicated and shared with the POE staff. At a minimum, periodic meetings shall be held with these various components to discuss any provider issues and potential mechanisms to resolve them. Documentation of these meetings and activities shall be retained by the *MAC* and provided to CMS when requested.

Additionally, 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

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

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 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 that 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.

20.3 - Data Analysis - *Overall*

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

MACs shall analyze all available data, such as CERT error rates, *Recovery Auditor* data, telephone and written inquiries data, claims submission errors, *claims payment errors,* appeals data, *Customer Service Representative (CSR)* feedback, *medical review referral data,* website satisfaction survey data, and other survey data, as well as feedback from across the *MAC*, as they develop their education methodology.

The data listed in this section shall not be construed as an all-inclusive list. *MACs* shall use their discretion to determine if their PCSP would benefit from analysis of data not mentioned in this section.

20.3.1 - *Analysis of Improper Payments Data*

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

To reduce improper payments, MACs shall analyze the following data as provided by the Recovery Auditors in reports in the Recovery Audit Contractor (RAC) Data Warehouse (see Pub. 100-06, Medicare Financial Management Manual, Chapter 4, section 10.2(C)): (a) the providers in the MAC's jurisdiction having the highest rate of improper payments; (b) the providers in the MAC's jurisdiction having the greatest total dollar amounts of improper payments; (c) the items and services that have the highest rates of improper payments in the MAC's jurisdiction; (d) the items and services furnished that are responsible for the greatest dollar amount of improper payments in the MAC's jurisdiction; and (e) other data CMS determines would assist in carrying out the program.

20.3.2 - *Analysis of Error Rate Reduction Data*

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

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.

MACs shall give priority to outreach and education activities as noted in section 20 of this chapter.

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 that their CERT educational activities focus on using existing Medicare Learning Network products or content whenever practicable. MACs shall avail themselves of the CERT materials available from CMS and suggest to CMS topics for MLN products or content. (See section 20.4 of this chapter.)

20.3.3 - *Analysis of Provider Inquiries*

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

For provider inquiry analysis, MACs shall maintain a systematic and reproducible provider inquiry analysis program that will produce a monthly list of the most frequently asked questions (FAQs) beyond claims status and eligibility for telephone inquiries and written inquiries. MACs shall utilize information or instructions furnished by CMS to classify or categorize provider inquiries. Educational efforts shall be developed and implemented to address the needs of providers as identified by this program. MACs shall also use the results of their inquiry analysis program to develop and deliver training to their PCC staff.

20.3.4 – *Analysis of Claims Submission Errors*

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

Data analysis is an essential first step in determining whether patterns of claims submission and payment indicate educational needs. MACs shall maintain a provider data analysis program that will produce a monthly list of the most frequent collective claims submission errors from all providers in their jurisdiction, to include those that are clearly due to common and inadvertent clerical or administrative errors and other types of errors that could be prevented through activities under the improper payment outreach and education program. Claims submission errors are those that result in rejected, denied, or incorrectly paid claims. This information shall be used to develop and modify the provider education contained in MAC POE plans. Such data analysis may include identification of aberrancies in billing patterns within a homogeneous group, or much more sophisticated detection of patterns within claims or groups of claims. Data analysis itself may be undertaken as part of general surveillance and review of submitted claims, or may be conducted in response to information about specific problems stemming from complaints, provider input, alerts, or reports from CMS and/or other MACs.

20.3.5 – Analysis of Errors Regarding Medicare Policies

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

MACs shall conduct an analysis of improper payment errors that are due to clear misapplication or misinterpretation of Medicare policies.

20.3.6 – Analysis of Medical Review Referrals

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

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 medical review. As part of this process, POE staff shall maintain information about referrals from medical review, requests for education from providers, follow-up communication with medical review, and disposition of problems referred from medical review, including type of education given. (See section 20.4.5.2 of this chapter.)

20.4 - Provider Education

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

To the extent practicable, *MACs* shall use CMS-provided national educational materials *(that is, Medicare Learning Network (MLN) products or content and the MLN Connects Provider eNews)* in their provider outreach and education activities.

MACs shall subscribe to the MLN products electronic mailing list. To subscribe, go to http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MLNProducts_listserv.pdf.

The MLN is a registered trademark of CMS and is the brand name for official CMS provider educational products, outreach activities, and information resources designed to promote national consistency of Medicare provider information. The MLN includes MLN educational products, MLN Connects National Provider Calls, and the *MLN Connects Provider eNews*. Examples of MLN products include fact sheets, web-based training courses, tools, CD-ROMs, *videos,* and MLN Matters Articles. MLN Connects National Provider Calls are announced in the weekly *MLN Connects Provider eNews* and *MACs* shall encourage provider participation in these calls. These MLN products and content shall be used to deliver a planned and coordinated provider education program to provide educational opportunities that accommodate health care professionals' busy schedules with the least amount of disruption to their normal business functioning. *MACs* shall use MLN products or content for all educational topics and for specialty groups of providers including, but not limited to, 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 MLN products or content (where practicable), MLN electronic mailing list links, and instructions for subscribing to the MLN electronic mailing lists on their provider education website. (See http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html.) *MACs* shall actively market and promote the benefits of MLN products and services and the MLN electronic mailing list.

The MLN Button shall be required on all provider education websites, displayed where providers would look for educational resources. To access the MLN Button and for further information on the MLN Button, see the detail page at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Multimedia-Items/MLN_Web_Button.html. (See section 50.2 of this chapter for additional provider education website requirements.)

A link to the CMS Continuing Education (CMSCE) webpage (https://www.cms.gov/Outreach-and-Education/Learn/Earn-Credit/Earn-Credit-page.html) shall be required on all provider education websites, displayed where providers would look for education and training resources. This webpage contains information on ways that providers may earn continuing education credit.

MACs shall send messages that market the MLN through various distribution methods including, but not limited to, their provider education website, and shall have an MLN ad in all bulletins and publications.

MACs shall train their CSRs and correspondents at least once in the contract year on the MLN website and how to access and use MLN products or content, *MLN Connects Provider eNews* and MLN Connects National Provider Calls.

If *MACs* identify a gap or lack of information about specific topics, they shall suggest to CMS topics for MLN Matters Articles or other products that would be useful in provider education. Suggestions should be sent to the MLN mailbox MLN@cms.hhs.gov.

MACs shall report POE events and self-paced provider education in PCID in accordance with section 70.2.3.3 of this chapter.

20.4.1 - Provider Bulletins/Newsletters

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

Unless otherwise established with CMS, *MACs* shall electronically distribute regular provider bulletins/newsletters, at least quarterly, that contain Medicare program and billing information. Providers without Internet access (if known by the *MAC*) shall receive paper provider bulletins/newsletters via U.S. Postal Service. *MACs* shall suggest to these providers ways that they can receive bulletins/newsletters electronically. When feasible and cost-effective, *MACs* shall send regular bulletins/newsletters only to active providers. Active providers are those *whose enrollment records in the Provider Enrollment, Chain and Ownership System (PECOS) are "active." MACs* shall post on their provider education website newly created bulletins/newsletters and educational materials. (See section 50.2 of this chapter.)

MACs shall provide within the introductory table of contents, summary, compilation, or listing of articles/information, an indicator (*for example,* word(s), icon, or symbol) that denotes whether the article/information is of interest to a specific provider audience(s) or is of general interest. *MACs* shall disregard this requirement if the introductory table of contents, summary, compilation, or listing of article/information is structured by specialty or provider interest groupings.

MACs shall encourage providers to obtain electronic copies of bulletins/newsletters and other notices through their provider education websites. 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 should be "fair and reasonable" and based on the cost of producing and mailing the publication.

20.4.2 – Direct Mailings for the PCSP

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

At the request of CMS, *MACs* shall print and distribute hardcopy mailings related to the PCSP (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 related to a direct mailing. A direct mailing may not be sent to the address of billing agencies or clearinghouses used by providers. If a direct mailing is urgent in nature, CMS will so indicate in the associated CR and *MACs* shall expedite the request in accordance with instructions from CMS. *The* CMS anticipates no more than two direct mailings related to the PCSP per calendar year.

20.4.3 - Training for New Medicare Providers

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

MACs shall offer training that is tailored to the needs of new Medicare providers and billing staff. Medicare Learning Network products or content shall be used to the extent practicable. (See section 20.4 of this chapter.) This training shall deal with 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. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

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. Medicare Learning Network products or content shall be used to the extent practicable. (See section 20.4 of this chapter.) This training may involve interactive communication such as occurs in face-to-face trainings and in certain web-based tutorials or instruction. *MACs* shall not be required to identify or validate providers meeting the definition of small provider.

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

20.4.5 – Educational Topics

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

MACs shall use their discretion in determining the educational topics most relevant to their provider population. Various sources of information, including provider feedback, policy and

procedure changes, and *MAC* data analysis should be used to determine these topics; however, at a minimum, *MACs* shall educate providers on the topics outlined in this section. Medicare Learning Network products or content shall be used to the extent practicable. (See section 20.4 of this chapter.)

20.4.5.1 – Local Coverage Determinations (LCDs)

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

MACs shall educate their provider community on new or significantly revised final LCDs. *MACs* shall include pertinent information about the LCDs on their provider education website and as part of regular bulletin distributions, including articles drafted by the medical review personnel.

Clinical questions about the LCDs, such as the rationale behind coverage of certain items or services versus other similar ones, shall be directed to medical review personnel who will respond in accordance with Pub. 100-08, Medicare Program Integrity Manual, Chapter 13, section 13.9.

20.4.5.2 - Education Resulting from Medical Review Referrals

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

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

Probe Review Referrals: When medical review staff performs a probe review, the provider is notified about the review. The notification letter may include an offer for provider education to address the issues found in the probe. If education is requested by a provider in response to one of these letters, POE staff shall be responsible for providing this education. The education can be of any type the *MAC* deems appropriate, including one-on-one training, referral of the provider to available web training, and upcoming workshops containing information on the topic. The *MAC* shall ensure that POE staff has ready access to copies of the probe notification letters should a provider contact POE staff to request education.

Priority Referrals: A priority referral results when medical review staff believes that education is important for a provider or small group of providers in order to prevent further errors and reduce fraud. POE staff should collaborate with medical review *staff* when evaluating these referrals to determine what type of education, if any, is appropriate and whether this education fits with the overall *MAC* strategy to reduce the error rate.

The *MAC* is under no obligation to provide specific education in response to all medical review referrals. The education provided as a result of medical review shall be determined in the context of the *MAC*'s goal of reducing the error rate within the resources available. The type of education and the involvement of clinical staff are at the discretion of the *MACs*. *MACs* shall not charge for this education. (See section 20.8.1 of this chapter.)

POE staff shall ensure that they provide timely feedback to medical review *staff* about the disposition of the referral, including whether a provider requested education in response to a probe letter. POE staff shall work with medical review staff to develop an effective system of communication that, at a minimum, maintains information about referrals from medical review *staff*, requests for education from providers, follow-up communication with medical review *staff*, and disposition of problems referred from medical review *staff*, including type of education given.

20.4.5.3 - Medicare Preventive Service Benefits

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

MACs shall promote to their provider community the use of preventive services and other benefits provided by the Medicare program to beneficiaries. *Information can be found at https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/.*

20.4.5.4 - Electronic Claims Submissions

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

MACs shall conduct training for providers or their staff in electronic claims submissions. The *MACs* shall conduct training activities for providers to educate them on, and expand their use of, Medicare billing software and the EDI transactions supported by Medicare.

20.4.5.5 - Remittance Advice (RA)

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

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, once a claim has been received and processed. An adjustment refers to any change that relates to how a claim is paid differently from the original billing. Adjustments can include a denied claim, zero payment, partial payment, reduced payment, penalty applied, additional payment and supplemental payment. Two important non-medical code sets are used to communicate an adjustment, or why a claim (or service line) was paid differently than the provider billed. These code sets are Claim Adjustment Reason Codes and Remittance Advice Remark Codes. Descriptions for both of these code sets appear at: http://www.wpc-edi.com/products/codelists/alertservice.

Where a specific instruction has not been given by CMS to use specific Claim Adjustment Reason Codes and Remittance Advice 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 system staff shall work together to identify Claim Adjustment Reason Codes and Remittance Advice Remark Codes to help communicate an adjustment and reduce provider inquiries.

MACs shall also promote the use of the free Medicare Remit Easy Print (MREP) software to obtain Electronic Remittance Advice (ERA). (See http://www.cms.gov/Research-Statistics-

Data-and-Systems/CMS-Information-Technology/AccesstoDataApplication/MedicareRemitEasyPrint.html.) The benefits of using MREP software include saving time and money by printing remittance information directly on the day the HIPAA 835 is available without waiting for the mail, the ability to create and print special reports, and the ability to create document(s) that can be included with claim submissions to secondary/tertiary payers. The ERA is the preferred method for claims payment communication. Standard paper remittance (SPR) advices are not sent to providers if they have been receiving ERAs for 45 days or more. 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/or provider electronic mailing list(s).

If a provider elects to receive the SPR, *MACs* shall use the SPR provider messaging properties, when available, of this notice 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. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

MACs shall ensure that all provider outreach and education materials are written in a manner that is clear, concise, and accurate. Medicare Learning Network products or content shall be used to the extent practicable. (See section 20.4 of this chapter.) POE materials produced by the *MAC* shall bear the month and year they were produced or re-issued. These materials shall be made available, whenever practicable, in both electronic and print formats, and be disseminated in a way that is timely, efficient, and cost-effective. *MACs* shall ensure that documents are section 508 compliant as required.

All materials developed by *MACs* using CMS funding as the principal source for their development are considered 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*, that other *MAC* shall be acknowledged either within the material, or on its cover, case or container.

20.6 - Regular Meetings

(Rev**. 26, Issued: 08-07-09, Effective: 09-01-09, Implementation: 09-08-09)**

20.6.1 – POE Advisory Groups (POE AGs)

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

Each *MAC* shall establish and maintain a POE Advisory Group (POE AG). The primary function of the POE AG is to assist the *MAC* in the creation, implementation, and review of 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 means of information dissemination to all appropriate providers and their staff,

including the use of the PCC to disseminate information to providers. The POE AG shall be used as a provider education consultant resource and not as an approval or sanctioning authority.

The POE AG shall generally convene quarterly but, at a minimum, shall meet three times per year. *MACs* may hold POE AG meetings in-person or via teleconferencing. Teleconferencing or other technological methods shall be available for POE AG members who cannot be physically present for an in-person POE AG meeting.

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

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

A *MAC* shall consider having more than one POE AG when the breadth of its geographic service area, or range of the providers serviced, diminishes the practicality and effectiveness of having a single POE AG. Each *MAC* shall have at least one separate group for each of its contracts (*that is,* at least one POE AG for each *MAC jurisdiction*). In addition, *a MAC* shall not share a POE AG with another *MAC*.

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

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

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

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

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

"Ask-the-Contractor" Teleconferences (ACTs) provide a means for providers to ask their *MAC* specific questions concerning billing and Medicare policies or procedures. ACTs also provide a method of sharing information and function as a tool for *MACs* to listen to their provider community.

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

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

20.7 - POE Reporting

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

MACs shall report POE activities in PCID in accordance with section 70.2.3.3 of this chapter.

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

Additional reporting may be required. (See section 20.7.*3* of this chapter.)

20.7.1 - Provider Service Plan (PSP)

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

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

Each *MAC* shall send the PSP electronically in MS Word *to the Provider Services mailbox at providerservices@cms.hhs.gov, and to the appropriate CMS Deliverables mailbox, according to the following schedule: If the contract award date was between the 1st and the 14th of a month, the PSP shall be due by close of business the last day of the month that followed the month of the contract award. If the contract award date was between the 15th and the last day of a month, the PSP shall be due by close of business the last day of the second month that followed the month of the contract award. 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 adhere to the PSP template/format and instructions located on the CMS website at *https://www.cms.gov/Medicare/Medicare-Contracting/FFSProvCustSvcGen/Downloads/PSP-Template-2015.pdf*. *MACs* shall ensure that they are utilizing the most recent version of the PSP template/format. *MACs* shall be notified of updated templates via the CMS PCUG electronic mailing list described in section10.1 of this chapter.

20.7.2 – Provider Customer Service Program Activity Report (PAR)

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

Each *MAC* shall prepare a semi-annual Provider Customer Service Program Activity Report (PAR). The PAR summarizes and recounts the *MAC*'s provider education and training activities during the previous time period. These activities include efforts to reduce the error rate, training events, Internet or website 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 that was contained in the PSP. HH+H MACs shall prepare separate PARs for their corresponding HH+H work. *MACs* are not required to attach to their PARs a listing of POE events because that information shall be reported to PCID in accordance with section 70.2.3.3 of this chapter.

The first PAR *is* due to CMS on the 30th calendar day after the first 6 months of the contract year. *For newly awarded MAC contracts, the first PAR is due on* the 30th calendar day *that follows the first 6 months after the contract award date. The first PAR shall contain information about PCSP activities in months 1-6 of the contract year. If the 30th calendar day* falls on a weekend or holiday, the report *is* due at close of business on the next business day. The second report, covering months 7-12 of the contract year, is due *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.* All PARs shall be sent electronically in MS Word to the Provider Services mailbox at providerservices@cms.hhs.gov and to the appropriate CMS Deliverables mailbox.

MACs shall adhere to the PAR template/format and instructions located on the CMS website at *https://www.cms.gov/Medicare/Medicare-Contracting/FFSProvCustSvcGen/Downloads/PAR-Template-2015.pdf*. *MACs* shall ensure that they are utilizing the most recent version of the PAR template/format. *MACs* shall be notified of updated templates via the CMS PCUG electronic mailing list described in section 10.1 of this chapter.

20.7.3 – *Additional Reporting*

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

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

Because the dates for the CERT sampling period and contract year do not always align, the MACs shall maintain or improve the overall CERT error rate of the outgoing MAC as stated in the last Improper Payments report published during the outgoing MAC's final contract year.

MACs shall achieve an error rate equal to or lower than the current Government Performance Results Act (GPRA) goal. The goal for each year is published in the Report on Improper Medicare Fee-for-Service Payments. For MACs who exceed this goal, CMS reserves the right to require additional reporting related to the way those MACs use outreach and education to achieve a reduction. MACs whose error rate is equal to or greater than 25 percent higher than the current GPRA goal may be required to provide quarterly updates to CMS on their efforts to use education to reduce their error rate. MACs whose error rate is equal to or greater than 50 percent higher than the current GPRA goal may be required to provide monthly updates to CMS on their efforts to use education to reduce their error rate. The need for quarterly and monthly updates will be re-evaluated after a CERT report is published. The CMS will notify MACs if additional reporting is required.

20.8 - Charging Fees to Providers for Medicare Education and Training

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

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

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

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

20.8.1 – No Charge

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

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 medical review 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. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

If fees are charged, they shall be "fair and reasonable." "Fair and reasonable" means that 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.

Fees that may be collected are intended only to cover the costs of certain POE materials and activities and may not be used to supplement *MAC* activities in other functional areas.

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

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

MACs may charge a fair and reasonable fee for duplication, shipping, and handling of materials available on their provider education website (including duplication in paper or in other formats, such as CD-ROM) that they send directly to providers.

20.8.2.2 – Fees for Education and Training Activities

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

MACs may charge fair and reasonable fees for education and training activities when those fees will be used to offset or recover the costs associated with the following: travel, facility rental and set-up (see section 20.8.3 of this chapter for additional information), equipment rental and set-up, and development and reproduction of materials expressly developed for, and disseminated at, an education or training activity.

Fees collected in keeping with the above guidance are intended only to cover the costs of these POE activities and may not be used to supplement *MAC* activities in other functional areas.

20.8.2.3 – Fees for Videotapes or Recordings of Education and Training Activities

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

Entities not employed by CMS or not under contractual arrangement with CMS are not permitted to videotape or otherwise record education and training activities for profit-making purposes. If a *MAC* records an education or training activity, then the *MAC* may charge a fair and reasonable fee for the duplication and mailing of the videotapes or other recordings to providers upon request.

20.8.3 – Prohibitions

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

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

the education or training activity. *MACs* shall not advertise the availability of light food or refreshments.

MACs shall not invite CMS employees to participate in or attend education and training activities unless the SOW specifically permits such participation or attendance.

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

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

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

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

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

20.8.5 – Excess Revenues from Provider Participant Fees

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

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 second 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 at servicereports@cms.hhs.gov 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.

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

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

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

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

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

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

20.8.7 – Considerations and Recordkeeping for Fee Collection

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

For each contract year, *MACs* shall keep records of the actual costs incurred for each education or training activity held. Where applicable, these records shall contain information on the actual costs related to the following: travel, facility rental and set-up, equipment rental and set-up, and development and reproduction of materials expressly developed for, and disseminated at, an education or training activity. In addition, *MACs* shall keep records of all fees charged to, and collected from, provider registrants. These records shall be kept for at least 1 year from the date of the education or training activity and shall document actual costs used to support the fees charged.

30 - Provider Contact Center (PCC)

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

The 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 that 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 (letters, e-mail, and fax) 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 *30.2.2* and 50 of this chapter *and in chapter 2 of this manual*, CMS is not requiring 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. To ensure that inquiries receive accurate and timely handling, *MACs* shall ensure, at a minimum, that 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).

MACs shall identify the following four points of contact for each PCC: a primary and an alternative contact for provider telephone inquiries and a primary and an alternative contact for provider written inquiries. MACs shall enter each contact's name, business telephone number, and business e-mail address in PCID. *See section 70.2.2 of this chapter for PCID reporting and data certification requirements.*

MACs shall also submit a high-level organizational chart for *their PCC* provider inquiry function to the Service Reports mailbox at servicereports@cms.hhs.gov. *The chart shall be due 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.*

It is important that CMS be aware of changes or events that have negative effects on *MACs*' PCCs, as 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. The CMS detects the changes in the performance statistics but may be unaware of the reason(s) for those changes, with the exception of reported telecommunications issues, until later—possibly even months later. To ensure that CMS has immediate knowledge of factors that impact the performance of the PCCs, *MACs* shall send an e-mail to the *Service Reports mailbox at servicereports@cms.hhs.gov* with the subject "Contractor Alert" as soon as they become aware of a change or event with the capability to adversely affect PCC performance. The e-mail 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

- *Unexpected increase in call volume and/or written correspondence due to, but not limited to, the following: implementation of a Change Request and/or other Medicare policy change, release of a new and/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)

The reporting of Contractor Alerts does not eliminate the requirements to report (1) problems that impact the ability to provide telephone service to the providers (section 30.2.4 of this chapter), (2) a call completion rate on the CSR-only, IVR-only, or IVR/CSR combined line(s) that is less than the applicable quarterly standard for the previous business day (section 60.2.2 of this chapter), (3) an average speed of answer (ASA) on the PCC line(s) that is higher than the applicable quarterly standard for the previous business day (section 60.2.4 of this chapter), (4) monthly reports to PCID of telecommunications service interruptions (section 70.2.3.7 of this chapter), or (5) monthly reports to PCID of unexpected portal service interruptions (section 70.2.3.8 of this chapter).

30.1 – Inquiry Triage Process

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

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

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

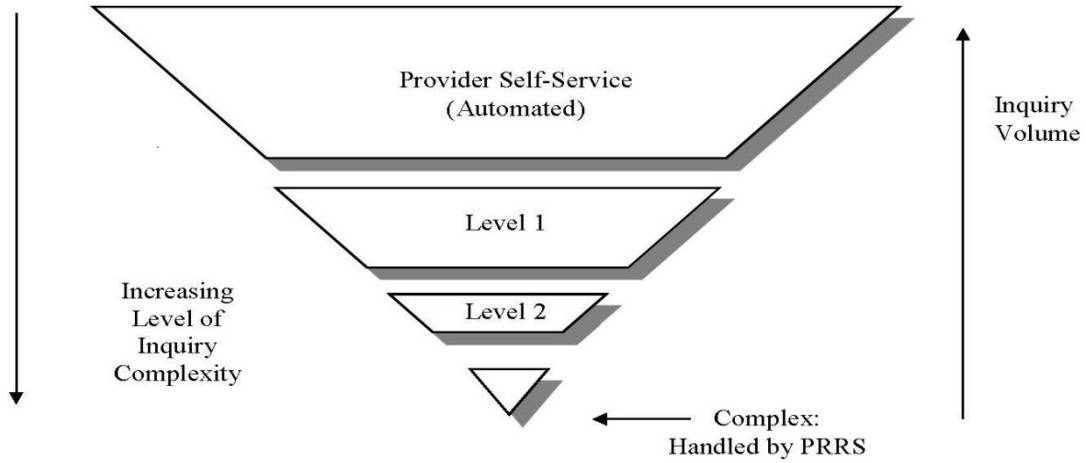
First-level CSRs shall answer a wide range of basic questions that cannot be answered by the IVR *system* or other interactive self-service technology. At a minimum, these CSRs shall handle questions that do not require substantial research and can easily be answered during the initial call; however,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

In the event that a first-level CSR cannot answer an inquiry, the first-level CSR shall have the authority to refer more complex questions to second-level CSRs.

Second-level CSRs shall have more experience and expertise, enabling them to answer more complex questions, including telephone inquiries requiring a higher level of research. *MACs* may organize these CSRs in any configuration that best suits the nature of the inquiries received. They may serve as consultant subject matter experts for first-level CSRs and, therefore, do not always have to speak directly to a provider. These CSRs may be used to answer first-level CSR questions, if the workload demands, and may also handle callbacks. The most complex questions shall be referred to the PRRS, discussed in section 30.5 of this chapter.

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

Figure 1



30.1.1 - Responding to Coding Questions

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

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 that have responsibility 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

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

Services (CPT-IS). This Internet-based service is a benefit to AMA members and is available as a subscription fee-based service for non-members and non-physicians. The AMA also offers CPT Assistant. Information about these resources is found at http://www.ama-assn.org/.

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

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

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

30.2 - Provider Telephone Inquiries

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

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

30.2.1 - *Provider* Inquiries Line*(s)*

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

A *MAC*'s PCC is held accountable to meeting standards and requirements, including those related to call handling and quality. *When multiple queues come into* a *MAC*'s PCC (*for example*, A/B, HH+H, *DME,* appeals, EDI, provider enrollment), the statistics for each queue are rolled up into a single set of data that determines whether or not the PCC met the standards and requirements. A queue that fails to meet the call handling and quality standards could cause the PCC as a whole to fail to meet those standards. *Each MAC is* given the flexibility to configure the PCC in the most effective way to meet the standards and requirements of its SOW. *A MAC* may have a single toll-free number through which providers are routed to the appropriate area, multiple toll-free numbers bringing callers directly to each area, or a combination of the two. *MACs* shall report all applicable data (*for example*, quality call monitoring, telephone inquiry tracking, and telephone inquiry reporting) for each queue.

At a minimum, the *provider toll-free* line*(s)* shall be used to handle questions related to billing, claims, eligibility, payment*, appeals, EDI, and provider enrollment (the latter is not applicable*

to DME MACs). If *MACs* need new service *to handle additional* Medicare applications, they shall follow the established process for adding additional toll-free numbers. *The* CMS will consider all requests for additional toll-free numbers.

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

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

30.2.2 - Teletypewriter (TTY) Lines

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

In accordance with Section 508 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 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 applicable to complex beneficiary inquiries.*)*

30.2.3 - Inbound Calls

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

CMS will pay for the rental of inbound T-1/PRI lines and all connect time charges for toll-free provider services. The costs associated with the installation and monthly fees for these services will be paid by CMS and shall not be considered by *MACs* in their budget requests. However, *MACs* shall remain responsible for all other internal telecommunications costs and devices, such as agent consoles, handsets, internal wiring and equipment (Automatic Call Distributor (ACD), IVR, Private Branch Exchange (PBX), etc.), and any local or outbound telephone services and line charges. Since these costs are not specifically identified in any cost reports, *MACs* shall maintain records for all costs associated with providing telephone service to providers (*for example*, costs for headsets) and shall provide this information upon request by CMS.

30.2.4 – Troubleshooting *PCC Service Interruptions*

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

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

1. Send an e-mail to the Service Reports mailbox at servicereports@cms.hhs.gov with a copy to the *Provider Network Services (*PNS*)* contractor to notify CMS of a service interruption. The e-mail 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. Eastern Time the next business day if the interruption began *after business hours the night before or before business hours that day. The e-mail shall summarize the problem and the steps taken to restore full service.*

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

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

2. The *MAC* shall send at least one daily follow-up e-mail to the Service Reports mailbox *at servicereports@cms.hhs.gov* by 3:00 p.m. Eastern Time providing a status until the problem has been resolved.

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

    - *I*nternal 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.

        - 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.

        - Use the toll-free carrier's online system to review documentation and track trouble tickets.

    - *Some other issue (e.g., data are unable to be retrieved from a back-end system, such as CWF).*

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

See section 70.2.*3.7* of this chapter for the *monthly* PCID reporting requirements related to telecommunications service interruptions.

30.2.5 - Requesting Changes to Telephone Configurations

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

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. All change requests associated with the toll-free network (*for example*, adding or removing channels or T1s, office moves, routing changes) shall be processed through the PNS contractor. 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. The CMS reserves the right to initiate changes based on this information.

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

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

30.2.6 - Hours of Operation

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

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 defined as 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 to 8:30 a.m. – 4:30 p.m. for all time zones. *MACs* adopting these alternate hours shall notify CMS by sending an e-mail to the Service Reports mailbox at servicereports@cms.hhs.gov within 30 calendar days of the start of the contract year, or 1 month in advance of the anticipated change within a contract year.

30.2.7 - PCC Closures

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

MACs shall report to CMS planned and unplanned closures of the PCC as *follows:*

30.2.7.1 - Pre-Approved PCC Closures

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

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

- New Year's Day
- Birthday of Martin Luther King, Jr.
- Washington's Birthday
- Good Friday
- Memorial Day
- Independence Day
- Labor Day
- Columbus Day
- Veteran's 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 70.2.2 of this chapter for the PCID reporting requirements.

30.2.7.2 – Planned PCC Closures that are not Pre-Approved *PCC* Closures

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

MACs shall request permission to close the PCC on days other than those *referenced in section 30.2.7.1 of this chapter* by reporting *these other* planned *PCC* closures in PCID *on a monthly basis*. *MACs shall consider these PCC closures to be approved unless they hear otherwise from CMS within 5 business days after the PCID reporting deadline.*

See section 70.2.3.2 of this chapter for the monthly PCID reporting requirements.

30.2.7.3 – Emergency PCC Closures

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

There may be occasions when a *MAC finds it necessary to close the* PCC if circumstances create sufficiently adverse working conditions at the PCC (examples include lack of heat, air conditioning, or water). *MACs* shall report *emergency* PCC closures to the Service Reports

mailbox at servicerports@cms.hhs.gov within 1 hour of the decision to close the PCC if the decision *to close* was made during normal business hours*, or by 9:00 a.m. Eastern Time the next business day if the decision was made after business hours the night before or before business hours that day. The e-mail shall explain the reason for the emergency PCC closure and, if known at the time, indicate when the PCC will reopen.*

See section 70.2.3.6 of this chapter for the monthly PCID reporting requirements.

30.2.8 - Providing Busy Signals

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

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

30.2.9 - Queue Message

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

MACs shall provide a recorded message that provides the following information while *providers* are waiting in queue to speak to an available 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 CSR.
- Educational information on issues identified by the *MAC*. (See section 20 of this chapter).

30.2.10 – PCC Staffing

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

PCC staffing, including permanent and temporary staff, shall be based on the pattern of incoming calls per hour and day of the week, ensuring that 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 has been experiencing high call volumes and/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.

30.2.10.1 – CSR Equipment Requirements

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

To ensure that inquiries receive accurate and timely handling, *MACs* shall provide each CSR with the following:

- Online access to a computer terminal for each CSR who requires online access to answer providers' questions (the computer terminal shall be physically located so that the CSR can research data without leaving his or her desk/seat).
- Access to the *MAC*'s provider education website.
- Access to CMS's website.
- An outgoing line for callbacks.

30.2.10.2 – CSR Sign-in Policy

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

MACs shall establish and follow a standard CSR sign-in policy in order for CMS to ensure that data collected for telephone performance measurement are consistent from *MAC* to *MAC*. The sign-in policy shall include the following:

- The CSRs available to answer telephone inquiries shall sign in to the telephone system to begin data collection.
- The 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 that 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).
- The CSRs shall sign off the telephone system at the end of their workday.

30.2.10.3 - CSR Identification to Callers

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

The CSRs shall identify themselves when answering call*s*. In order to provide a unique identity for each CSR for accountability purposes *and to protect the privacy of a CSR if an inquiring provider asks the CSR for his/her name,* PCC management *may* permit *each* 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.

30.2.11 - Monitoring CSR Calls

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

CMS has three monitoring programs to ensure quality *responses* to *calls from* provider*s*: (1) *quality call* monitoring, (2) quality assurance monitoring, and (3) remote monitoring. Monitoring the accuracy, completeness, adherence to the Privacy Act, and professionalism of CSR-handled calls will lead 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 CSRs. *MACs* shall document the actions, to include corrective action plans, as applicable, that they take to improve CSR-handled calls if CMS monitoring, or their own monitoring, indicates that improvements are recommended or required. Such information shall be provided to CMS upon request.

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

30.2.11.1 – *Quality Call Monitoring (QCM)*

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

See section 30.2.13 of this chapter for the guidelines and requirements of quality call monitoring.

30.2.11.2 – Quality Assurance Monitoring (QAM)

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

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

The CMS has established a Provider Contact Center Quality Monitoring Portal (PQM) at https://portal.pccqualitymonitoring.com/. The PQM Portal is accessed by CMS and MAC staffs to review QAM Scores, Issues, Rebuttals, and Reports.

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

The Annual MAC QAM Attestation document shall:

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

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

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

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

In addition to submitting the Annual MAC QAM Attestation document, each MAC shall assist CMS in QAM by:

- *Sending an e-mail to the CMS QAM mailbox at QAM@cms.hhs.gov, subject: "QAM Environment Planned Change" if 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, and/or upgrades to its QAM environment. The e-mail shall be sent no later than the last business day of the month prior to the month in which the planned change(s) is scheduled to occur. The e-mail shall describe the change(s) and the scheduled implementation date(s). MACs shall attach to the e-mail a completed CMS QAM Environment Change Control Form that describes the upcoming change(s) to help ensure that 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 on the PQM Portal. Prior to implementing any planned change, the MACs shall have conducted all necessary testing of the QAM environment to ensure proper and continuous operations of QAM.*

- *Sending an e-mail to the CMS QAM mailbox at QAM@cms.hhs.gov, subject: "QAM Environment – No Planned Changes" if the MAC does not plan to make any changes to its QAM environment in the upcoming month. The e-mail shall be sent no later than the last business day of the month prior to the month in which no planned changes are scheduled.*

- *Sending an e-mail to the CMS QAM mailbox at QAM@cms.hhs.gov, subject: "QAM Environment – Adverse Event" if the MAC experiences an unexpected event that adversely affects, or has the potential to adversely affect, QAM. The e-mail 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 the adverse effect. The e-mail shall be sent within 1 hour after the adverse event was detected if it was detected during normal business hours, or by 9:00 a.m. Eastern Time 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 CMS QAM mailbox at QAM@cms.hhs.gov providing a status until the adverse effect has been eliminated.*

- *Sending an e-mail to the CMS QAM mailbox at QAM@cms.hhs.gov, subject: "QAM Environment – Emergency Change" within 2 business days after the MAC determines that an emergency situation exists and the MAC must take immediate action that will have an effect (adverse or otherwise) on the QAM environment.*

- *Recording* audio and video for at least 30 percent of incoming CSR-handled calls 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).*

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

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

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

- *Retaining* audio and video recordings for all calls that were scored for QAM during a contract year for a period of 150 calendar days past the contract year end date. MACs shall identify calls that are scored for QAM by utilizing the MAC Call Reference Detail Report, which is posted on a monthly basis to the PQM Portal.

30.2.11.3 – Remote Monitoring

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

MACs shall *maintain remote monitoring instructions, access codes, and CSR IDs that would enable CMS monitoring personnel to* monitor live provider calls in their entirety by specific workstation (CSR), next call from the network or next call from the CSR queue, and/or specific business line. *MACs shall make this information available to CMS by furnishing it to their PCSP Business Function Lead upon request from CMS. In addition, and upon request from CMS, MACs shall* provide CMS with remote access to their incoming provider toll-free line*(s)*. The CMS will take reasonable measures to ensure the security of this access (*for example*, passwords will be controlled by one person.)

30.2.12 – *Disaster Recovery Plan*

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

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 that *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 P*lan shall cover, at a minimum, all items outlined in the *Disaster Recovery* Plan Checklist located at *https://www.cms.gov/Medicare/Medicare-Contracting/FFSProvCustSvcGen/Downloads/Contingency_Plan_Checklist.pdf*. The *Disaster Recovery P*lan shall also contain a Compliance Matrix that identifies where each item in the checklist can be found in the *MAC*'s *Disaster Recovery P*lan. The *Disaster Recovery P*lan 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 P*lan *electronically in MS Word* to the Service Reports mailbox at servicereports@cms.hhs.gov *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.*

Instead of developing a stand-alone telecommunications Disaster Recovery Plan, MACs may choose to submit the telecommunications *portion of their overall MAC contingency plan that*

was developed in accordance with the requirements found in Pub. 100-17, Centers for Medicare & Medicaid Services (CMS) Business Partners Systems Security Manual.

30.2.13 - Guidelines for High Quality Responses to *Provider* Telephone Inquiries

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

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

30.2.13.1 – Telephone Response Quality Monitoring Program

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

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).*

As *MACs* are ultimately responsible for their responses to provider inquiries, *MACs* shall use the results of their quality program to identify and act upon areas of needed improvement, both for the PCC as a whole and for individual PCC staff. *MACs* shall document their monitoring efforts and corrective action plans as applicable and provide such information to CMS upon request.

30.2.13.2 – Telephone Responses *to Provider Inquiries* -- Quality Call Monitoring (QCM) Program Minimum Requirements

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

A *MAC*'s monitoring program shall, at a minimum, follow the requirements and performance standards as set forth in the Quality Call Monitoring (QCM) program. *MACs* shall monitor and report data for all calls that are handled by the PCC. (See section 30.2.13.1 of this chapter.) Copies of the official QCM scorecard, User Guide, Handbook, and Scoring Chart can be obtained through the QCM database website at https://www.qcmscores.com/. 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 that:

1. All CSRs 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 shall monitor five calls per CSR per month per jurisdiction.

3. Calls monitored are from providers and are of the type that the CSR's level typically handles (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. CSR trainees and new CSRs are adequately monitored. However, scores for 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 CSRs.

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

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

12. The QCM Handbook *and User Guide are* followed.

30.2.13.3 – Recording Calls

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

MACs may record calls as part of their contract with CMS to ensure the quality of telephone inquiries. If a *MAC* chooses to record calls, it 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 CSR may inform the provider that the *MAC* records calls for the sole purpose of quality assurance and training and the recording system cannot be stopped by an individual CSR. If the provider still objects and does not want to continue with the recorded call, the CSR may inform the provider that the provider may send the inquiry in writing. The *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 that are no longer used in a manner that would prohibit someone from obtaining any personally identifiable information (PII) and/or protected health information (PHI) from the recordings.

30.2.13.4 – QCM Calibration

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

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.

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. *The 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 sessions, which shall include attendance lists. These records shall be provided to CMS upon request.

30.3 – Provider Written Inquiries

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

MACs typically handle the following three types of *provider* written inquiries:

1. General--General *provider* written inquiries are those that are *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 60.3.2.1 of this chapter.

2. PRRS--PRRS *provider written* inquiries are *those that are handled within the PCC* that require extra research and cannot be handled by the general inquiries staff. *(*PRRS inquiries also include all beneficiary inquiries that are referred to the *MAC* from the Beneficiary Contact Center (BCC). *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 60.3.2.2 of this chapter.

3. Congressional--Congressional *provider written* inquiries are those that 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 60.3.2.4 of this chapter.

All *provider* written inquiries, including letters, faxes, and e-mails, shall be handled consistently for accuracy, professionalism and timeliness. Every *provider written* inquiry shall receive a final response that accurately and completely addresses the *issue(s) contained* in the incoming inquiry. For *provider* written inquiries received that could be handled by the IVR *system*, such as claim status and eligibility *inquiries*, it is strongly suggested that *MACs* include language in the responses to those inquiries that the information being requested is available on the IVR *system*. (See section 50.1 of this chapter.) 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.

In cases where a *MAC is easily able to determine that a provider has sent a* duplicate *written* inquiry *to the MAC, the MAC may* verify, by telephone or letter, that the provider received a response *to the initial inquiry. If the MAC uses a letter to obtain verification that the provider received a response to the initial inquiry, the MAC counts that letter as an interim response. After verification that the provider received a response to the initial inquiry, the MAC shall close the duplicate inquiry and exclude it from workload reporting. If the provider did not receive a response to the initial inquiry, the MAC shall prepare a response to the duplicate inquiry and include it in workload reporting. If the MAC does not receive a response from the provider within 14 business days after attempting to verify the receipt of a response to the initial inquiry, the MAC shall prepare a response to the duplicate inquiry and include it in workload reporting.*

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 30.3.4 of this chapter regarding specific requirements for e-mail and fax responses to provider inquiries.

30.3.1 - Controlling *Provider* Written Inquiries

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

MACs shall control all *provider* written inquiries until they are closed by the written *inquiry* unit. *Provider written inquiries are closed by the written inquiry unit (1) upon release of the final response, (2) upon transfer of the inquiry to another department within the MAC, or (3) upon rerouting of the inquiry to the appropriate external entity.*

The *MAC* shall stamp the cover page of all *provider* written inquiries including letters, e-mails and faxes, and the top page of all attachments with the date of receipt in the corporate mailroom. E-mails and faxes that contain system-generated date stamps are not required to receive an additional corporate date stamp; however, e-mails and faxes received after the close of *a MAC*'s normal business day shall be date-stamped the next business day. For provider inquiry timeliness purposes, the date of receipt shall be counted as day one.

MACs shall not be required to keep the incoming envelope. However, if it is a *MAC*'s normal operating procedure to keep envelopes with the incoming correspondence, the envelope, incoming *correspondence*, and the top page of all attachments shall be date-stamped in the corporate mailroom.

The corporate mailroom shall forward provider written inquiries, with the exception of misrouted provider written inquiries, to the PCC's written inquiry unit where they will be controlled.

The following definitions and handling instructions shall be applied to provider written inquiries that are transferred or misrouted:

- *A transferred inquiry is a correspondence received in the written inquiry unit that should be handled by another department within the MAC. The written inquiry unit shall transfer it to the proper department within the MAC, which closes the inquiry in the written inquiry unit. The written inquiry unit shall report transferred inquiries in PIES. Transferred inquiries are reported in PCID/Inquiry Tracking using the appropriate Category or Subcategory.*

- *A misrouted inquiry is a correspondence received either in the corporate mailroom or in the written inquiry unit that was not intended for the MAC. The corporate mailroom or the written inquiry unit shall reroute it to the proper external entity which, if the inquiry had been received by the written inquiry unit, closes the inquiry in the written inquiry unit. The written inquiry unit shall report misrouted inquiries in PIES and in PCID/Inquiry Tracking. In rerouting a misrouted inquiry, MACs shall use one of the options below:*

    1. *Contact the provider and inform the provider that the correspondence was misrouted and is being rerouted to the appropriate external entity; inform the provider of the name and mailing address of the appropriate external entity (for the provider's possible future use); and reroute the correspondence to the appropriate external entity.*

    2. *Contact the provider and inform the provider that the correspondence was misrouted and is being returned to the provider; inform the provider of the name and mailing address of the appropriate external entity (so that the provider can send it to the appropriate external entity); and return the correspondence to the provider.*

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

30.3.2 - *Provider* Written Inquiry Storage

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

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

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

See section 70.2.2 of this chapter for the PCID reporting and data certification requirements.

30.3.3 - Telephone Responses to *Provider* Written Inquiries

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

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

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

- Provider name.
- Provider telephone number.
- Provider number *(National Provider Identifier [NPI] or Provider Transaction Access Number [PTAN]).*
- Date of contact.
- Internal inquiry control number.
- Subject/nature of inquiry.
- Summary of discussion.
- Status: closed, pending research, open.
- Follow-up action required (if any).
- Name of the correspondent who handled the inquiry.

If the *provider* requests a copy of the report of contact, *the MAC shall send* a response letter containing all the information in the "Summary of Discussion" section of the report of contact. *MACs* may send the information via e-mail or fax, if requested by the provider*; if* the *e-mail or fax* response *would* contain any *protected or sensitive information, such as* PII or PHI, *MACs*

shall follow the requirements of section 30.3.4 of this chapter. It is not acceptable to send the report of contact itself. All timeliness and quality guidelines for a written response apply to the response sent.

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

30.3.4 - E-mail and Fax Responses to *Provider* Written Inquiries

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

In some cases, *provider* written inquiries can be responded to by e-mail or fax. Since both represent official correspondence with the public, it is paramount that *MACs* use sound e-mail and fax practices and proper etiquette when communicating electronically. *MACs* shall ensure that e-mail and fax responses follow the same timeliness and quality guidelines that pertain to all *provider* written inquiries. *MACs shall transmit e-mail and fax responses that contain protected or sensitive information in accordance with the CMS Acceptable Risk Safeguard controls and/or 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.*

E-mail content, as well as attachments to e-mails, must be section 508 compliant. (See *https://www.cms.gov/About-CMS/Agency-Information/Aboutwebsite/Policiesforaccessibility.html* for information about section 508 compliancy.)

30.3.5 - Check Off Letters

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

Check-off letters are appropriate for *responding to* routine *provider written* inquiries like claim status or eligibility *inquiries*. 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.

30.3.6 - Guidelines for High Quality Responses to *Provider* Written Inquiries

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

MACs shall ensure that the responses sent to *provider* written inquiries are accurate, complete, responsive, clearly written, and presented in a professional manner.

Written responses *to provider inquiries* shall adhere to the basics of the Plain Writing Act of 2010, to the extent practicable. The Plain Writing Act of 2010 requires all federal agencies and, by extension, their contractors to use plain writing in any document that (1) is necessary to obtain a federal benefit or service, (2) gives information about a federal benefit or service, and/or (3) explains how to comply with federal requirements. *MACs* shall refer to the document entitled, "Toolkit for Making Written Material Clear and Effective" for assistance in meeting the requirements of the Plain Writing Act of 2010. The Toolkit is a health literary resource from

CMS that consists of 11 parts. It is available at http://www.cms.gov/Outreach-and-Education/Outreach/WrittenMaterialsToolkit/index.html.

In addition, *MACs* shall use the CMS Writing Guide to assist in the preparation of written responses *to provider inquiries*. The Writing Guide can be found on the QWCM website at https://www.qwcmscores.com/Docs/WritingGuideFINAL.pdf.

Because the Toolkit and the CMS Writing Guide cannot possibly address every issue encountered in responding to *provider* written inquiries, *MACs* may also use other resources (*for example*, grammar guides) to supplement their writing process.

30.3.7 – Stock Language/Form Letters

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

Periodically, CMS may request that *MACs* submit their most frequently used stock language and/or form letters that they send to providers. CMS will review the stock language and/or form letters and provide suggestions on how the language they contain can be improved. If CMS determines that the *stock language and/or* form letters contain accuracy errors or other errors that affect the readability and/or meaning of the response, *MACs* shall have 60 business days from receipt of the information from CMS to make any necessary changes. Please refer to the Toolkit and the CMS Writing Guide described in section 30.3.6 of this chapter for additional guidance.

30.3.8 - *Provider* Written Response Quality Monitoring Program

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

MACs shall have a monitoring program in place to ensure the quality of written responses to provider inquiries. The monitoring program applies to *MACs*' written responses to *all provider inquiries (*general, Congressional, and PRRS*)*. The standards shall not apply to those *responses to provider* written inquiries handled by other *departments* within the *MAC*.

As *MACs* are ultimately responsible for their responses to provider inquiries, *MACs* shall use the results of their quality program to identify, and act upon, areas of needed improvement, both for the PCC as a whole and for individual PCC staff. *MACs* shall document their monitoring efforts and corrective action plans, as applicable, and provide such information to CMS upon request.

30.3.8.1 – Written Responses *to Provider Inquiries* -- Quality Written Correspondence Monitoring (QWCM) Program Minimum Requirements

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

The *MAC*'s *written response quality* monitoring program shall, at a minimum, follow the requirements and performance standards as set forth in the Quality Written Correspondence Monitoring (QWCM) program. Copies of the official QWCM scorecards, Scoring Charts, Handbook, and User Guide can be obtained through the QWCM database website at https://www.qwcmscores.com/. A detailed description of each evaluation criterion can be found on the official QWCM Scoring Charts and Handbook. In addition, a *MAC*'s provider written inquiries monitoring program shall ensure that:

1. All correspondents responding to *provider* general, *provider* PRRS or *provider* Congressional written inquiries are monitored throughout the month. This includes written responses prepared by temporary employees and part-time employees.

2. *Each PCC shall monitor five written responses per correspondent per month per jurisdiction.*

3. Responses monitored are those prepared for providers and of the type that the correspondent typically handles (general, PRRS, Congressional.)

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 QWCM scorecards and Scoring Charts and recorded in the QWCM database.

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

7. Correspondent trainees and new correspondents are adequately monitored. However, scores for correspondent trainees will be excluded from QWCM 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 correspondents.

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

11. All *correspondents, reviewers, and supervisors have copies of the official QWCM scorecards, Scoring Charts, Handbook, and Writing Guide.*

12. The QWCM Handbook *and User Guide are* followed.

30.3.8.2 – QWCM Calibration

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

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

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

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

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

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

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

30.3.9 - Replying to Correspondence from Members of Congress

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

In addition to the guidelines outlined above, *MACs* shall follow the following instructions when preparing replies to correspondence from Members of Congress:

A – Sending the Response

Generally, the *MAC* sends the original and the courtesy copy of the reply to the Washington, *D.C.* office of the Member of Congress. However, if it is clear that the inquiry was sent from a home office, the *MAC* directs the original and the courtesy copy there.

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

When replying to a letter signed by more than one Member of Congress, the *MAC* prepares a reply for each Member and encloses a courtesy copy with each. The *MAC* releases the replies to each Member of Congress at the same time.

The *MAC* states in the opening paragraph that the same reply is being sent to each person who signed the letter and makes an official file copy for each Member of Congress. The *MAC* may use the following in its final reply:

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

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

The *MAC* addresses replies to the Members of Congress even when the inquiries are signed by staff members.

D - Replying Directly to a Constituent at the Request of a Member of Congress
When addressing a reply to a constituent, the *MAC* sends a courtesy letterhead copy to the Member of Congress, along with a copy of the constituent's letter.

E - Replying to an Inquiry from Former Members of Congress
Unless the former Member of Congress requests otherwise, the *MAC* addresses the reply to the constituent. The *MAC* shall send a courtesy copy to the former Member of Congress.

F – Addressing the response

The Honorable (full name)	or	The Honorable (full name)
United States Senate		House of Representatives
Washington, D.C. 20510		Washington, D.C. 205l5
Dear Senator (surname):		Dear Mr./Mrs./Miss/Ms./Dr. (surname):

When replying to a home office, address the letter:

The Honorable (full name)	The Honorable (full name)
United States Senator	Member, United States House of
(local address)	Representatives
Dear Senator (surname):	(local address)
	Dear Mr./Mrs./Miss/Ms./Dr. (surname):

See the CMS Writing Guide for additional forms of address and salutations.

G - Courtesy Copies
The *MAC* prepares a courtesy copy for each congressional response if the congressional office has indicated by telephone or letter that it wants one. Document the file if the Member of Congress indicates that he/she does not need a copy.

H - Constituent's Letter
Members of Congress frequently forward the constituent's letter for assistance in replying. The *MAC* should return the constituent's letter, if it is an original, with the first written response. When the constituent's letter is the only enclosure, on the courtesy copy and all other copies of the reply (but NOT ON ORIGINAL), the *MAC shall* type:

Enclosure:
Constituent's inquiry

When an enclosure in addition to the constituent's letter is forwarded to the Member of Congress:

- On the original only, at the left margin two lines below the signer's title, the *MAC shall* type: Enclosure

- On the copies, beginning at the same place (at the left margin), the *MAC shall* type: Enclosures 2: Including constituent's inquiry

30.4 - *Provider* Walk-In Inquiries

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

In the rare circumstance that a provider comes on site to the *MAC* to make an inquiry, the *MAC* shall address the provider's concern(s) and shall count and report the contact as a *provider* written inquiry. The *MAC* shall maintain a log or record of walk-in inquiries. The log, at a minimum, shall include the following:

- Name of *provider*.
- Date and time of arrival.
- Time service was provided.
- Name of the person handling the inquiry.
- A statement indicating *the resolution of the inquiry and the date resolved.*

30.4.1 – Guidelines for *Provider* Walk-In Service

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

The *MAC* shall use the following guidelines when providing high quality walk-in service:

- The *provider* shall be given the opportunity to meet with a service representative.
- Waiting room accommodations shall provide seating.
- Inquiries shall be handled completely during the initial interview to the extent possible.
- Current Medicare publications shall be available to the provider (upon request).
- *MACs* shall maintain a log or record of *provider* walk-in inquiries handled during the year.

30.5 - Provider Relations Research Specialists (PRRS)

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

MACs shall maintain PRRS as a joint effort between the PCC and POE units in order 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 and/or require significant research. Therefore, *MACs* shall design and staff the PRRS component so that questions beyond the expertise of the CSRs or general written inquiry staff 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 that 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 the BCC.*)*

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

30.5.1 - Complex Provider Inquiries

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

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

The PRRS shall include at least one certified coder to ensure adequate coding expertise although that staff does not have to be assigned exclusively to the PRRS. DME MACs are exempt from the requirement to have a coding expert since the PDAC Contractor resolves DME coding questions. The coding questions appropriately answered by the PRRS are those concerning the underlying Medicare payment or coverage policy. Pure coding questions (not related to a Medicare payment or coverage policy) shall be answered with referrals to the correct organizations such as the American Medical Association and the American Hospital Association's Coding Clinic. For more information, see section 30.1.1 of this chapter.

30.5.2 - Complex Beneficiary Inquiries

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

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

30.6 - *Provider* Inquiry Tracking

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

The CMS requires *MACs* to track and report the nature of their inquiry types (reason for the inquiry) for telephone and written inquiries using the categories and subcategories listed according to the definitions provided in the CMS Standardized Provider Inquiry Chart. The chart is found at *https://www.cms.gov/Medicare/Medicare-Contracting/ContractorLearningResources/Downloads/Standardized_Provider_Inquiry_Chart.pdf* and in PCID documentation at *https://www.p-cid.com/*. Inquiry tracking and reporting is

applicable to all PCC call center locations (if a *MAC* has multiple call center locations), all PCC triage levels, and all provider calls handled by the PCC, in accordance with a *MAC*'s SOW.

A. Inquiry Tracking and Reporting System

MACs shall maintain a tracking and reporting system for all provider inquiries that identifies at a minimum:

- The type of inquiry (telephone, letter, e-mail, fax, walk-in).
- The person responsible for answering the provider inquiry (by name or other unique identifier).
- Nature of the inquiry (according to the categories and subcategories in the CMS Standardized Provider Inquiry Chart).
- The disposition of the inquiry, including referral to other PCSP areas or areas elsewhere at the *MAC* (*for example*, medical review, MSP) and including in the referral information about how to contact the provider in case there is a need to clarify the question.
- The timeliness of the response.

B. Use of Inquiry Tracking Data

Inquiry tracking data provide indicators that reflect the information needs of Medicare providers. Uses of inquiry tracking data include, but are not limited to:

1. Generation of monthly reports for CMS's use. However, CMS encourages *MACs* to review inquiry tracking data as often as possible to prevent inquiry volume from rising, to identify patterns of providers' inquiries for specific information, and to monitor provider inquiry trends.
2. Identification of areas for broader provider education.
3. Identification of areas for broader CSR education.
4. Analysis of the number and types of inquiries in order to generate FAQs to be posted on the *MACs*' provider education websites.
5. Identification of areas or processes within the *MAC*'s organization that may need follow-up.

C. Tracking and Logging of Provider Inquiries

MACs shall meet these additional requirements when tracking or logging their inquiry types:

1. Inquiries reported to CMS shall use categories and subcategories in the CMS Standardized Provider Inquiry Chart. However, *MACs* may use contractor-specific subcategories to capture an additional level of detail, if necessary, to assist in identification of provider education or CSR and correspondent training needs. (See section 70.2.3.1.C of this chapter.)

2. Categories and subcategories in the CMS Standardized Provider Inquiry Chart are to be used to capture the reason for the inquiry, not the status, the disposition, or the action taken.

3. For all provider general telephone and *provider* written inquiries, *MACs* shall track multiple issues raised by a provider during a single call or in a single written inquiry.

4. *MACs* shall not create a subcategory "Other" under any of the existing categories in the CMS Standardized Provider Inquiry Chart. Instead, inquiries that do not fall under any of the existing predefined subcategories shall be reported under the "Not Classified" field for the appropriate category as reflected in PCID (see section 70.2.3.1.B of this chapter) with the exception of the "Other Issues" subcategory under the "General Information" category.

5. The "Other Issues" subcategory under the "General Information" category shall be exclusively used for inquiries that are general in nature and do not fall under any other category or subcategory in the CMS Standardized Provider Inquiry Chart or any contractor-specific subcategory.

MACs shall report the number of telephone and written inquiries logged for each category and subcategory monthly. These data shall be entered in PCID within 10 calendar days after the end of each month for the previous month's data. (See section 70.2.3.1.A of this chapter.)

D. Contractor-Specific Subcategories

MACs shall adhere to the following requirements when adding contractor-specific subcategories to the Monthly Contractor Inquiry Tracking Report:

1. *MACs* shall avoid the reporting of contractor-specific subcategories when the CMS Standardized Provider Inquiry Chart provides 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."

2. *MACs* shall assign a specific descriptive name to a contractor-specific subcategory reported to CMS. The use of "Subcategory 1" or "Subcategory 2" as names is not acceptable.

3. *MACs* shall create contractor-specific subcategories for issues that are significant to their operations and represent a significant amount of inquiries related to a topic.

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.

30.6.1 - Updates to the CMS Standardized Provider Inquiry Chart

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

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

- A definition of the inquiry type to be added.
- Examples of questions where the inquiry type could be used.
- Information about the number of inquiries associated with it.

The chart will be updated as needed. CMS will define categories to be tracked under the "Temporary Issues" category" and the reporting period for those subcategories in the "Temporary Issues" category through separate instructions. Between updates, *MACs* may create and add contractor-specific temporary subcategories if their call volume requires them to do so.

30.7 - Fraud and Abuse

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

MACs shall ensure that when a provider inquiry or complaint of potential fraud and abuse is received, it is immediately sent, along with a referral package, to the Program Safeguard Contractor (PSC) or Zone Program Integrity Contractor (ZPIC). The referral package shall consist of the following information:

1. Provider name and address.
2. Type of provider involved in the allegation and the perpetrator, if an employee of a provider.
3. Type of service involved in the allegation.
4. Relationship to the provider (*for example*, employee or another provider).
5. Place of service.
6. Nature of the allegation(s).

7. Timeframe of the allegation(s).
8. Date of service, procedure code(s).
9. Name and telephone number of the *MAC* employee who received the complaint.
10. Beneficiary name who received the service, if known.
11. Health Insurance Claim (HIC) number of the beneficiary receiving the service, if known.
12. Date the referral is forwarded to the PSC or ZPIC.

30.8 - Surveys

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

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

MACs shall assist CMS in performing surveys, such as the provider satisfaction survey and the provider education website satisfaction survey, which are described below.

30.8.1 – Provider Satisfaction Survey

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

The Medicare Modernization Act requires CMS to measure provider satisfaction with the performance of *MACs*. *MACs* shall assist CMS in its efforts to implement this requirement. The MAC Satisfaction Indicator (MSI) is a tool CMS uses to measure this satisfaction and *MACs* shall assist CMS in developing and implementing current and future provider satisfaction surveys.

In accordance with CMS instructions, *MACs* shall:

1. *Disseminate jurisdiction-specific, unique survey URLs to their provider community by*:

    a. *Posting the custom survey URLs at the top-center of their provider education website home page so that they will be highly visible.*

    b. *Displaying the custom survey URLs on their provider Internet-based portal and, if applicable, social media channels.*

    c. *Including the custom survey URLs in all MSI survey messaging during the survey administration, as directed by CMS through a TDL.*

2. Perform ongoing marketing and outreach for the MSI *survey*. *MACs* shall support CMS in communicating information about the MSI *survey* to providers by:

a. Disseminating information about the *MSI* survey on electronic mailing lists (listservs), newsletters, bulletins, and other provider communications channels*, as appropriate.*

b. Posting information about the MSI *survey* on provider education websites, provider Internet-*based* portals, social media channels, and IVR messaging, and including links to the MSI web page (www.cms.gov/Medicare/Medicare-Contracting/MSI).

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

d. Posting information about improvements made within the past year of operations in response to MSI *survey* feedback and reports including, but not limited to, areas where changes were implemented.

3. Appoint a maximum of three MSI *survey* points of contact for each jurisdiction. These people will serve as liaisons on MSI *survey* activities between CMS and the *MAC*. Following the administration of the MSI *survey*, these contacts will also have access to a secure website with their *MAC's MSI* survey results.

a. *MACs* shall submit the name, business address, business telephone number, and business e-mail address of these contacts to MSI@cms.hhs.gov no later than January 31 of each year.

b. *MACs* shall inform CMS of any changes to the MSI *survey* liaison(s) by sending an e-mail to MSI@cms.hhs.gov within 2 business days of the change.

4. Participate in conference calls, focus group evaluations, and in-depth interviews that will provide feedback about *MAC*-provider interaction, the MSI *survey*, and any other related MSI *survey* activities that will enhance CMS's ability to measure provider satisfaction with *MACs*. Arrangements for conference calls will be made in advance by CMS.

5. *Ensure that its employees and its contractors do not take the MAC's own survey or the survey for any other MAC.*

30.8.2 – Telephone Satisfaction Survey

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

In the past, CMS had established call center telephone satisfaction surveys at several *MACs*' PCCs. These surveys evaluated provider satisfaction with CSRs and/or IVR *systems*. The American Customer Satisfaction Index methodology was used to measure nationally benchmarked indicators for satisfaction, future behavior, and customer impact. The CMS used the survey results to identify opportunities to improve customer service.

The CMS has discontinued the *call center* telephone satisfaction surveys. *If* CMS *should* decide to reinstitute these surveys, *CMS would notify MACs* in advance and *MACs* would be required to participate in *the surveys* in accordance with instructions from CMS that would be issued at that time.

30.8.3 – Provider Education Website Satisfaction Survey

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

Medicare providers and their staffs are increasingly using *MACs*' provider education websites *and Internet-based provider portals* to obtain information for their business and professional needs. As such, it is important to gauge the effectiveness of the provider education websites. The Medicare website satisfaction survey provides a tool to determine *satisfaction with the provider education website (to include provider portals)* because it is based on actual usage and produces measures that are understandable, consistent, reliable, and nationally benchmarked.

ForeSee, a corporate web-satisfaction management company, is responsible for administering the website satisfaction surveys; collecting, analyzing and housing the data; and reporting results in understandable and useful terms and metrics. The initial website satisfaction score is calculated after 300 completed survey responses are collected. After that, website satisfaction scores and their impacts are generated on a daily basis but always encompass 300 responses.

At the request of CMS, *MACs* shall participate in the website satisfaction surveys. Participation includes, but is not limited to:

- Meeting with CMS and ForeSee to implement and manage the website satisfaction survey and analyze the results;
- Developing *MAC*-specific questions for the website satisfaction survey;
- Adding code supplied by ForeSee to the *MAC*'s provider education website and initiating action to add it to functioning web portal pages;
- Reviewing survey results on a regular basis; and
- Improving the *MAC*'s provider education website based on website satisfaction survey results.

Each MAC shall send a written communication to its employees and to its contractors stating that its employees and those of its contractors shall not take the MAC's own website satisfaction survey or the website satisfaction survey of any other MAC. Upon request from CMS, each MAC shall furnish documentation of those written communications.

40 - PCSP Staff Development and Education

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

MACs shall be fully responsible for the education, development, evaluation, and management of PCSP staff. This shall be accomplished by *MACs* providing initial and ongoing education and training of all PCSP staff. In addition, *MACs* shall have an education and development plan in place and documented for each staff member that addresses the education of new staff and the continued education and development of existing staff. Education and reference materials and tools, as well as policy manuals, shall be made readily available and accessible to all staff. *MACs* shall ensure that educational opportunities are afforded to all PCSP staff, and that staff are afforded promotion pathways through the design and implementation of the PCC and POE functions.

40.1 - POE Staff Training

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

MACs shall implement a plan for training new POE personnel and periodically assess the training needs of existing POE staff. The plan, which shall be written and available to the POE staff, shall include schedules, course or instruction vehicle descriptions, and satisfaction criteria. Training materials such as workbooks, manuals, and policy guidelines shall always be readily available to the POE staff.

40.2 - PCC Staff Development and Training

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

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

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

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

CMS will also continue to increase and improve the consistent national training information available to CSRs and correspondents. *Within 5 business days after* receipt of CMS-developed standardized training materials *or other CMS-developed information for use by CSRs and correspondents, MACs* shall *initiate processes to* implement these materials for all CSRs and

correspondents on duty and *to ensure that these materials will be implemented for* those hired in the future. Since the development of these materials will be done by CMS, there will not be any costs to the *MACs* to use these materials. Standardized training materials and other training information will be posted at *https://www.cms.gov/Medicare/Medicare-Contracting/FFSProvCustSvcGen/Contractor-Resources.html*. *MACs* may supplement the standard materials with their own materials as long as there is no contradiction of policy or procedures.

40.2.1 - Required Training *for PCC Staff*

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

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

1. *MACs* shall train their CSRs, correspondents, *and PRRS* on how to find, navigate and use their provider education website (including the *MAC*'s FAQs, the schedule of upcoming outreach and education events, and all available online education) and other self-service tools, to include the IVR *system* and the provider Internet-based portal.

2. *MACs* shall train their CSRs, correspondents, *and PRRS* on how to find, navigate and use the CMS website. This includes the CMS FAQs and all online education resources provided through the Medicare Learning Network at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html.

3. *MACs* shall train their CSRs, correspondents, *and PRRS* on how to find, navigate, and use the PCSP website http://www.cms/Medicare/Medicare-Contracting/FFSProvCustSvcGen/Index.html. This website strengthens *MACs*' PCSPs by providing support information and documents, performance data, and helpful resources.

4. *MACs* shall train their CSRs, correspondents, *and PRRS* on the Medicare Learning Network. (See section 20.4 of this chapter.)

5. *MACs* shall train *their* CSRs, correspondents, *and PRRS* on 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 located at http://www.cms.gov/Medicare/Medicare-Contracting/ContractorLearningResources/Downloads/Standardized_Provider_Inquiry_Chart.pdf and in PCID documentation at https://www.p-cid.com.

6. *MACs* shall train *their* CSRs, correspondents, *and PRRS* about the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act of 1996. Training about protecting beneficiary and provider identifiable information is provided by CMS and can

be found on the CMS website at http://www.cms.gov/Medicare/Medicare-Contracting/FFSProvCustSvcGen/Contractor-Resources.html.

7. *MACs shall train their CSRs, correspondents, and PRRS on 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 at https://www.cms.gov/Medicare/Medicare-Contracting/FFSProvCustSvcGen/Downloads/DDR-Guide-0113.pdf.*

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's 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 www.Medicare.gov website, the MAC's provider education website, regulations, laws, and other information tools to accurately and completely respond to complex provider inquiries. (PRRS also handle complex beneficiary inquiries. See chapter 2 of this manual for information about complex beneficiary inquiries.)

See section 70.2.3.2 of this chapter for the monthly PCID reporting requirements.

40.2.2 - PCC Training Program

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

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

Continuous training for *PCC staff, particularly for* CSRs and correspondents, is highly recommended. *MACs* should implement an approach that best fits their operation and performance. PCC training closures, as well as 8 hours of training each month, are not mandatory. If a *MAC* closes its PCC for training, the requirements in sections 40.2.*1* – 40.2.2.*5* of this chapter apply.

The *MACs* shall adhere to the following guidelines when closing *their PCC* for training on days other than *those listed in section 30.2.7.1 of this chapter*:

- The 8 hours per month shall be used for training only.
- The 8 hours per month shall not be used for corporate meetings.

- *MACs* shall assume approval of *PCC* closures *for training that they have reported to PCID* unless they receive notification to the contrary *from CMS within 5 business days after the PCID reporting deadline.*

- Training time not used within a specific month shall not be carried over to the next month.

- *See section 70.2.3.2 of this chapter for the monthly PCID reporting requirements.*

40.2.2.1 - *PCC Training* Closure Determination
(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

MACs shall perform an analysis to evaluate the appropriate time for *PCC* closure to anticipate the impact on their ability to meet all CMS performance requirements. *MACs* shall consult their POE AG about the best hours for *PCC* training closures and training topics. Training time closures shall not be the justification for poor performance.

40.2.2.2 - Provider Complaints *about PCC Training Time Closures*
(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

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

40.2.2.3 - Provider Notifications *of PCC Training Closures*
(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

MACs shall notify providers *of all of their PCC training closure times.* At a minimum, *MACs* shall post a *PCC* closure notification for providers on their IVR *system* and their provider education website. *MACs* with separate IVR and CSR *line*s shall post a *PCC* closure notification for providers on both lines. *In addition, note that MACs are required by section 50.1 of this chapter to include on their IVR system the hours of operation for CSR service. MACs* shall use their electronic mailing list(s) to notify their provider community of their *PCC training* closure times.

MACs shall notify providers of all *PCC* training closures or changes in their training *PCC training* closure schedule at least 2 weeks in advance of *every PCC* training *closure* date.

40.2.2.4 - *PCC Staff Feedback and MAC Evaluation of PCC Training*
(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

To assure that CSRs*,* correspondents*, and PRRS* are receiving the maximum benefit of the training program, *MACs* shall implement a process to evaluate the staff's progress on a monthly basis. Also, *MACs* shall implement a process to evaluate the staff's retention of training information on a periodic basis. *MACs* shall use pre-and post-training evaluation results and staff feedback to improve their training program.

40.2.2.5 - *PCC Training Documentation*
(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

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

50 - Provider Self-Service (PSS) Technology
(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

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

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

1. IVR s*ystem* for telephone inquiries.
2. A provider education website.
3. Internet-based provider educational offerings.
4. Electronic mailing lists.
5. Social media, if used (usage is at the discretion of the *MAC*).
6. Internet technology *(see* the "MAC Internet-based Provider Portal Handbook" *located at http://www.cms.gov/Medicare/Medicare-Contracting/FFSprovCustSvcGen/downloads/Portal-handbook.pdf).*

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

50.1 - Interactive Voice Response *(IVR)* System
(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

Although the provider shall have the ability to speak to a CSR during normal PCC operating hours, automated "self-help" tools, such as IVR *system*s, 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 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 the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule by authenticating *providers* as required by the Disclosure Desk Reference, which is referenced in section 80 of this chapter and is available at https://www.cms.gov/Medicare/Medicare-Contracting/FFSProvCustSvcGen/Downloads/DDR-Guide-0113.pdf.

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 the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule by authenticating *providers* as required by the Disclosure Desk Reference, which is referenced in section 80 of this chapter and is available at http://www.cms.gov/Medicare/Medicare-Contracting/FFSProvCustSvcGen/Downloads/DDR-Guide-0113.pdf.)

Providers shall be required to use *the* IVR *system* to access claim status and beneficiary eligibility information. CSRs shall refer providers back to the IVR *system* if they have questions about claims status or eligibility that can be handled by the IVR *system*. CSRs may provide claims status and/or eligibility information if it is clear that the provider cannot access the information through the IVR *system* because the IVR *system* is not functioning. IVR s*ystems* shall be updated 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 that providers use the Internet-based provider portal for claim status and eligibility inquiries if the portal has these functionalities.

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. 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 70.2.2 of this chapter for PCID reporting and data certification requirements.

50.2 - Provider Education Website

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

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

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

50.2.1 – General Requirements

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

The information contained on the *MAC*'s provider education website shall be structured in such a way that 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.*

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

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

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

See section 70.2.3.10 of this chapter for the monthly PCID provider education website analytic data reporting requirements.

50.2.2 – Webmaster and Attestation Requirements

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

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

See section 70.2.2 of this chapter for the PCID Webmaster identification reporting and data certification requirements.

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

50.2.3 – Feedback Mechanism

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

Each MAC shall develop and implement a feedback mechanism for users of its provider education website. Users shall be able to easily reach the feedback instrument from the provider education website. This mechanism shall ask provider education website users for their appraisals of the helpfulness and ease of use of the provider education website and the information contained on it, as well as their thoughts and suggestions for improvement or additions to the provider education website. Any *MAC* response provided that is directly related to feedback received related to the format of the provider education website shall not be counted and reported as part of the *MAC*'s provider inquiry workload.

Within its feedback mechanism, a *MAC* shall provide information about how providers can offer comments to CMS about the *MAC*'s performance in dealing with providers. Each *MAC* shall provide the e-mail address of the resource mailbox at the CMS regional office that has jurisdiction over the *MAC*. The resource mailbox address for each regional office, along with the MAC jurisdictions served by each regional office, is available under "Feedback Mechanism" found at http://www.cms.gov/Medicare/Medicare-Contracting/FFSProvCustSvcGen/Contractor-Resources.html.

50.2.4 – Contents

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

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

1. Provider bulletins or newsletters for the past 2 years.

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

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

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

4. A schedule of upcoming provider education and outreach activities (*for example*, seminars, workshops, fairs*)*.

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

6. Search engine functionality.

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

8. 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."

9. A tutorial explanation of how to use the provider education website that is 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.

10. Information for providers on electronic claims submission.

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

12. An IVR *system* operating guide.

13. CMS products, articles and messages posted, as directed.

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

15. The embedded link to the *MLN Connects Provider eNews* as mentioned in section 50.2.4.1 of this chapter.

16. MLN products or content, MLN electronic mailing list links and sign-up instructions, *the MLN Button, and the link to the CMSCE webpage,* as described in section 20.4 of this chapter.

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

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

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

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

3. *Links to the CMS social media pages (applicable only to MACs who do not use social media):*

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

4. The MLN at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html.

5. The sites for downloading CMS manuals and transmittals at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/index.html and http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/index.html.

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

7. The website that contains descriptions for Remittance Advice reason codes and remark codes at http://www.wpc-edi.com/reference/codelists/healthcare/remittance-advice-remark-codes/.

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

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

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

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

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

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

50.2.4.1 – Dissemination of Information from CMS to Providers

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

MACs shall receive *messages* from CMS, via *the MAC* electronic mailing list *described in section 10.1, item 2 of this chapter. The messages sent by CMS to the MACs via this electronic mailing list contain* information for providers and instructions *for the MACs* on *how, and sometimes when,* to disseminate the information to providers. (*The information in this* section is not applicable to MLN Matters Articles or Special Edition MLN Matters Articles that CMS sends to *the MACs through the MLN Matters electronic mailing list*.)

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

When distributing the MLN Connects Provider eNews to providers via their electronic mailing list(s), MACs shall use the same format/medium (that is, web link, .pdf file) that CMS used to distribute it to the MACs.

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

1. Timeliness *of Dissemination of Information to Providers*

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

    b. Information that is urgent or of a time-sensitive nature will be identified as such *in the instructions from* CMS. *Unless the urgent or time-sensitive information is identified by CMS as requiring "immediate release" or as requiring "specific*

date and time of day release" to providers, MACs shall distribute the urgent or time-sensitive information to providers via their electronic mailing list(s) and post relevant information from CMS on their provider education website by close of business the next business day after the date CMS sent the instructions and information to the *MACs. MACs shall include the information in their next regularly scheduled MAC bulletin or MAC newsletter if the information is current at the time the MAC bulletin or MAC newsletter is published. If the information is not current at that time, MACs have the discretion to include the information if they also include a statement in the MAC bulletin or MAC newsletter that informs the readers that the information had been included in the MLN Connects Provider eNews (weekly and/or Special Edition) dated [MACs shall insert the date] and that the information is being provided for informational purposes only because it had been time-sensitive information or it is no longer applicable and/or in effect.*

Urgent or time-sensitive information will be infrequent.

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

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

- *Urgent or time-sensitive information requiring "specific date and time of day release"*
  If CMS identifies the information for providers as urgent or time-sensitive and requiring "specific date and time of day release" to providers, MACs shall distribute that information to providers via their electronic mailing list(s) and post relevant information on their provider education website on the specified date and at the specified time. MACs shall include the information in their next regularly scheduled MAC bulletin or MAC newsletter if the information is current at the time the MAC bulletin or MAC newsletter is published. If the information is not current at that time,

MACs have the discretion to include the information if they also include a statement in the MAC bulletin or MAC newsletter that informs the readers that the information had been included in the MLN Connects Provider eNews (weekly and/or Special Edition) dated [MACs shall insert the date] and that the information is being provided for informational purposes only because it had been time-sensitive information or it is no longer applicable and/or in effect.

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

2. Distribution and Posting

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

   b. *MACs shall distribute and post all information received from CMS for providers and post relevant information on their provider education website. If specified by CMS in its instructions to the MACs, MACs shall highlight information that is especially relevant, or is solely relevant, to a particular line of business (A/B, HH+H, or DME) or provider type (if the MAC has an appropriate targeted electronic mailing list for the specified provider type). (See section 50.3.1 of this chapter for information about targeted electronic mailing lists.)*

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

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

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

information from the provider education website if it becomes outdated before the end of the 2-month period.

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

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

50.2.4.2 – Frequently Asked Questions (FAQs)

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

All *MACs* shall maintain regularly updated local FAQs on their provider education website and link to the CMS FAQs for national information. 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 medical review topics.

50.2.4.3 - Quarterly Provider Update (QPU)

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

The Quarterly Provider Update (QPU) is a listing of the regulations and program instructions issued by CMS that impact Medicare providers. The QPU is maintained by CMS and available to providers through the CMS website. Providers may elect to subscribe to a CMS electronic mailing list to be notified periodically of additions to the QPU. *MACs* shall promote the existence and usage of the QPU and its electronic mailing list to their provider community.

50.2.4.4 - Internet-based Provider Educational Offerings

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

MACs shall offer internet-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 electronic mailing lists on both

websites 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.

50.2.5 – Provider Education Website Promotion

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

MACs shall actively promote, market, and explain their Medicare provider education website and the information and features it contains, including the Medicare Learning Network resources discussed in section 20.4 of this chapter. Information about the *MAC*'s provider education website shall be part of, or made available at, all *MAC* POE workshops and seminars, training sessions with individual providers, and all other provider education activities a *MAC* arranges or in which it participates. *MACs* shall determine if their PCC may also be an effective way to promote the*ir* provider education website.

50.3 - Electronic Mailing List (Listserv)

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

MACs shall offer electronic mailing lists (listservs) to assist Medicare providers in gaining information about the Medicare program. These electronic mailing lists shall notify subscribers via e-mail of important, time-sensitive Medicare program information, upcoming provider communications events, and other announcements necessitating immediate attention. The Medicare Learning Network electronic mailing lists shall also be offered and available. (See section 20.4 of this chapter.) It is recommended that electronic mailing list(s) be constructed for only one-way communication*:* from *MACs* to subscribers.

1. Subscribe/Unsubscribe

   Providers shall be able to subscribe to electronic mailing list(s) via their *MAC*'s provider education website. Subscribers to the electronic mailing list(s) shall also be able to unsubscribe via the *MAC*'s provider education website. *MACs shall publish notices* on the*ir* provider education website and in *their* bulletins/newsletters that encourage subscription to the electronic mailing *list(s)*. Subscriptions to the electronic mailing list(s) shall also be promoted by the *MAC*'s PCC. *A MAC's* electronic mailing *list(s)* shall be capable of accommodating all of the providers *served within the MAC's jurisdiction*.

2. Protection of Electronic Mailing Lists

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

3. Electronic Mailing List Records

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

50.3.1 - Targeted Electronic Mailing Lists (Listservs)

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

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

50.3.2 – Electronic Mailing List (Listserv) Promotion

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

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*, bulletins *and newsletters*, workshops, education events, POE AG meetings, ACTs, PCC*s*, and written materials.) The Medicare Learning Network electronic mailing lists shall also be marketed and promoted. (See section 20.4 of this chapter.) *MACs* shall consider having CSRs subscribe providers to the electronic mailing list(s) during calls if the providers are not currently subscribed and the CSRs believe the providers would benefit from the information provided through the electronic mailing list(s). *MACs* shall also coordinate internally with other *MAC departments* to encourage electronic mailing list subscription.

50.4 – Social Media

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

MACs may, at their discretion, use social media in their PCSP. *MACs* who make use of social media shall *market offerings on high priority CMS items and, if applicable, use any available CMS social media offerings.*

MACs who make use of social media shall submit a report each calendar quarter using the PCSP Quarterly Social Media Activity Report template available in PCID documentation at *http://www.p-cid.com*. Each quarterly report shall reflect information for the previous calendar quarter. *MACs* who use social media shall send their quarterly reports to the Provider Services mailbox at *providerservices@cms.hhs.gov*. If a *MAC* who is not currently using social media later begins to use it, that *MAC* shall begin reporting social media usage in the report that is

submitted in the first calendar quarter after the usage begins. Example: If a *MAC* begins using social media in May, it would report the usage in the next quarterly report *(July-September)*.

50.5 – *MAC* Internet-based Provider Portals

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

CMS has developed the "MAC Internet-based Provider Portal Handbook" located at *http://www.cms.gov/Medicare/Medicare-Contracting/FFSProvCustSvcGen/downloads/Portal-handbook.pdf*. *MACs shall take into account the guiding principles outline in the Handbook when redesigning or modifying their Internet-based provider portal. CMS will notify MACs of updates to the "MAC Internet-based Provider Portal Handbook" via TDLs.*

50.5.1 – Internet-based Provider Portal Service Interruptions

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

MACs shall report Internet-based portal service interruptions to CMS. Portal service interruptions include unexpected portal downtimes and/or loss of one or more portal functions that cause the portal or function(s) to be unavailable to providers. 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 70.2.3.8 of this chapter for the requirement to report portal service interruptions to PCID.

60 - PCSP Performance Management

(Rev. 29; Issued: 06-27-14; Effective: 07-02-14; Implementation: 07-02-14)

NOTE: Deliverables, Deliverable dates, and/or requirements in a contractor's Statement of Work (SOW) supersede any such Deliverables, Deliverable dates, and/or requirements stated in this chapter, should the documents conflict.

60.1 - POE – Electronic Mailing List (Listserv) Subscribership

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

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

At 1 year after the date a *MAC* contract was awarded, the number of subscribers to a *MAC*'s electronic mailing list(s) shall equal at least 30 percent of the active provider count in the jurisdiction. (See the definition of "active" provider in section 20.4.1 of this chapter.) For an HH+H *MAC*, the number of subscribers would be the combined total subscribed to its A/B and HH+H electronic mailing lists. *To calculate this percentage, MACs shall divide the number of subscribers at 1 year after the contract award date by the number of Active Providers Served that is displayed in PCID at 1 year after the contract award date.*

A *MAC* who is awarded the same *jurisdiction* contract after a contract re-compete shall, at a minimum, maintain the percentage of electronic mailing list subscribers during the first year of the new contract that was the highest percentage achieved in the last year of the previous contract.

For the purpose of calculating this percentage, *MACs* shall, to the extent possible, eliminate duplicate e-mail addresses in their electronic mailing list subscribership.

It is a goal of CMS for the number of subscribers to *MACs*' electronic mailing lists to continue to increase. As such, *MACs* shall increase the number of subscribers by 2 percent per contract year, with the ultimate goal of having all of the *active* providers in the jurisdiction subscribe.

60.2 – Telephone Standards

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

Each *MAC*'s PCC is held accountable for meeting call handling and quality standards, such as call completion rates, average speed of answer, and quality call monitoring. *A*ll calls handled by a *MAC*'s PCC contribute to that *MAC*'s success or failure in meeting the standards described in *sections 60.2.1 – 60.2.6 of this chapter*.

60.2.1 – Customer Service Representative (CSR) Callback Rate

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

The CSR callback rate was formerly known as "initial call resolution." The term "CSR callback rate" more accurately describes this measure. *MACs* shall report CSR callback data to PIES in the exact same manner in which they reported initial call resolution data.

MACs shall not have a CSR callback rate greater than 10 percent for those telephone inquiries that are handled by CSRs. A call is considered resolved during the initial contact if it does not require a return call by a CSR or is referred to the PRRS. This standard is measured monthly and is cumulative for the quarter.

60.2.2 - Call Completion

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

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

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

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

- *MACs shall send an e-mail to the Service Reports mailbox at servicereports@cms.hhs.gov by 11:00 a.m. Eastern Time if their PCC completion rate for the previous business day was less*

than the applicable standards described above. The e-mail 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 e-mail shall also specify if the completion rate was impacted by staffing, call volume, or technical telecommunications or connectivity issues. The e-mail shall be sent with the subject line "Completion Rate."

60.2.3 – Call Acknowledgment

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16))

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

60.2.4 – Average Speed of Answer (ASA)

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

The average speed of answer (ASA) is the average time callers spend in the CSR queue waiting to be connected to a CSR. When determining the ASA, the wait time begins when the caller enters the CSR queue and ends when the caller is connected to a 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 CSR. Should the caller need to be transferred to another level CSR, the time associated with that transfer shall not be included in the ASA calculation. *MACs* shall maintain an ASA of 60 seconds or less. This standard is measured quarterly and is cumulative for the quarter.

MACs shall send an e-mail to the Service Reports mailbox at servicereports@cms.hhs.gov by *11:00 a.m.* Eastern Time if the ASA on the PCC line(s) *was* higher than the applicable quarterly standard for the previous *business day*. The e-mail 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 e-mail shall be sent with the subject line "ASA."

60.2.5 – Callbacks

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

MACs shall make three attempts to reach a provider for a callback. The *MAC* may leave a message requesting a return call, including the beneficiary's name if appropriate, but no PHI or PII (other than the beneficiary's name, if appropriate) *shall* be left on the message. If the provider does not respond after three callbacks, the *MAC* has the discretion to prepare a written response, completed within 10 business days of receipt of the original inquiry. The *MAC* shall not close out the inquiry without any type of response to the *provider*. *MACs* shall not leave the responses on provider voicemail *systems*. All callbacks shall be completed and closed out within 10 business days of receipt of the original inquiry and documented in the inquiry tracking system, discussed in section 30.6 of this chapter. A callback shall be considered completed and may be closed out if a final response has been given to the provider or if the *MAC* has informed the provider that the inquiry was escalated to a different *department* within the *MAC* for

resolution. Inquiries that are not closed out within 10 business days of receipt of the original inquiry are considered untimely.

60.2.6 – QCM Performance Standards

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

MACs shall monitor a minimum of five telephone calls per 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.

- For all calls monitored for the quarter, the percent scoring as "Pass" shall be no less than *95* percent for Adherence to the Privacy Act. This standard is measured quarterly and is cumulative for the quarter.

- For all calls monitored for the quarter, the percent scoring as "Achieves Expectations" or higher shall be no less than *95* percent for Customer Skills. This standard is measured quarterly and is cumulative for the quarter.

- For all calls monitored for the quarter, the percent scoring as "Achieves Expectations" or higher shall be no less than *95* percent for Knowledge Skills. This standard is measured quarterly and is cumulative for the quarter.

60.2.7 – Quality Assurance Monitoring (Telephone) Performance Standard

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

The quality of CSR responses to provider telephone calls shall be monitored throughout the contract year for each MAC jurisdiction using Quality Assurance Monitoring (QAM) (Telephone). The goal of QAM (Telephone) is to ensure the 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 30.2.11.2 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 95% 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 that were 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.

60.3 – *Standards for* Written *Responses to Provider* Inquiries

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

MACs shall evaluate the responses to written provider inquiries by employing CMS's Quality Written Correspondence Monitoring (QWCM) process. If a correspondent responds to types of inquiries that are not handled by the PCC, those responses shall not be included in the required minimum number of responses evaluated and entered into the QWCM database.

60.3.1 – QWCM Performance Standards

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

Currently, *MACs* shall evaluate and enter into the QWCM application a minimum of five provider responses per correspondent 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 standards:

- For all *written* provider responses monitored for the quarter, the percent scoring as "Pass" shall be no less than *95* percent for Adherence to the Privacy Act. This standard is measured quarterly and is cumulative for the quarter.

- For all *written* provider responses monitored for the quarter, the percent scoring as "Achieves Expectations" or higher shall be no less than *95* percent for Customer Skills. This standard is measured quarterly and is cumulative for the quarter.

- For all *written* provider responses monitored for the quarter, the percent scoring as "Achieves Expectations" or higher shall be no less than *95* percent for Knowledge Skills. This standard is measured quarterly and is cumulative for the quarter.

60.3.2 – *Timeliness of Responses to* Written *Provider* Inquiries

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

Standards for responding timely to provider written inquiries (general, PRRS and Congressional) are calculated using business days. See the chart below for assistance with converting calendar days to business days. This chart is provided as a guide only and is not definitive. The chart assumes the *MAC* was open for business every day during the reporting period. Days where the *MAC* is closed for business shall not count as business days.

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

Business Days	Calendar Days
45	63

60.3.2.1 - *Timeliness of Responses to General Provider* Inquiries

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

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

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

There may be instances when an inquiry is mistakenly sent to another address used by the *MAC*. The 45-business-day timeframe will begin once the inquiry is received in the *MAC* mailroom where written inquiries are routinely sent. This does not apply to *MACs* who choose to have all of their mail sent to a separate location and then forwarded to the proper *location*. For these *MACs*, the 45-business-day timeframe starts the day that the mail is received at the initial location.

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

60.3.2.2 - *Timeliness of Responses to* Complex Provider Inquiries *(PRRS)*

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

The PRRS staff shall provide clear and accurate answers *to complex provider inquiries* within 25 business days of receipt for at least 75 percent of provider inquiries referred by telephone CSRs. The remaining 25 percent of provider inquiries referred by telephone CSRs and all provider inquiries referred by the general written inquiries *unit* area shall receive clear and accurate written responses within 45 business days of receipt.

This timeframe begins the day the inquiry is originally received and date-stamped by the *MAC* and ends the day the *MAC* sends the final response. For those PRRS inquiries that cannot be

answered in final within 45 business days of receipt, *MACs* shall issue an interim response acknowledging receipt of the inquiry and explaining the reason for the delay. When possible, inform the provider about how long it will be until a final response will be sent. Sending an interim response does not resolve the issue and the inquiry is not considered closed until the final response is sent. The final response shall be sent within 5 business days after receipt of the needed information. Any interim responses sent to PRRS inquiries will count toward the *MAC*'s overall allowance of no more than 5 percent of interim responses for the universe of *written responses to provider* inquiries.

60.3.2.3 - *Timeliness of Responses to* Complex Beneficiary Inquiries *(PRRS)*

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

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

60.3.2.4 - *Timeliness of Responses to* Congressional Inquiries

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

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

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

70 - PCSP Data Reporting

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

70.1 - Provider Inquiries Evaluation System (PIES)

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

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

MACs are reminded to report data by jurisdiction and, where necessary, by queue. (See section 30.2.1 of this chapter.)

70.1.1 - Access to PIES

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

The PIES is an interactive web-based tool that is password protected and accessible only to authorized users. To help ensure the integrity of the data, CMS limits the number of user accounts per contract (A/B, HH+H, DME). *MACs* may assign the same person to more than one contract type. To request access to PIES, *MACs shall* send the following information to the PIES mailbox at pie-system@cms.hhs.gov:

- Name
- Telephone number
- E-mail address
- *MAC* Contract (A/B, HH+H, DME)

Incoming *MACs* shall request access for at least one staff member within 30 calendar days after contract award.

70.1.2 - Due Date for Data Submission *to PIES*

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

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 are not considered late until after the 16th of the month.*

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

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

70.1.3 - Data to be Reported Monthly *in PIES*

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

- 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.

- Provider Internet portal data: *MACs* shall capture and report in PIES the data elements specified in the PIES database related to their provider Internet portal services.

The list of data elements and their corresponding definitions are available on the PIES website.

70.2 - Provider Customer Service Program Contractor Information Database (PCID)

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

The PCID is a secure web-based system developed to serve as a central place to capture and store information about *MACs*' PCSP activities as well as provide an online reporting mechanism for the *MACs*' quarterly inquiry tracking reports. The database and its accompanying user guide are located at https://www.p-cid.com.

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

70.2.1 - Access to PCID

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

The PCID is an interactive web-based tool that is password protected and accessible only to authorized users. To request access to PCID, *MACs shall* send the following information to the PCID mailbox at p-cid@cms.hhs.gov:

- Name
- Telephone number
- E-mail address
- *MAC* Contract (A/B, HH+H, DME)

Incoming *MACs* shall request access for at least one staff member within 30 calendar days after contract award.

70.2.2 - *MAC* Contract *and PCSP* Data to be Reported in PCID

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

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, Provider Enrollment, other), and Use (CSR, IVR, TDD)*
- *MAC PCSP* Points of Contact *and Contact Information*
    - PCSP Program Manager
    - POE Contact (Primary)
    - PCC Contacts *– Telephone Inquiries (Primary, Alternate) and Written Inquiries (Primary, Alternate)*
    - *Webmaster*
    - *MLN Connects Provider eNews 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 are 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 the*se* data in *PCID, make updates or changes as necessary, and certify that the data are correct.*

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

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

MACs shall report in PCID the data described below in sections 70.2.3.1 – 70.2.3.*10* 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 70.2.3.2 of this chapter, between the 1st and the 10th of the month for the upcoming month.* After the 10th of the month, the data entry capability will no longer be available to the *MACs*. After the 10th of the month, *any missing* data will be considered late and will need to be entered into PCID by CMS staff. *If a MAC did not report data timely, the MAC* shall inform CMS of the data to be entered into PCID *by submitting that* information *within 2 business days after it becomes available* to *the* PCID *mailbox* at pcid@cms.hhs.gov.

If the MAC entered data timely but, after the *PCID reporting due date*, determined 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)* that are to be changed. This information shall be submitted to *the* PCID *mailbox* at pcid@cms.hhs.gov.

70.2.3.1 – Inquiry Tracking Data to be Reported in PCID

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

A. Inquiry Tracking Monthly Report

MACs shall report their monthly telephone and written inquiry tracking information in PCID *between the 1st and the 10th* of *each* month for the previous month's data.

B. Reporting "Not Classified" Inquiries

PCID does not allow *MACs* to choose the main inquiry category if the reason for the inquiry does not relate to the existing subcategories. For this reason, there is a subcategory for every category (except "General Information") called "Not Classified" where *MACs* shall report any inquiries related to a particular category that do not relate to any of the existing subcategories. (See section 30.6.C.4 of this chapter.)

C. Reporting Contractor-Specific Categories

MACs may also create contractor-specific subcategories for inclusion under every category (except "General Information"). *MACs* who have at least one contractor-specific subcategory shall enter the total number of inquiries for all the contractor-specific subcategories into the "Contractor-Specific" field for the category.

Contractor-specific inquiry *data* shall be reported in PCID within 10 calendar days after the end of the month for the previous month*'s data*.

See section 70.2.3 of this chapter for additional information about reporting.

70.2.3.2 – PCC Training Closure Information to be Reported in PCID

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

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*:

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

- Topics and subtopics of CSR*, correspondent, and/or PRRS* training that occurred in the *previous* month; and,

- Categories and subcategories (from the Standardized Provider Inquiry Tracking Chart) that correspond to the CSR*, correspondent, and/or PRRS* 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.

70.2.3.3 – POE Data to be Reported in PCID

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

MACs shall enter POE event and self-paced education data in PCID *on a monthly basis between the 1st and* the 10th of each month for the previous month's data.

Definitions, additional instructions, and the POE Topic/Subtopic listing are available in PCID documentation at https://www.p-cid.com.

MACs with multiple jurisdictions shall report POE event data and self-paced education data by jurisdiction.

POE event data to be reported in PCID include the following:

- Event Type – The kind of POE event
- Date – The date the event occurred
- Time – The time of day the event occurred
- Program *(Line of Business)* (A/B MACs only) -- *A, B,* HH+H
- Media Type – Media used to deliver the event
- Number of Participants – Total participants per event
- 1-on-1 – The event was with a single provider
- CERT Task Force Initiated – CERT Task Force event
- Provider Location – The State(s) *for* which the POE event was offered (*for example,* providers in all States within the jurisdiction or providers in a subset of States within the jurisdiction)
- Topic/Subtopic – The topic(s)/subtopic(s) the POE event was designed to cover

Self-paced Education data to be reported in PCID include the following:

- Event Type – The kind of self-paced education
- Name – The name of the course
- Program *(Line of Business)* (A/B MACs only) – *A, B,* HH+H
- Active – The status of the self-paced education

- Archive Date – Deactivation date of the self-paced education if the course is no longer being offered*/is inactive.*
- Topic(s)/Subtopic(s) – The topic(s)/subtopic(s) the self-paced education was designed to cover

70.2.3.4 – Provider Electronic Mailing List (Listserv) Subscriber Data to be Reported in PCID

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

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

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

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

70.2.3.5 – Special Initiatives *Activities* to be Reported in PCID

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

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

70.2.3.6 – Emergency PCC Closure Data to be Reported in PCID

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

If an emergency PCC closure occurred (see section 30.2.7.3 of this chapter), the MAC shall enter that closure in PCID between the 1st and the 10th of the month for the previous month's data. No reporting is necessary for months in which there were no such closures.

70.2.3.7 – Telecommunications Service Interruptions to be Reported in PCID

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

If a telecommunications service interruption (toll-free carrier-related or in-house) occurred, the MAC shall enter that interruption in PCID between the 1st and the 10th of the month for the previous month's data. No reporting is necessary for months in which there were no such interruptions. See section 30.2.4 of this chapter for information about telecommunications service interruptions in general and other required service interruption reporting.

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

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

70.2.3.8 – Provider Internet-based Portal Service Interruptions to be Reported in PCID

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

If an Internet-based 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 Internet-based portal service interruptions are as follows:

Date the Internet-based portal service interruption occurred.
Time of day (local time) the Internet-based portal service interruption occurred.
Date and time of day (local time) the Internet-based 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.

70.2.3.9 – Provider Internet-based Portal Functionality to be Reported in PCID

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

MACs shall enter current 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 portal functionality in the Portal Functionality module by selecting the available functionalities from a list. MACs shall also report additional functionalities that are available but are not in the list.

Additional information is available in PCID documentation.

70.2.3.10 – Provider Education Website Analytic Data to be Reported in PCID
(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

MACs shall enter provider education website analytic data in PCID on a monthly basis between the 1st and the 10th of each month for the previous month's data. MACs shall report provider education website analytic data in the Website Analytics module using the definitions provided by CMS.

MACs shall report the following provider education website analytic data by jurisdiction and by line of business (A, B, HH+H, DME):

- *Visits (total visits, new visits, return visits, visits via mobile devices, average visit duration, bounce rate).*
- *Pages (total page views, average page views per visit, top 5 pages viewed most often).*
- *Other (number of on-site search queries initiated, top 5 search terms entered by visitors).*

Definitions and additional information are available in PCID documentation.

70.3 – QCM Data Reporting
(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

The Quality Call Monitoring (QCM) system is an interactive web-based tool that is password protected and accessible only to authorized users. MACs may assign the same person to more than one contract type. To request access to QCM, MACs shall send the following information to the QCM mailbox at qcmscores@cms.hhs.gov:

Name
Telephone number
E-mail address
MAC contract (AB, HH+H, DME)

New MACs shall request access for at least one staff member within 30 calendar days after the date of the contract award. If the 30th calendar day falls on a weekend or holiday, MACs shall request access by close of business on the next business day.

MACs shall complete scorecards and enter data into the QCM database before the 10th of each month. See section 30.2.13 of this chapter for additional information.

70.4 – QWCM Data Reporting

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

The Quality Written Correspondence Monitoring (QWCM) system is an interactive web-based tool that is password protected and accessible only to authorized users. MACs may assign the same person to more than one contract type. To request access to QWCM, MACs shall send the following information to the QWCM mailbox at qwcmscores@cms.hhs.gov:

Name
Telephone number
E-mail address
MAC contract (AB, HH+H, DME)

New MACs shall request access for at least one staff member within 30 calendar days after the date of the contract award. If the 30th calendar day falls on a weekend or holiday, MACs shall request access by close of business on the next business day.

MACs shall complete scorecards and enter data into the QWCM database *before* the 10th of *each* month. See section 30.3.6 of this chapter for additional information.

80 - Disclosure of Information

(Rev. 35, Issued: 10-07-16, Effective: 11-08-16, Implementation: 11-08-16)

MACs shall protect the confidentiality of Medicare beneficiary personally-identifiable information (PII) and protected health information (PHI) *as well as provider personally-identifiable information* in accordance with the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act of 1996. To ensure compliance, *MACs* shall comply with the requirements in the Disclosure Desk Reference prepared and made available by CMS. The Disclosure Desk Reference is available at http://www.cms.gov/Medicare/Medicare-Contracting/FFSProvCustSvcGen/Downloads/DDR-Guide-0113.pdf.

Transmittals Issued for this Chapter

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

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

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