CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-09 Medicare Contractor Beneficiary and Provider Communications	Centers for Medicare & Medicaid Services (CMS)
Transmittal 28	**Date: May 2, 2014**
	Change Request 8491

SUBJECT: 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.

I. SUMMARY OF CHANGES: The purposes of this Change Request (CR) are to (1) revise Pub. 100-09, Chapter 6, which includes the URL for the MAC Internet-based Provider Portal Handbook so that the Handbook can be cleared as part of the revision of Chapter 6, and (2) delete Pub. 100-09, Chapter 3, Provider Inquiries, which became obsolete in 2009 when its contents were merged into Chapter 6. Chapter 6 is being re-released in its entirety as changes were made to most sections. We updated the referenced CMS URLs; we rearranged and relocated information already in Chapter 6 to improve the information flow and aid comprehension; we included requirements that were established and put in place after the prior revision of this Chapter; and we deleted information that is no longer appropriate for inclusion (i.e., references to carriers, fiscal intermediaries, and the CSAMS reporting system, and the deletion of the following sections: section 20.4.1.1 was deleted because it addressed paper bulletins/newsletters, section 20.8.2.2.1 was deleted because its content was moved into section 20.8.4, the subsections of section 80 were deleted because the Disclosure Desk Reference is now available on the CMS PCSP web page, and section 90 was deleted because the CMS Standardized Provider Inquiry Chart is now availableon the CMS PCSP web page). The previous revision numbers and associated dates remain for those sections that did not undergo changes via this CR.

EFFECTIVE DATE: July 2, 2014
IMPLEMENTATION DATE: July 2, 2014

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

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
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R	6/10.1/PCSP Electronic Mailing Lists (Listservs)
R	6/10.2/Provider Customer Service Program User Group (PCUG) Calls
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N	6/10.4/Integration of POE, PCC and PSS Activities in the PCSP
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R	6/20.4/Provider Education
R	6/20.4.1/Provider Bulletins/Newsletters
D	6/20.4.1.1/Alternative Distribution Methods
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R	6/20.4.5/Educational Topics
R	6/20.4.5.1/Local Coverage Determinations (LCDs)
R	6/20.4.5.2/Education Resulting from Medical Review Referrals
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R	6/20.5/POE Materials
R	6/20.6.1/POE Advisory Groups (POE AGs)
R	6/20.6.2/"Ask-the-Contractor" Teleconferences (ACTs)
R	6/20.7/POE Reporting
R	6/20.7.1/Provider Service Plan (PSP)
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R	6/20.7.3/Error Rate Reduction Plan (ERRP)

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
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R	6/20.8.2.2/Fees for Education and Training Activities
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R	6/20.8.3/Prohibitions
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R	6/20.8.5/Excess Revenues from Provider Participant Fees
R	6/20.8.6/Refunds/Credits for Cancellation of Education and Training Activities
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R	6/30.2.1/General Inquiries Line
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R	6/60.2.4/Average Speed of Answer (ASA)
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N	6/70.2.3.3/POE Data to be Reported in PCID
N	6/70.2.3.4/Provider Electronic Mailing List (Listserv) Subscriber Data to be Reported in PCID
N	6/70.2.3.5/Special Initiatives to be Reported in PCID
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N	6/70.4/QWCM Data Reporting
N	6/70.5/Reporting Provider and Beneficiary Inquiry Workload Data in the Contractor Reporting of Operational Workload Data (CROWD)
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III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC statement of Work. The contractor is not obliged to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-09	Transmittal: 28	Date: May 2, 2014	Change Request: 8491

SUBJECT: 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 Pub. 100-09, Chapter 3, Provider Inquiries.

EFFECTIVE DATE: July 2, 2014
IMPLEMENTATION DATE: July 2, 2014

I. GENERAL INFORMATION

A. Background: The purposes of this Change Request (CR) are to (1) publish an update to Pub. 100-09 Chapter 6 to reflect changes and additions to requirements, deletion of requirements, and clarification of requirements, and to provide via URL within Chapter 6, for clearance, the CMS MAC Internet-based Provider Portal Handbook, and (2) delete Pub. 100-09 Chapter 3, which became obsolete in 2009 when its contents were merged into Chapter 6.

B. Policy: The Medicare Prescription Drug, Improvement, and Modernization Act (MMA), P.L. 108-173, section 921.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
8491.1	Contractors shall implement all requirements contained within the Pub. 100-09 Chapter 6 Medicare Contractor Beneficiary and Provider Communications Manual.	X	X	X	X					RRB-SMAC
8491.2	Contractors shall comply with all requirements in the MAC Internet-based Provider Portal Handbook, referenced in the revised Pub. 100-09, Chapter 6."	X	X	X	X					RRB-SMAC

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility		
		A/B MAC	DME	CED

		A	B	HHH	MAC	I
	None					

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): Patricia Peyton, 410-786-1812 or Patricia.Peyton@cms.hhs.gov

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

VI. FUNDING

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

ATTACHMENTS: 0

Medicare Contractor Beneficiary and Provider Communications Manual

Chapter 6 - Provider Customer Service Program

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(Rev.28, 5-2-14)

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Provider Customer Service Program

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

***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.**

Unless stated otherwise, *contractors* shall continue to send contract *D*eliverables to their appropriate *D*eliverables mailbox.

In this chapter, the term "provider" applies to all Medicare provider and supplier types. *T*he term "contractor" applies to all *Part A/Part B (A/B), Home Health and Hospice (HH+H), and Durable Medical Equipment (DME) Medicare Administrative Contractors (MACs), as well as the Railroad Retirement Board (RRB) Specialty MAC, in accordance with each MAC's SOW.*

10 – Introduction to Provider Customer Service Program (PCSP)

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

The CMS requires that all contractors 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 contractors.

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

10.1 – PCSP *Electronic Mailing Lists (*Listservs*)*

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

***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, contractors shall *subscribe to* the CMS PCUG *electronic mailing list*. To *subscribe to this electronic mailing list*, contractors 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* contractor *POE manager, the contractor PCC managers, those managing PSS technology,* and quality analysts shall *subscribe to the electronic mailing list. Additional contractor staff may also subscribe.* There is no limitation as to the number of *subscribers* for any contractor.

2. Contractor *electronic mailing list – CMS utilizes an electronic mailing list to send contractors* 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,* contractors shall

subscribe to the CMS Contractor *electronic mailing list*. To *subscribe or unsubscribe to this electronic mailing list*, contractors shall send an *e-mail* to *MLNConnectsMAC@cms.hhs.gov*. The *e-mail* shall include the e-mail addresses of the individuals *who wish to subscribe to the electronic mailing list*, as well as a permanent corporate/resource box at the contractor. *The contractor staff noted in item 1 above shall subscribe, as may additional contractor staff.* There is no limitation as to the number of *subscribers* for any contractor.

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

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

The PCUG conference call is held *on a regularly scheduled basis* with staff from *CMS and* the contractor*s'* PCSP functions. The call allows CMS to update contractors on issues, directives, and policies impacting the PCSP and provides a forum for contractors to ask questions and share ideas. Contractors shall ensure that staff from their PCC*, POE, and PSS* functions *attend each* monthly PCUG call. Contractors 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*. *The PCUG Call schedule is available in the PCSP Contractor Sharing and Collaboration Team Room (described in section 10.3 of this chapter).*

10.3 – *PCSP Contractor Sharing and Collaboration Team Room*

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

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

10.4 - *Integration of POE, PCC and PSS Activities in the PCSP*

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

Since the PCSP is an integration of POE, PCC and PSS activities, contractors 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. Contractors 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 contractor's electronic mailing list or to publicize the contractor's provider education website while callers are on hold. Contractors 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.

Contractors or even individual contractor 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, contractors are encouraged to continue and increase

these efforts. If these activities are not currently happening, then contractors shall implement these types of efforts.

20 – Provider Outreach and Education (POE)

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

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 the Recovery Audit*or (RA)* data.

*C*ontractors 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 contractor, 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 contractors 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.

Contractors 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. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

Contractors 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 contractor and provided to CMS when requested.

Additionally, *the* POE *staff may* send a representative to the contractor'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. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

Contractors shall establish and maintain partnerships with external entities to help disseminate Medicare provider information. Whenever feasible, events and activities shall be coordinated with other 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, contractors shall routinely and directly notify other interested entities of their upcoming provider education events and activities. Partnership activities shall not take the place of contractor-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 or collaborative provider information and education efforts may include, but *are not* limited to:

1. Printing information 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; and*

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

20.3 - Data Analysis

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

*C*ontractor*s* shall analyze all available data, such as CERT error rates, RA data, telephone and written inquiries data, claims submission errors, appeals data, CSR feedback, *website satisfaction survey data, and other survey data,* as well as feedback from across the contractor, as *they* develop *their* education methodology. *C*ontractor *shall* also use referrals from medical review, as discussed below. The data elements listed in this section shall not be construed as an all-inclusive list. Contractors shall use their discretion to determine if their PCSP would benefit from analysis of data not mentioned in this section.

20.3.1 - Error Rate Reduction Data

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

*C*ontractor*s* shall implement a provider education plan that focuses on reducing the CERT error rate. Contractors shall focus on data from the CERT and RA programs, as appropriate. Additionally, contractors 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. *(See section 20.7.3 of this chapter.)*

CERT data, including the inpatient claims error rate, are primary sources of information to target education activities. Contractors 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 the contractor's area may be driving any unusual patterns. Contractors shall consider other sources of data when evaluating the CERT findings in order to develop an educational plan.

Contractors shall ensure that their CERT educational activities focus on using existing Medicare Learning Network® products or content whenever practicable. Contractors 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.)

20.3.2 - Inquiry Analysis

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

For provider inquiry analysis, contractors 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. Contractors 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. Contractors shall also use the results of their inquiry analysis program to develop and deliver training to their *PCC* staff.

20.3.3 - Claims Submission Errors

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

Data analysis is an essential first step in determining whether patterns of claims submission and payment indicate educational needs. Contractors 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. Claims submission errors are those that result in rejected, denied, or incorrectly paid claims. This information shall be utilized to develop and modify the provider education contained in contractor 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 contractors.

20.3.4 – Medical Review Referrals

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

In accordance with *Pub.* 100-*0*8, *Medicare Program Integrity Manual,* Chapter*s* 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*.)

POE staff shall use this information to look for trends in the universe of probe review letters and priority referrals to determine whether broader education to the provider community may be warranted. POE staff shall also evaluate the medical review referrals and work with medical review *staff* to determine whether there are topics that are appropriate for FAQs to be posted on the *provider education website. (See section* 50.2.4.2 *of this chapter.*)

20.4 - Provider Education

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

To the extent practicable, contractors shall use CMS-provided national education*al* materials in their provider outreach and education activities; i.e., *Medicare Learning Network® (MLN) products or content and the MLN Connects™ Provider eNews.*

Contractors 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 education*al* 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, and MLN Matters® Articles. MLN Connects™ National Provider Calls are announced in the weekly MLN Connects™ Provider eNews and contractors 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. Contractors 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. Contractors shall supplement MLN products or content and other CMS materials with specific information unique to their jurisdictions.

Contractors 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.) Contractors 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 http://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.)

Contractors 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.

Contractors 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 contractors 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.

Contractors 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. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

Unless otherwise established with CMS, contractors 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 contractor) shall receive paper provider bulletins/newsletters via U.S. Postal Service. Contractors shall suggest to these providers ways that they can receive bulletins/newsletters electronically.* When feasible and cost-effective, contractors shall *send regular bulletins/newsletters only to active providers. Active providers are those providers that are organizations (e.g., hospitals, medical groups, skilled nursing facilities) and those who are individuals (e.g., physicians, nurse practitioners, physician assistants) who have an ACTIVE status in their record in the Provider Enrollment, Chain and Ownership System (PECOS).* Contractors shall post on the*ir* provider education *website* newly created bulletins/newsletters *and* educational materials. (See *section* 50.2 *of this chapter*.)

Contractors shall provide within the introductory table of contents, summary, compilation, or listing of articles/information, an indicator (e.g. 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. Contractors 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.

Contractors shall encourage providers to obtain electronic copies of bulletins/newsletters and other notices through the*ir* provider education *websites.* If providers *who receive paper copies are interested in obtaining additional paper copies on a regular basis,* contractors 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. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

At the request of CMS, contractors 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.) Contractors 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 contractors 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. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

Contractors 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. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

*C*ontractors 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. Contractors 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 contractor resides with that staff.

20.4.5 – Educational Topics

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

Contractors 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 contractor data analysis should be used to determine these topics; however, at a minimum, contractors 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. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

Contractors shall educate the*ir* provider community on new or significantly revised final LCDs. Contractors 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. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

In accordance with *Pub.* 100-*0*8, *Medicare Program Integrity Manual,* Chapter*s 1 and* 3, the contractor'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 contractor deems appropriate, including one-on-one training, referral of the provider to available web training, and upcoming workshops containing information on the topic. The contractor 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 when evaluating these referrals to determine what type of education, if any, is appropriate and whether this education fits with the overall contractor strategy to reduce the error rate.

The contractor 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 contractor'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 contractors. Contractors 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 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, requests for education from providers, follow-up communication with medical review, and disposition of problems referred from medical review, including type of education given.

20.4.5.3 - Medicare Preventive Service Benefits

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

Contractors shall promote to *their* provider community the use of preventive services and other benefits provided by the Medicare program to beneficiaries. These preventive services may include, but are not limited to, initial physical examinations, cardiovascular and diabetes screening tests, screening mammography, and screenings for colorectal, cervical, and prostate cancer.

20.4.5.4 - Electronic Claims Submissions

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

Contractors shall conduct training for providers or their staff in electronic claims submission. The contractor 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. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

Contractors 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, contractors shall use appropriate codes. Contractor 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.

Contractors 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. *S*tandard 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, contractors 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, contractors 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. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

Contractors 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 contractor 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. *Contractors shall ensure that documents are section 508 compliant as required.*

All materials developed by Medicare contractors 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 contractor reproduces or uses material, in whole or in part, originally developed by another contractor, that *other* contractor 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. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

*Each c*ontractor shall establish and maintain a POE Advisory Group (POE AG). The primary function of the *POE AG* is to assist the contractor 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. Contractors 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 contractor shall maintain the *POE AG*. It is not permissible for the contractor to allow outside organizations to operate the *POE AG*. After soliciting suggestions from the provider community, the contractor 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 contractor's POE area. At a minimum, the contractor 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 contractor 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 contractor advisory group. Contractors 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 contractor 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 contractor shall have at least one separate group for each of its contracts (i.e., at least one POE AG for each Jurisdiction). In addition, contractors shall not share a *POE AG* with another contractor.

A contractor shall not reimburse or charge a fee to *POE AG* members for membership or for costs associated with serving on *the POE AG*. *A contractor* shall have a specific area on *its provider education website* that allow*s* 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 contractor 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 contractor 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. After each meeting, minutes shall be posted on the contractor's *provider education website* within 30 *business* days *after the meeting*.

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

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

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

Contractors shall organize toll-free ACTs to complement, but not replace, the work of the *POE AG.* (See *section* 20.6.1 *of this chapter*). Contractors shall offer ACTs at least quarterly. In designing ACTs, contractors shall consider other technological approaches, such as web-chat capabilities. Contractors shall also invite CMS Central and Regional Office staff to listen to ACTs. After each *ACT, a complete* question-and-answer document shall be posted to the contractor's *provider education website* within 30 *business* days *after the 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 contractors 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*.

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

20.7 - POE Reporting

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

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

Contractors shall prepare and submit the PCSP documents described in section 20.7.1 through 20.7.3 of this chapter and submit updates as necessary.

Additional reporting may be required. (See section 20.7.4 of this chapter.)

20.7.1 - Provider Service Plan (PSP)

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

Each contractor shall prepare and submit *to CMS a single* PSP *that outlines the* strategies, projected activities, efforts, and approaches the contractor 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 *contractor's* Statement of Work. *An HH+H MAC shall prepare a separate PSP for its corresponding HH+H work.*

Each contractor shall send the PSP electronically in MS Word by the last day of the first month of *first year of the contract* to CMS using the *P*rovider *S*ervices mailbox at providerservices@cms.hhs.gov. *Each contractor* shall send *its* PSP to the appropriate CMS *D*eliverables mailbox.

Contractors shall adhere to the PSP template/format and instructions located on the CMS *website* at *http://www.cms.gov/Medicare/Medicare-Contracting/FFSProvCustSvcGen/Contractor_Reporting.html*. Contractors shall ensure that they are utilizing the most recent version of the PSP template/format. Contractors shall be notified of updated templates via the CMS PCUG *electronic mailing list* described in *section*10.*1 of this chapter*.

20.7.2 – *Provider Customer Service Program* Activity Report (*PAR*)

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

Each contractor shall prepare a semi-annual *Provider Customer Service Program Activity Report (PAR)*. The *PAR* summarizes and recounts the contractor'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. Contractors 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* will be due to CMS on the 30th *calendar* day after the first *6* months of the contract year with 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 will be due at close of business on the next business day. The second report, covering months 7-12 of the contract year, is due 30 *calendar* days after the last day of the contract year. All *PAR*s shall be sent electronically in MS Word to the *P*rovider *S*ervices mailbox at providerservices@cms.hhs.gov *and to the* appropriate CMS *D*eliverables mailbox.

Contractors shall adhere to the *PAR* template/format and instructions located on the CMS *website* at *http://www.cms.gov/Medicare/Medicare-Contracting/FFSProvCustSvcGen/Contractor_Reporting.html*. Contractors shall ensure that they are utilizing the most recent version of the *PAR* template/format. Contractors shall be notified of updated templates via the CMS PCUG *electronic mailing list* described in *section* 10*.1 of this chapter*.

20.7.3 – Error Rate Reduction Plan (ERRP)

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

Every *year (generally, in* November*)*, CMS publishes a report on Medicare fee-for-service improper payments. The report includes national, contractor-type, and contractor-specific error rates. Each contractor responsible for a jurisdiction that received a contractor-specific error rate shall develop and submit an Error Rate Reduction Plan *(ERRP)*. The ERRP shall describe the corrective actions the contractor plans to take in order to lower the error rate. The Initial ERRP is due 30 days after the release of the annual improper payments report.

After the release of the mid-year improper payments report *(which is generally published in May)*, each contractor *who submitted an ERRP* shall submit an updated plan informing CMS of the progress on the error rate reduction actions described in the initial plan. Any changes to the plan should be made directly to the body of the plan in *the* database and then summarized in the revision history portion of the ERRP. The ERRP Update is due 30 days after the release of the mid-year improper payments report.

The *I*nitial ERRP and the ERRP *U*pdate shall follow the format required by CMS and shall describe how the contractor will utilize the CERT findings to develop and implement outreach and education efforts.

20.7.4 – Additional Reporting

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

The CMS will emphasize the importance of integration of data analysis across all business functions within the contractor, as the *contractor* continuously assess*es* the effect of *its* outreach and education efforts upon the error rate. Contractors shall work to maintain or improve upon their CERT scores. Contractors 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 *contractors* shall maintain or improve upon the overall CERT error rate of the outgoing contractor as stated in the last Improper Payments report published during the outgoing contractor's final contract year.

Contractors 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 contractors who exceed this goal, CMS reserves the right to require additional reporting

related to the way *those contractors* use outreach and education to achieve a reduction. Contractors 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. Contractors 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 contractors if additional reporting is required.*

20.8 - Charging Fees to Providers for Medicare Education and Training

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

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

However, there are some circumstances under which contractors 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. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

Contractors shall not charge providers who are attending or participating in an education *or training activity (i.e., a non-conference outreach program)* based upon a medical review identified need for education. (See *sections* 20.3.4 and 20.4.5.2 *of this chapter.*)

20.8.2 – Fair and Reasonable Fees

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

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 contractor 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 contractor activities in other functional areas.

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

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

Contractors 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 form*ats, such as* CD-ROM) *that they send directly to providers.*

20.8.2.2 – *Fees for* Education and Training *Activities*

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

Contractors 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 contractor activities in other functional areas.

20.8.2.3 – Fees for Videotapes or Recordings of Education and Training Activities
(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

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 contractor records an education or training activity, then the contractor 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. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

Contractors 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, contractors may not include the costs of those items in any fees they may charge providers for the education or training activity. Contractors shall not advertise the availability of light food or refreshments.

Contractors 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. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

There may be times when providers or provider societies/associations offer to pay the travel costs for a contractor's POE staff so that this staff is able to attend and participate in provider meetings. In most instances, contractor 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 contractor shall not accept travel reimbursement.

Before accepting the provider society's/association's offer, the contractor 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 contractor's staff is to give a presentation or discuss as part of a panel or general question/answer discussion.

In all cases, contractors shall not accept speakers' fees, but they may accept small gifts such as pens engraved with the host logo, coffee mugs, plaques, flowers, etc. Contractors 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. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

Excess revenues from participant fees may occur when the total of the fees collected exceeds the total of the allowable costs. Contractors 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 contractor may incorporate the excess revenue into its POE program. If the total collected exceeds 10 percent, the contractor shall evenly refund the entire excess amount collected to all registrants who paid a fee for attending the activity. For example, the contractor charged 250 participants a $50 registration fee for an activity that cost the contractor $10,000 (for meeting facility, equipment rental). Therefore, the contractor 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 contractor shall total the fees collected to attend completed fee-associated provider education and training activities for that year. To that amount, the contractor shall add the estimated fees the contractor anticipates collecting from all remaining scheduled fee-associated education and training activities. The contractor 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 contractor 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 contractor 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 contractor's plan to equally refund the entire excess revenue to all provider registrants who attended any of the contractor's fee-based education or training activities.

20.8.6 – *Refunds/Credits for Cancellation of Education and Training Activities*
(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

Contractors shall develop and implement a refund policy and apply it to any education or training activity for which they charge a fee. Contractors 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 contractor may have to make commitments under which it will incur contractual expenses. Contractors may take this into consideration when determining their refund/credit policy. The policy must, at a minimum, adhere to the following guidelines:

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

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

20.8.7 – Considerations and Recordkeeping for Fee Collection
(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

For each contract year, contractors 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, contractors 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. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

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.

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 today. Medicare contractors 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 provider*s'* verbal and written inquiries. The PCC includes the provider telephone inquiries staff, the general written inquiries *staff*, and walk-in inquiries staff.

With the exception of technologies discussed in *sections* 30.5.2 and 50 *of this chapter*, CMS is not requiring the use of any specific technologies, as long as the contractor 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, contractors shall ensure, at a minimum, that PCC staff have readily-accessible information and tools (i.e., access to claims-related information, access to and training on the contractor's and CMS'*s websites*, a computer, and an outbound telephone line).

By the end of the *1st* month of the contract year, each *PCC* shall appoint a primary provider inquiry contact person (i.e., the *PCC* manager or other designee.) The contact's name, business address, *business* telephone number, and *business* e-mail address shall be entered into the Provider Customer Service Program Contractor Information Database (PCID). If the contact person is replaced, the contractor shall submit the new contact information to PCID within 14 calendar days of the change. *Each contractor's PCC* shall also submit a high-level organizational chart for *its* provider inquiry function to *the Service Reports mailbox at* servicereports@cms.hhs.gov.

It is important that CMS be aware of changes or events that have negative effects on contractors' 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, contractors shall send an e-mail to the Provider Services mailbox at providerservices@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 and 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*
- *Receipt of inquiries necessitating the creation of new Inquiry Tracking topics or subtopics*
- *Abnormal or unexpected changes in CSR availability (e.g., absences due to illness, severe weather, or urgent training)*
- *Implementation of CRs*
- *Medicare policy changes or new initiatives*
- *Shared systems issues*
- *Unavailability of data*

30.1 – Inquiry Triage Process

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

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 contractor may choose to employ a similar mechanism to triage general written inquiries as well. Contractors *shall*

develop mechanisms to quickly identify complex written inquiries needing referral to the Provider Relations Research Specialists (PRRS). Figure 1 illustrates the levels of complexity and the corresponding provider inquiry volume.

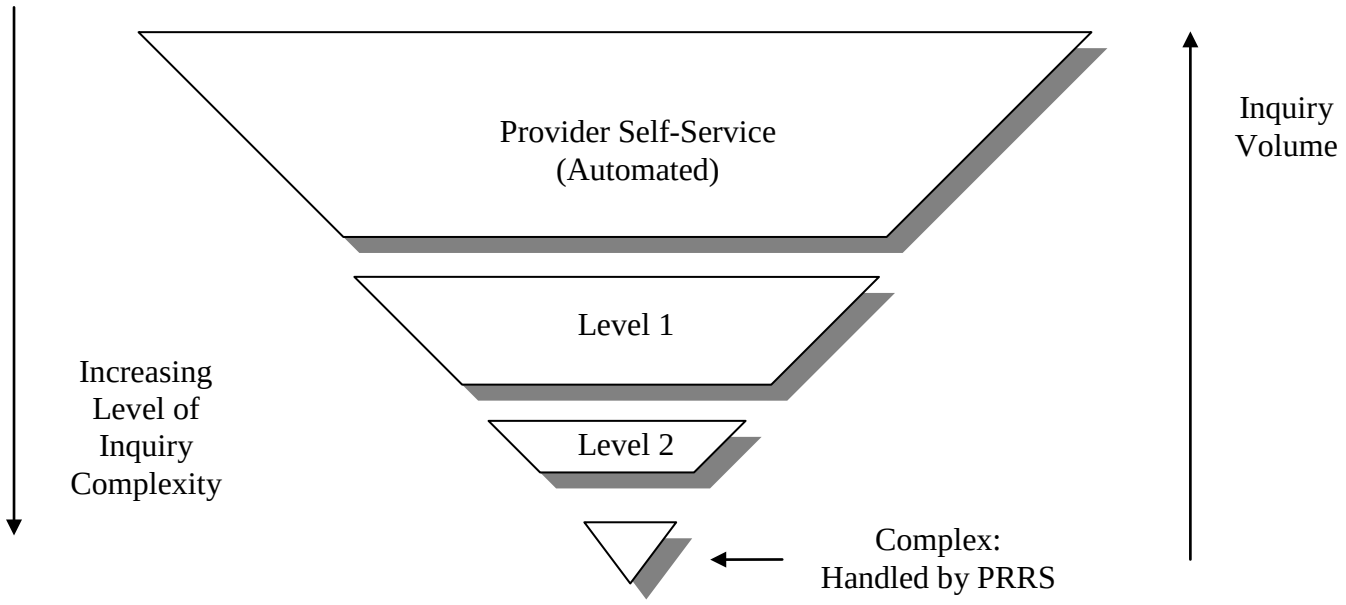
Each contractor shall organize its dedicated provider telephone CSRs into at least two levels to handle questions of varying complexity. *A c*ontractor may also choose to specialize *its* CSRs within levels or across *PCC call center locations (if a contractor has more than one call center location)* to take full advantage of skills-based routing. *A c*ontractor 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 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, contractors 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. Contractors 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. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

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. There are four places that CSRs shall refer callers with questions about coding.

1. Current Procedural Terminology (CPT) codes are proprietary to the American Medical Association (AMA). As such, CPT coding questions from providers (with exception noted in 4 below) shall be referred to the AMA. The AMA offers CPT Information Services (CPT-IS). This new 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. ICD-9-CM *and ICD-10-CM* related questions are handled by the American Hospital Association's Coding Clinic. Details about this resource are available at http://www.ahacentraloffice.org.

3. Level II Healthcare Common Procedure Coding System (HCPCS) codes related to *d*urable *m*edical *e*quipment 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. The American Hospital Association's Coding Clinic for HCPCS responds to questions related to CPT codes for hospital providers and Level II HCPCS codes, specifically A-codes for ambulance service and radiopharmaceuticals, C-codes, G-codes, J-codes, and Q-codes (except Q0136 through Q0181), for hospitals *and* physicians and other health professionals who bill Medicare. Details about this resource are available at http://www.ahacentraloffice.org/. Additional information can be found about these resources at: *http://www.cms.gov/Medicare/Coding/MedHCPCSGenInfo/index.html*.

30.2 - Provider Telephone Inquiries

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

CMS *uses* the General Services Administration's *Networx* for its telecommunications network. All inbound provider telephone service will be handled *by Networx* with the designated Network Service Provider (NSP). Therefore, contractors 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 *Networx.*

30.2.1 - General Inquiries Line

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

The provider toll-free numbers installed for *contractors'* general provider inquiry traffic *may also* be used for other *program area* applications (e.g., *appeals,* EDI, provider enrollment) *in accordance with a contractor's SOW. A contractor's PCC is held accountable to meeting standards and requirements, including those related to call handling and quality. If there are multiple queues coming in to a contractor's PCC (e.g., A/B, HH+H, 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. A contractor whose PCC absorbs additional program area applications is given the flexibility to configure the PCC in the most effective way to meet the standards and requirements of its SOW. Such a contractor 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. Contractors shall have the ability to report, and may be required to report, all applicable data (e.g., quality call monitoring, telephone inquiry tracking, and telephone inquiry reporting) for each queue.*

At a minimum, the general *inquiry* lines shall be used to handle questions related to billing, claims, eligibility, and payment. If contractors need new service for other Medicare applications currently being handled on the provider claims inquiry numbers, they shall follow the established process for adding additional toll-free numbers. CMS will consider all requests for additional toll-free numbers.

The general *inquiry lines* shall answer provider inquiries. Contractors may choose to require other parties without provider numbers, such as consultants, lawyers and manufacturers, to submit their inquiries in writing. *PCCs* may limit the number of inquiries discussed during one *tele*phone 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. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

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.) Contractors 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. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

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 contractors in their budget requests. However, contractors 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, contractors shall maintain records for all costs associated with providing telephone service to providers (e.g., costs for headsets) and shall provide this information upon request by CMS.

30.2.4 – Troubleshooting Problems

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

Contractors shall be responsible for monitoring 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. To monitor and report a problem, contractors shall follow these steps:

1. *Send an e-mail to the Service Reports mailbox at servicereports@cms.hhs.gov with a copy to the PNS contractor at pnstechsupport@flashpointis.com 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 before business hours that day or after business hours the night before.*
    - *A service interruption is defined as 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, or a total loss of service.*
    - *A major service interruption is defined as any incident lasting 2 or more hours and having the impact(s) described above. The e-mail shall summarize the problem and the steps taken to restore full service.*

    The contractor shall send at least one daily follow-up e-mail to the Service Reports mailbox by 3:00 p.m. Eastern Time providing a status until the problem has been resolved. At the time of resolution, the contractor shall send an e-mail of resolution to the Service Reports mailbox at servicereports@cms.hhs.gov.

2. Isolate the problem and determine whether it is caused by internal customer premise equipment or network service.

- Internal Problem - The contractor's local telecommunications personnel shall resolve, but report *as indicated above.*
- External or Network Service Problem – *The c*ontractor shall report the problem to the toll-free carrier and also report *it* to CMS *as indicated above.*

3. Involve personnel from the Provider Network Services (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. The PNS contractor can be contacted by sending an e-mail to pnstechsupport@flashpointis.com
4. *Use the toll-free carrier's online system to review documentation and track trouble tickets.*

See section 70.2.5 of this chapter for the PCID reporting requirements related to telecommunications service interruptions.

30.2.5 - Requesting Changes to Telephone Configurations

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

The ongoing management of the entire provider toll-free system requires a process for making changes, which may be initiated by either the contractor or CMS. All change requests associated with the toll-free network (e.g., adding or removing channels or T1s, office moves, routing changes) shall be processed through the PNS contractor. Any CMS-initiated changes (*e.g.,* 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 contractor 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 *tele*phone system (e.g., additional lines, trunk group reconfiguration). This information shall be sent to the *S*ervice *R*eports mailbox at servicereports@cms.hhs.gov. This information shall be gathered through the contractor'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.

Unless circumstances require immediate resolution, contractors shall make requests for changes to telephone configurations to CMS in a timely manner. Contractors 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. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

Contractors 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. Contractors adopting these alternate hours shall notify CMS by sending an e-mail to the *S*ervice *R*eports 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. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

Contractors shall report to CMS planned and unplanned closures of the PCC as required in the following paragraphs.

30.2.7.1 - Pre-Approved *PCC* Closures

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

The CMS allows contractors 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

Contractors shall notify CMS through PCID within 30 *calendar* days of the start of the contract year about all planned closures. Changes made to this schedule shall be updated in PCID within *2* weeks of the change. *PCCs* shall notify the provider community of planned closure*s* at least *2* weeks in advance of *a* closure.

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

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

Contractors shall request permission to close the *PCC* on days other than those pre-approved by CMS *by reporting the planned closures in PCID. Contractors shall report planned closures in PCID by the 10th of the month for the upcoming month. (See section 70.2.2 of this chapter.) Examples of such closures could be PCC training closures of more than 4 hours, corporate meetings, contract/system transitions, contractor holidays, etc.* If CMS approves *a* closure *of more than 4 hours for training,* the contractor shall *report the planned closure in PCID and shall* notify the provider community at least *2* weeks in advance of the closure.

30.2.7.3 – Emergency PCC Closures

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

There may be occasions when a PCC must close if circumstances create sufficiently adverse working conditions at the PCC (examples include lack of heat, air conditioning, or water). Contractors shall report such 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 was made during normal business hours or by 9:00 a.m. Eastern Time the next business day if the decision to close was made before business hours that day or after business hours the night before.

Contractors shall report emergency PCC closures in PCID. (See section 70.2.4 of this chapter.)

30.2.8 - Providing Busy Signals

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

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, and/or ACD/PBX accept the call by providing answer back supervision to *Networx-provided service* and then providing a busy signal to the caller and/or dropping the call. *C*ontractor*s* 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. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

Contractors shall provide a recorded message that provides the following information while callers 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 callers to call back when the *PCC* is less busy*;*
- Information the provider should have available before speaking with a CSR*; and*
- Educational information on issues identified by the contractor. (See *section* 20 *of this chapter*).

30.2.10 – *PCC* Staffing

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

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. 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. Contractors shall not disconnect a call prior to *2* minutes. Contractors shall, if possible, give prior notice to the caller that the CSR may disconnect if the CSR is placed on hold for *2* minutes *and shall politely advise the caller 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 callers 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 callers of the best time to call with all the required information at hand. In consideration of callers, when the PCC is contacted with the appropriate information more than once about the same transaction, contractors shall exercise discretion in assuring prompt completion of inquiries.

30.2.10.1 – CSR Equipment Requirements

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

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

- Online access to a computer terminal for each CSR *who requires online access to answer providers' questions (t*he computer terminal shall be physically located so that *the CSR* can research data without leaving *his or her desk/seat);*
- Access to the contractor's *provider education website;*
- Access to CMS'*s website; and*
- An outgoing line for callbacks.

30.2.10.2 – CSR Sign-in Policy

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

Contractors 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 contractor to contractor. 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); and

- The CSRs shall sign-off the telephone system at the end of their workday.

30.2.10.3 - CSR Identification to Callers

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

The CSRs shall identify themselves with at least a first name when answering a call. In order to provide a unique identity for each CSR for accountability purposes, where a number of CSRs have the same first name, it is suggested that the CSRs also use the initial of their surname. If the caller specifically requests that a CSR identify himself/herself, the CSR shall provide both first and last name. Where the personal safety of the CSR is an issue, or for other security reasons, *PCC* management shall permit the CSR to use an alias, such as an Operator ID or a telephone extension. This alias shall be known by the contractor and provided to CMS for remote monitoring purposes.

30.2.11 - Remote Monitoring Access

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

Contractors shall provide CMS with remote access to their incoming provider inquiries toll-free lines. CMS*'s* monitoring personnel shall have the capability 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. Whenever possible, CMS prefers to remotely monitor calls based upon next call in queue. This approach facilitates the monitoring process and increases the ability to monitor various CSRs. *The* CMS will take reasonable measures to ensure the security of this access (e.g., passwords will be controlled by one person.)

Contractors shall enter the instructions, access codes, and CSR IDs, when applicable, to remotely monitor their provider inquiry toll free lines in PCID. If the contractor monitoring system requires changes in its access codes or other parts of the instructions from what was previously submitted, the contractor shall enter the revised instructions or access codes in PCID at least 3 business days before the beginning of the affected month.

When requested to do so by CMS, contractors shall provide CMS with access to their monitoring systems, which will enable CMS to more effectively monitor contractors' calls. (See section 30.2.14 of this chapter for more information.)

30.2.12 – Contingency Plans

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

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 callers are made aware of the situation. This is intended to supplement the contractor's existing contingency plans. 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 at pnstechsupport@flashpointis.com. For all other telecommunications support requests, *PCCs* shall follow their normal procedures.

By the end of the *3rd* month of the contract year, *PCCs* shall submit to CMS their current written contingency plan describing how the Medicare provider telecommunications operations will be maintained or continued in the event of manmade or natural disasters. The plan shall cover, at a minimum, all items outlined in the Contingency Plan Checklist located at *http://www.cms.gov/Medicare/medicare-Contracting/FFSProvCustSvcGen/Contractor_Reporting.html*. The plan shall also contain a Compliance Matrix that identifies where each item in the checklist can be found in the contractor's plan. The plan may include arrangements with one or more other contractors to assist in telephone workload management during the time the *PCC* is unable to receive provider *tele*phone calls. Plans shall be submitted to the *S*ervice *R*eports mailbox at servicereports@cms.hhs.gov or via postal mail.

Contractors may choose to submit the portion of their contingency plan that deals with telecommunications developed in relation to the Centers for Medicare & Medicaid Services (CMS) Business Partners Systems Security Manual.

30.2.13 - Guidelines for High Quality Responses to Telephone Inquiries

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

Contractors must monitor, measure, and report the quality of service continuously by employing CMS's quality call monitoring (QCM) process. Contractors 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. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

Contractors shall have a monitoring program in place to ensure the quality of telephone *inquiry* responses. The monitoring program applies to contractors' general provider inquiry telephone numbers *which, if so indicated in a contractor's SOW, may include other program areas, such as EDI, provider enrollment, and appeals*.

As contractors are ultimately responsible for their responses to provider inquiries, contractors 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. Contractors 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 --* Quality Call Monitoring *(QCM)* Program Minimum Requirements

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

A contractor's monitoring program shall, at a minimum, follow the requirements and performance standards as set forth in the Quality Call Monitoring (QCM) program. *Contractors 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 each evaluation criteria can be found on the official QCM *S*coring *C*hart and Handbook. In addition, the contractor'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*; and*

12. The QCM Handbook is followed.

30.2.13.3 – Recording Calls

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

Contractors may record calls as part of their contract with CMS to ensure the quality of telephone inquiries. If a contractor 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 contractor 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 contractor shall then provide the appropriate address for written correspondence.

Contractors who record calls for QCM purposes 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. Contractors 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. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

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

Contractors 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 *section*10.*1 of this chapter.*)

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

- March 1;
- June 1;
- September 1; and,
- December 1.

These calls shall be actual provider inquiries responded to within the prior contract quarter. Rather than looking for perfect calls, CMS would prefer calls that generate discussion among the contractor 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. Calls may be submitted electronically or through postal mail. All calls submitted through e-mail shall have all *PII and* PHI removed from the call*s*. Regardless of the method of submission, all calls shall be submitted in the .wav format and shall be under 10MB per call. Contractors who encrypt their calls shall use the code contained in the PCID system as their encryption password.

E-mail submissions shall be sent to the QCM Scores mailbox at qcmscores@cms.hhs.gov. All postal submissions shall be mailed to the following address:

Centers for Medicare & Medicaid Services
7500 Security Boulevard
Mail Stop: C4-13-07
Attn: DCPC-QCM Calibration
Baltimore, MD 21244

Contractors shall conduct monthly internal calibration sessions. Contractors 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.

30.2.14 - CMS Monitoring

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

For monitoring purposes, contractors' telephone systems shall allow calls from CMS or CMS representatives to CSRs. These CMS callers will not have a provider number. CSRs shall respond to these calls as if they were calls from the provider community. CMS will provide contractors with feedback about results of monitoring and provide information about the evaluation process used through the PCUG *electronic mailing list* and monthly meetings.

As contractors are ultimately responsible for their responses to provider inquiries, contractors 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. Contractors shall document their monitoring efforts and corrective action plans, as applicable, and provide such information to CMS upon request.

Upon request, contractors shall provide CMS with remote access to their quality monitoring systems. CMS and the contractors will take reasonable measures, as necessary and appropriate, to ensure the security of

this access. This secured access will give CMS staff and CMS monitoring personnel increased capability to monitor provider calls for accuracy, completeness, and professionalism.

30.3 – Provider Written Inquiries

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

Contractors typically handle the following three types of written inquiries:

1. General--General written inquiries are those that are not forwarded to a specialized unit with its own CMS-mandated timeliness standards, such as MSP and *a*ppeals. General inquiries are subject to the performance standards in this section. Timeliness standards for *g*eneral inquiries are defined in *section* 60.3.2.1 *of this chapter*.

2. PRRS--PRRS inquiries are provider inquiries 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 *contractor* from the Beneficiary Contact Center (BCC). All PRRS inquiries are subject to the performance standards in this section. Timeliness standards for PRRS inquiries are defined in *sections* 60.3.2.2 and 60.3.2.3 *of this chapter*.

3. Congressional--Congressional inquiries are those that the contractor receives either directly from a Congressional office or are transferred to the contractor from either CMS *Central Office* or a CMS Regional Office. Congressional inquiries are subject to the performance standards in this section. Timeliness standards for Congressional inquiries are defined in *section* 60.3.2.4 *of this chapter*.

All written inquiries, including letters, faxes, and e-mails, shall be handled consistently for accuracy, professionalism and timeliness. Every inquiry shall receive a final response that accurately and completely addresses the issues contained in the incoming inquiry. For written inquiries received that could be handled by the IVR, such as claim status and eligibility, it is strongly suggested that contractors include language in the responses to those inquiries that the information being requested is available on the IVR. (*S*ee *section* 50.1 *of this chapter*.) Additionally, responses should include information about relevant training seminars or computer-based training on the contractor's provider education *website* if that is appropriate to the topic of the inquiry.

In cases where a duplicate inquiry is received, contractors shall verify, by telephone or letter, that the provider has received a response.

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

30.3.1 - Controlling Written Inquiries

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

Contractors shall control all general written inquiries until they are closed by the written inquiries unit. If an inquiry is transferred to another unit that has its own reporting system and timeliness standards, such as MSP and *a*ppeals, the inquiry shall be closed by the general written inquiries unit and responsibility for the inquiry shall be transferred to the unit to which the inquiry was referred. Documentation shall be kept in the provider inquiry tracking system to identify that the inquiry was referred and/or forwarded to another unit. *(See section 30.6 of this chapter.)*

If a contractor receives an inquiry or document from a provider and it is clear, upon review, that the inquiry or document should have been sent to a different contractor, the receiving contractor shall take one of the following two series of actions: (1) contact the provider and inform the provider that the inquiry/document was misdirected and is being forwarded to the correct contractor, inform the provider of the correct contractor name and mailing address (for the provider's possible future use), and forward the inquiry/document to the correct contractor; or (2) contact the provider and inform the provider that the inquiry/document was misdirected and is being returned to the provider, inform the provider of the correct

contractor name and mailing address, and return the inquiry or document to the provider. Contractors shall follow the stamping procedures described below upon receipt of these inquiries/documents and enter them into their control systems. Contractors shall not report these items to CROWD (in accordance with Pub. 100-06, Medicare Financial Management Manual, Chapter 6, section 20.4, item D – Miscellaneous Data – Inquiries). However, contractors shall enter these items into the inquiry tracking system described in section 30.6 of this chapter.

The contractor shall stamp the cover page of all written inquiries including letters, e-mails and faxes, and the top page of all attachments with the date of receipt in the corporate mailroom and control them until a final answer is sent. 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 the contractor'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.

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

30.3.2 - Written Inquiry Storage

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

Contractors shall allow CMS access to all written inquiries stored off site within 24 hours of notification to the contractor. All 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.

By the end of the first month of the contract year, contractors shall enter the physical address of where they store their provider written inquiries into PCID. This requirement only applies to those contractors who only maintain hard copy files. This requirement does not apply to contractors who maintain electronic versions of written inquiries. Any changes to this information shall be entered in PCID within 2 weeks of the change.

30.3.3 - Telephone Responses *to Written Inquiries*

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

Contractors may respond to general and PRRS written inquiries by *tele*phone within 45 business days *of receipt of the inquiry*. Contractors shall use their discretion when identifying which written inquiries (e.g., provider correspondence that represents simple questions) can be responded to by *tele*phone.

For tracking and evaluation purposes, the contractor shall develop a report of contact for each telephone response. 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 t*elephone number;
- Provider number;
- 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); and
- Name of the correspondent who handled the inquiry.

If the inquirer requests a copy of the report of contact, a response letter containing all the information in the "Summary of Discussion" *section of the report of contact* shall be sent. Contractors may send the information via e-mail or *fax*, if requested by the provider and the response does not contain any *PII or PHI.* 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 contractor cannot reach the provider by *tele*phone, the contractor shall develop a written response within 45 business days from *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 Written Inquiries*

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

In some cases, *written* inquiries can be responded to by e-mail or fax. Since both represent official correspondence with the public, it is paramount that contractors use sound e-mail and fax practices and proper etiquette when communicating electronically. Contractors shall ensure that e-mail and fax responses follow the same timeliness and quality guidelines that pertain to all written inquiries. Responses that contain financial *information, PII, or PHI* shall not be sent by e-mail or fax. If the response contains this information, it shall be mailed in hardcopy to the provider or a telephone response shall be used. *E-mail content, as well as attachments to e-mails, must be section 508 compliant. (See http://www.cms.gov/web/508/accessiblefiles/checklists.html for information about section 508 compliancy.)*

30.3.5 - Check Off Letters

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

Check-off letters are appropriate for routine inquiries like claim status or eligibility. 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 inquiries.

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

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

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

Written responses 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. Contractors 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, contractors shall use the CMS Writing Guide to assist in the preparation of written responses. 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 written inquiries, contractors may also use other resources (e.g., grammar guides) to supplement their writing process.

30.3.7 – Stock Language/Form Letters

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

Periodically CMS may request that contractors 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 form letters and/or stock language contain accuracy errors or other errors that affect the readability and/or meaning of the response, contractors 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 - Written *Response* Quality Monitoring Program

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

Contractors shall have a monitoring program in place to ensure the quality of written *responses to provider* inquiries. The monitoring program applies to contractors' *written responses to* general, Congressional, and PRRS *provider inquiries.* The standards shall not apply to those written *provider* inquiries handled by other units within the contractor.

As contractors are ultimately responsible for their responses to provider inquiries, contractors 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. Contractors 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 --* Quality Written *Correspondence* Monitoring *(QWCM)* Program Minimum Requirements

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

The contractor's 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, *S*coring *C*harts, 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 *S*coring *C*harts and Handbook. In addition, *a* contractor's *provider* written inquiries monitoring program shall ensure that:

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

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

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

4. Monitoring is done using the official QWCM scorecards and *S*coring *C*harts and recorded in the QWCM database. *S*eparate scorecards and scoring criteria are used to evaluate written and telephone responses *to providers' inquiries*.

5. 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.

6. Correspondent trainees and new correspondents are adequately monitored. However, scores for correspondent trainees will be excluded from QWCM performance for one 30-*business*-day period following the end of their formal classroom training.

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

8. Timely feedback is provided to correspondents.

9. PCC staff is properly educated about the program and its use; and all correspondents, reviewers, and supervisors have copies of the official QWCM scorecards, *S*coring *C*harts, Handbook, and Writing Guide.

10. The QWCM Handbook is followed.

30.3.8.2 – QWCM Calibration

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

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.*

Contractors 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, contractors 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; and,
- December 1.

The cases shall be actual provider written inquiries responded to within the prior 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. Contractors who submit their *cases* via an encrypted CD shall use the code contained in the PCID system as their encryption password.

All submissions shall be mailed to the following address:

Centers for Medicare & Medicaid Services
7500 Security Boulevard
Mail Stop: C4-13-07
Attn: DCPC – QWCM Calibration
Baltimore, MD 21244

Contractors shall conduct monthly internal calibration sessions. Contractors 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. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

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

A – Sending the Response

Generally, the contractor sends the original and the courtesy copy of the reply to the Washington office of the Member of Congress. However, if it is clear that the inquiry was sent from a home office, the contractor 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 contractor prepares a reply for each Member and encloses a courtesy copy with each. The contractor releases the replies to each Member of Congress at the same time.

The contractor 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 contractor 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 contractor 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 contractor 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 contractor addresses the reply to the constituent. The contractor 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 contractor prepares a courtesy copy for each congressional response if the congressional office has indicated by *tele*phone 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 contractor 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 contractor types:

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 contractor types: Enclosure

- On the copies, beginning at the same place (at the left margin), the contractor types:

Enclosures 2: Including constituent's inquiry

30.4 - Walk-In Inquiries

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

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

- Name of inquirer
- *Date and t*ime of arrival
- Time service was provided
- Name of the person handling the inquiry
- A statement indicating whether the inquiry was closed or is still pending

30.4.1 – Guidelines for Walk-In Service

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

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

- The inquirer 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)
- Contractors shall maintain a log or record of walk-in inquiries *handled* during the year

30.5 - Provider Relations Research Specialists (PRRS)

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

Contractors 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 contractor's telephone or written inquiries staff and/or require significant research. Therefore, contractors 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 contractor determines that general provider education on these specific topics would be practical and useful to the provider community and reduce inquiries. In addition, the PRRS shall also handle complex beneficiary inquiries that cannot be resolved by the BCC.

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

30.5.1 - Complex Provider Inquiries

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

Once an 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 contractor's resources (e.g., contractor *provider education website*, bulletins, medical review staff, contractor medical directors, claims processing staff), and CMS resources (e.g., Internet-Only Manual, contractor instructions, training packages, Medicare law*s* and regulations, the CMS *website*, MLN *products or content,* provider-specific *w*eb 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. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

*C*omplex 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. Once an inquiry is referred, the PRRS shall take ownership of the inquiry and be accountable for its resolution. While the PRRS is held accountable for the response, the contractor may use other resources to develop the response, as appropriate. *If a referral is made to a department that has its own separate control process and timeliness standards (e.g., appeals), PRRS may close the inquiry in NGD. PRRS will document reliable and accurate information into the resolution details field, including guidance on how the inquirer/beneficiary can contact the contractor regarding the nature of the case (e.g., checking the status, asking follow-up questions).* The contractor shall respond directly to the beneficiary via telephone, written mail*, fax,* or e-mail and document the response in NGD. (See *c*hapter 2, *section* 20.1.10 *of this manual* for NGD technical specifications). Complex inquiries from beneficiaries shall receive the same priority and attention as complex inquiries from providers. For Benefit Integrity Unit escalations, the contractor should consider the action complete and close the Complex Inquiry in NGD when the Benefit Integrity Unit referral is placed into the 2nd level screening work flow, and not when the 2nd level screening is complete.

The contractor shall have adequate language capabilities (English, Spanish, and TTY/TDD) to handle telephone communications with beneficiaries. Contractors shall not be required to install a separate TTY/TTD for complex beneficiary inquiries. The contractor shall obtain foreign language support service by contract for languages other than Spanish. Additionally, the contractor shall fog written responses for reading level (8th grade or less), in accordance with *c*hapter 2, *section* 20.2.1 *of this manual*.

The contractor shall provide feedback via the NGD to the BCC identifying inappropriate referrals (routine inquiries that *should* have been handled by the BCC) to the PRRS.

30.6 - Inquiry Tracking

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

The CMS requires contractors 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 http://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 contractor has multiple call center locations), all PCC triage levels, and all provider calls handled by the PCC, in accordance with a contractor's SOW.

A. Inquiry Tracking and Reporting System

Contractors 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 contractor (e.g., 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*; and
- 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 contractors 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 contractors' provider education websites.*
5. *Identification of areas or processes within the contractor's organization that may need follow-up.*

C. Tracking and Logging of Provider Inquiries

Contractors 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, contractors 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 written inquiries, contractors shall track multiple issues raised by a provider during a single call or in a single written inquiry.*
4. *Contractors 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.*

Contractors 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.) To report contractor-specific subcategories, contractors shall complete the Excel spreadsheet available in PCID documentation (see section 70.2.3.1.C of this chapter), which is due the same day the contractor enters its Inquiry Tracking Report in PCID.

D. Contractor-Specific Subcategories

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

1. *Contractors 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 contractor 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. *Contractors 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. *Contractors shall create contractor-specific subcategories for issues that are significant to their operations and represent a significant amount of inquiries related to a topic.*
4. *Contractors 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 contractor 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. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

Contractors 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. Contractors shall submit changes or comments related to the CMS Standardized Provider Inquiry Chart via the *P*rovider *S*ervices 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, and
- 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*" c*ategory" and the reporting period for those subcategories *in the "Temporary Issues" category* through separate instructions. Between updates, contractors may create and add contractor-specific temporary *subcategories* if their call volume requires them to do so.

30.7 - Fraud and Abuse

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

Contractors 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 (e.g., 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 contractor 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; and
12. Date the referral is forwarded to the PSC or ZPIC.

The contractor shall keep a record of the cost and workload associated *with* all provider inquiries of potential fraud and abuse that are referred to the PSC or ZPIC using Activity Code 13201/01 in the Beneficiary Inquiries function.

30.8 - Surveys

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

The CMS requires contractors 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.*

Contractors 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. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

The Medicare Modernization Act *requires* CMS to measure provider satisfaction with the performance of contractors. Contractors 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 contractors shall assist CMS in developing and implementing current and future provider satisfaction surveys.*

In accordance with CMS instructions, contractors shall:

1. *Provide current data for the MSI. Contractor-provided data shall be used to:*
   a. *Determine if a provider is enrolled in the Medicare program.*
   b. *Provide CMS with updated provider contact lists including, but not limited to: provider names, National Provider Identifiers (NPIs), Provider Transaction Access Numbers (PTANs), business mailing and practice location addresses, business telephone numbers, business e-mail addresses, State associated with the NPI, and provider types.*
   c. *Address non-response bias in the survey (e.g., claims volume/workload, practice size, number of beneficiaries served) as requested by CMS.*
2. *Perform ongoing marketing and outreach for the MSI. Contractors shall support CMS in communicating information about the MSI to providers by:*

a. *Disseminating information about the survey on electronic mailing lists (listservs), standard paper remittance advice (SPR) notices, newsletters, bulletins, and other provider communications channels;*
b. *Posting information about the MSI on provider education websites, provider Internet 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 at conferences, webinars, workshops, events, and meetings;*
d. *Encouraging POE AG members and partners (e.g., State associations) to distribute information to their members about the MSI; and*
e. *Posting information about improvements made within the past year of operations in response to MSI feedback and reports including, but not limited to, areas where changes were implemented.*

3. *Appoint a maximum of three MSI points of contact for each jurisdiction. These people will serve as liaisons on MSI activities between CMS and the contractor. Following the administration of the MSI, these contacts will also have access to a secure website with their contractor's survey results.*
   a. *Contractors 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. *Contractors shall inform CMS of any changes to the MSI 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 contractor-provider interaction, the MSI, and any other related MSI activities that will enhance CMS's ability to measure provider satisfaction with contractors. Arrangements for conference calls will be made in advance by CMS.*
5. *Create a Plan of Action based on the MSI survey results. The Plan of Action shall include areas in which the contractor will concentrate on improving, steps that will be taken to increase customer satisfaction, and timeframes for implementing the changes. The Plan of Action shall be submitted to the COR and e-mailed to MSI@cms.hhs.gov within 60 calendar days of receiving the results of the survey.*

30.8.2 – Telephone Satisfaction Survey

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

In the past, CMS *had* established call center telephone satisfaction surveys at several *contractors' PCCs.* These surveys evaluate*d provider* satisfaction with *CSRs* and/or IVR units. 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 PCC telephone satisfaction surveys. Should CMS decide to reinstitute these surveys, contractors would be notified in advance and would be required to participate in them in accordance with instructions from CMS that would be issued at that time.

30.8.3 – *Provider Education* Web*site* Satisfaction Survey

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

Medicare providers and their staffs are increasingly using contractors' *provider education websites* 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 this 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 approximately 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, contractors shall participate in the *website s*atisfaction *s*urveys. Participation includes, but is not limited to:

- Meeting with CMS and Fore*S*ee to implement *and manage the website satisfaction survey and analyze the results;*
- Developing contractor-specific questions for the web*site satisfaction* survey*;*
- Adding code supplied by Fore*S*ee to the contractor's *provider education website and any functioning web portal pages;*
- Reviewing survey results on a regular basis*; and*
- Improving the contractor's *provider education website* based on *website satisfaction* survey results.

40 - PCSP Staff Development and Education

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

Contractors shall be fully responsible for the education, development, evaluation, and management of PCSP staff. This shall be accomplished by contractors providing initial and ongoing education and training of all PCSP staff. In addition, contractors 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. Contractors 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. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

Contractors 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. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

Contractors shall provide training for all new PCC hires 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. Contractors shall have a training evaluation process in place for new hire*s* 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. Contractors shall consider data sources such as inquiry analysis, quality scores, direct and remote 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 of the PCC.

Contractors 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 contractor'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. Upon receipt of CMS developed standardized training materials, contractors shall implement these materials for all CSRs and correspondents on duty and those hired in the future. Since the development of these materials will be done by CMS, there will not be any costs to the contractors to use these training materials. Standardized training materials and other training information will be posted at *http://www.cms.gov/Medicare/Medicare-Contracting/FFSProvCustSvcGen/Contractor-Resources.html.* Contractors 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

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

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

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

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

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

5. Contractors shall train CSRs and correspondents 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 contractor. *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.*

Contractors shall train CSRs and correspondents 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.*

40.2.2 - *PCC* Training Program

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

To help contractors provide ongoing training for their CSRs and correspondents, on Federal holidays, in lieu of answering telephone inquiries, *contractors may choose to close their PCCs* to provide CSR training. In addition, PCCs may close 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)* for CSR training and/or staff development. The goal is to help 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 CSRs and correspondents is highly recommended. Contractors 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 contractor closes its PCC for training, the requirements in sections 40.2.2 – 40.2.2.7 and section 70.2.3.2 of this chapter apply.

The PCCs shall adhere to the following guidelines when closing for training on days other than Federal holidays:

- The 8 hours per month shall be used for training only;
- The 8 hours per month shall not be used for corporate meetings;
- Contractors shall assume approval of closures unless they receive notification to the contrary; and
- Training time not used within a specific month shall not be carried over to the next month.

40.2.2.1 - Closure Determination

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

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

40.2.2.2 - Provider Complaints

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

Contractors shall monitor provider complaints about 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 - Training Schedule

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

Contractors shall enter information about their *PCC* training closures*, including CMS-approved training closures of more than 4 hours,* in PCID for each PCC that serves a particular *jurisdiction*. By the *10th* of the month, contractors shall report their planned training closure dates and times for the upcoming month and their training information for the prior month, in accordance with *section* 70.2.*3.2*. If a contractor chooses not to close for training during a particular month, the contractor shall send an e-mail to the Provider Services mailbox at providerservices@cms.hhs.gov indicating that *it is* not closing during business hours to conduct CSR training. *(Refer to section 40.2.2.5 of this chapter for provider notification requirements of training closures and changes to training closures.)*

40.2.2.4 - Training Closures of More Than Four Hours

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

Contractors shall assume approval of *training* closures of 4 hours or less unless they receive notification to the contrary.

For *a* training *closure* of more than 4 hours on the same day, *a* contractor shall request CMS approval in advance of the training closure date *by reporting the planned training closure in PCID. (See section 30.2.7.2 of this chapter.)* CMS will provide *a* one-time authorization for *a* training closure request of more than 4 hours *on the same day*. CMS will evaluate this type of *request* on a case-by-case basis and authorize it under special circumstances within 1 week *after the PCID reporting deadline of the 10th of the month prior to the month of the planned closure. (See section 30.2.7.2 of this chapter.) If a contractor does not receive a response from CMS within the 1-week time period described, the contractor may close for training under the assumption that its request was approved.*

Once a training closure request of more than 4 hours on the same day has been approved by CMS, the contractor shall report the planned closure in PCID. (See section 40.2.2.3 of this chapter.)

In instances where changes to previously *reported* training *closures of more than 4 hours on the same day* are necessary, contractors shall submit requests for *those* changes to the *P*rovider *S*ervices mailbox at providerservices@cms.hhs.gov using the subject line "Change of One Time Approval Request." A *new* CMS approval is required to proceed with *changes to these types of previously reported training closures.* Changes shall be submitted to CMS within a reasonable time to allow provider notification.

40.2.2.5 - Provider Notifications

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

Contractors shall notify providers about their closure time for training. At a minimum, contractors shall post a closure notification for providers on their IVR and *their provider education website.* Contractors with separate lines for IVR and CSRs shall post a closure notification for providers on both lines. Additional instructions regarding IVR posting are in *section* 50.1 of this chapter. Contractors shall use their *electronic mailing list(s)* to notify their provider community of their closure times the first time they close their site for training. Contractors shall also use their *electronic mailing list(s)* to notify providers of a CMS-authorized one-time only training closure or a training closure out of the contractor's regular training schedule.

Contractors shall notify providers of all training closures or changes in their training closure schedule at least *2* weeks in advance of the training date. For training of more than *4* hours approved by CMS, contractors shall notify providers at least *3* weeks in advance of training closures.

40.2.2.6 - CSR and Correspondent Feedback

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

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

40.2.2.7 - Training *Closure* Information Reporting

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

Contractors shall report the following about their training closures:

- The number of hours per month that the contractor closed for training during normal business hours
- The number of hours per month used for training on Federal holidays

Contractors who did not close for training during the month should enter a zero in these fields *in PCID.* For more details about *reporting training closure data in PCID,* please refer to *section 70.2.3.2 of this chapter.*

Copies of CMS's written approval, training schedule, training plan, and training materials, as well as CSR attendance sheets, shall be made available upon request.

40.3 - PRRS Staff Training

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

Education and training opportunities shall provide PRRS staff with the knowledge and tools to enable them to answer the full range of complex beneficiary and 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 contractor's provider education website, regulations, laws, and other information tools to accurately and completely respond to complex provider and beneficiary inquiries.

50 - Provider Self-Service (PSS) Technology

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

Contractors shall use self-service and electronic communication technologies as efficient, cost-effective means of disseminating Medicare provider information, education, and assistance. As such, contractors 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 contractor's provider education website and IVR.

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 contractor staff. Contractors shall offer a variety of self-service options to providers including, but not limited to:

1. IVRs 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 contractor); and
6. Internet technology for the transmission of and/or receipt of health care transactions, if approved by CMS. (See the "MAC Internet-based Provider Portal Handbook" located at http://www.cms.gov/Medicare/Medicare-Contracting/FFSprovCustSvcGen/downloads/Portal-handbook.pdf).

Contractors shall expand the use of their self-service options and offerings, as appropriate, and shall periodically 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 System (IVR)

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

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

1. Contractor 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.)

3. General Medicare program information. (Contractors shall target individual message duration to be under 30 seconds. Contractors 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 contractor shall use its own discretion.)

4. Specific information about claims in process and claims completed. *(*For claims status inquiries handled in the IVR, all *PCCs* shall adhere to the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule by authenticating callers 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.)*

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

6. Routine eligibility information. *(*Eligibility inquiries handled in the IVR shall adhere to the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule by authenticating callers 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 IVRs to access claim status and beneficiary eligibility information. CSRs shall refer providers back to the IVR if they have questions about claims status or eligibility that can be handled by the IVR. CSRs may provide claims status and/or eligibility information if it is clear that the provider cannot access the information through the IVR because the IVR is not functioning. IVRs shall be updated to address provider needs as determined through the contractors' PCSP inquiry analysis at least once every *6* months.

The IVR 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 and system maintenance. When information is not available, contractors shall post a message alerting providers on the IVR.

Contractors shall print and distribute a clear IVR operating guide to providers upon request. The guide shall also be posted on the contractor's *provider education website*. As IVR functionality changes, the operating guide shall be updated timely and the revisions posted to the *provider education website*.

50.2 - Provider *Education Website*

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

Contractors 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.

Contractors shall consider the use of their *provider education website* for every educational offering they provide to Medicare providers, including approaches such as *w*eb-based conferencing and trainings and computer-based training. However, contractors shall have solutions in place for providers who lack Internet access, such as hosting sites for *w*eb- 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, and the MLN Button on the provider education website.)

50.2.1 – General Requirements

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

The information contained on the contractor'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 user*s have* to go through in order to gain access to the information they are seeking.

To reduce costs, the contractor shall use existing resources and technologies whenever possible. *Contractors 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. Contractors 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

To maintain the quality of the*ir provider education web*site, contractors shall periodically ensure that information posted is current and does not duplicate information posted at *http://www.cms.gov/* and http://www.medicare.gov/. *Contractors 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*).*

50.2.2 – Webmaster and Attestation Requirements

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

Contractors shall assign a Webmaster responsible for maintaining and updating relevant portions of the contractor'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.)*

Contractors shall periodically review the CMS Contractor *Website* Guidelines to determine their continued compliance. By the end of the *6th* month of their contract year, contractors shall send two statements from their Webmaster attesting that their *provider education website* complies with:

- CMS Contractor *Website* Guidelines
- Requirements stated in Pub. 100-*0*4, *Medicare Claims Processing Manual, c*hapter 23*, section* 20.7 regarding the use of Current Procedural Terminology (CPT)[1] codes and descriptions

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

Contractors shall submit their statements using the appropriate MAC *D*eliverables mailbox.

[1] Current Procedural Terminology © 2005 American Medical Association.

50.2.3 – Feedback Mechanism

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

Each contractor 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 contractor 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 contractor's provider inquiry workload.

Within *its* feedback mechanism*, a* contractor shall provide information about how providers can offer comments to CMS about *the contractor's* performance in dealing with providers. *Each contractor* shall provide the *e-mail address of the resource mailbox at the CMS regional office that has jurisdiction over the contractor. 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. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

Each contractor'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* contractor*'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*);

4. A schedule of upcoming provider education *and outreach activities* (e.g., seminars, workshops, fairs);

5. Ability to register for contractor-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 web*site *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 contractor, 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 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; and*

16. *MLN products or content, MLN electronic mailing list links and sign-up instructions, and the MLN Button as described in section 20.4 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 MLN at *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html*.

3. The site*s* 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*.

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

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

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

7. CMS'*s* central provider *web* page at *http://www.cms.gov/Center/Provider-Type/All-Fee-For-Service-Providers-Center.html*.

8. CMS'*s* Physician Quality Reporting Initiative *web* page at *http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html*.

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

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

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

12. *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. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

Contractors shall receive *from CMS, via electronic mailing list messages, information for providers and instructions on how to disseminate the information to providers. (This section is not applicable to MLN Matters® Articles or Special Edition MLN Matters® Articles that CMS sends to contractors.) The instructions from CMS may require contractors to disseminate the information via their electronic mailing*

list(s), to include the information in their provider bulletins or newsletters, and/or to post the information on their provider education website. Generally, this information consists of the link to the weekly MLN Connects™ Provider eNews and stand-alone messages, such as special editions of the MLN Connects™ Provider eNews or messages that CMS creates separately from the weekly or special editions of the MLN Connects™ Provider eNews. Each week, when sending the link to the MLN Connects™ Provider eNews to providers and when distributing and posting the link, contractors shall use the embedded redirect link that is sent to contractors by CMS in that week's electronic mailing list message.

1. *Timeliness*
    a. *Unless specifically directed otherwise, contractors shall post the information from CMS on their provider education website and distribute the information to providers via their electronic mailing list(s) within 2 business days after the date CMS sent the instructions and information to the contractors, and shall include the information in their next regularly scheduled bulletin or newsletter.*
    b. *Information that is urgent or of a time-sensitive nature will be identified as such by CMS and contractors shall distribute and post the information by close of business the next business day after the date CMS sent the instructions and information to the contractors.*
2. *Distribution and Posting*
    a. *Contractors shall send messages that CMS identifies as urgent without editing or supplementing, when directed by CMS. These messages are infrequent and may sometimes be sensitive.*
    b. *Unless otherwise specified by CMS, contractors are only required to distribute and post information that is relevant to their jurisdiction's line of business (i.e., A/B, HH+H, or DME).*
    c. *When distributing information from CMS to providers via their electronic mailing list(s), contractors shall easily differentiate for providers the information generated by CMS from other information that contractors send to providers 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, contractors shall make it clear that the information is from CMS. To avoid possibly confusing the providers, contractors 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 contractors.*
    d. *Occasionally, some information from CMS is related to a Technical Direction Letter (TDL). When explicitly stated to do so in a TDL, contractors 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, contractors shall not reference a TDL number.*
    e. *The information shall remain on the provider education website for 2 months or until the bulletins or newsletters in which it is appearing are put on the provider education website, whichever is later.*
    f. *If the information has been revised, contractors shall ensure that the information posted on the provider education website represents the most current information from CMS. Revised information shall be posted within 2 business days after the electronic mailing list notification about the revision is sent.*
    g. *Contractors shall ensure that CMS information posted on their provider education website represents the most current information from CMS. Contractors shall remove the outdated information after receiving revised information from CMS. If there is an accompanying Change Request (CR) and it has been cancelled, contractors shall i remove the information from their provider education website no later than close of business the next business day after the date CMS cancelled the CR.*

50.2.4.2 – *Frequently Asked Questions (*FAQs*)*

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

All contractors 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 contractor*s'* FAQs must be updated for accuracy and relevance at least quarterly and the date *an* FAQ was last reviewed must be noted on the *provider education website*. *Contractors* shall develop local FAQs based upon *their* data analyses described in *section* 20.*3 of this chapter*. At a minimum, *each* contractor 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. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

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. Contractors 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. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

Contractors 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. Contractors 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. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

Contractors 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 contractor's *provider education website* shall be part of, or made available at, all contractor *POE* workshops and seminars, training sessions with individual providers, and all other provider education *activities* a contractor *arranges* or *in which it participates.* Contractors shall determine if the*ir* PCC may also be an effective way to promote the contractor's provider education *website*.

50.3 - Electronic Mailing List *(*Listserv*)*

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

Contractors 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, i.e., from contractors to subscribers.

1. *Subscribe/Unsubscribe*

   Providers shall be able to subscribe to electronic mailing list(s) via their contractor's provider education website. Subscribers to the electronic mailing list*(s)* shall also be able to unsubscribe via the *contractor's provider education website.* Notices shall be published on the *provider education*

website and in bulletins/newsletters that encourage subscription to the electronic mailing lists. Subscriptions to the *electronic mailing list(s)* shall also be promoted by the *contractor's* PCC. Contractors' electronic mailing lists shall be capable of accommodating all of the providers *a contractor* serves.

2. *Protection of Electronic Mailing Lists*

Contractors shall protect electronic mailing list(s) addresses from unauthorized access or inappropriate usage. Electronic mailing lists, 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 contractor shall first obtain express written permission from its *COR*.

3. *Electronic Mailing List Records*

Contractors shall maintain records of *the usage of* their electronic mailing *list(s)*. These records shall include when the electronic mailing list(s) were used, *the* text of the messages sent, the number of subscribers *to whom messages were sent (per message),* and the author*s* of the message*s*. Records shall be kept for *1* year from the date of usage.

50.3.1 - Targeted Electronic Mailing Lists *(*Listservs*)*

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

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. Contractors 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. *Contractors may combine the 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. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

The contractors 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 (e.g., bulletins, workshops, education events, *POE AG* meetings, ACT*s*, *PCC*, and written materials.) *The Medicare Learning Network® electronic mailing lists shall also be marketed and promoted. (See section 20.4 of this chapter.) Contractors 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). Contractors shall also coordinate internally with other areas to encourage electronic mailing list subscription.*

50.4 – Social Media

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

Contractors may, at their discretion, use social media in their PCSP. Contractors 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. Contractors who use social media shall send their quarterly reports to the Provider Services mailbox at providerservices@cms.hhs.gov. If a contractor who is not currently using social media later begins to use it, that contractor shall begin reporting social media usage

in the report that is submitted in the first calendar quarter after the usage begins. Example: If a contractor begins using social media in May, it would report the usage in the next quarterly report.

50.5 – Contractor Internet-based Provider Portals
(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

Upon CMS approval, contractors may develop provider portals that offer Internet-based transactions. Contractors who are interested in creating or modifying existing portals shall follow the guidelines outlined in the "MAC Internet-based Provider Portal Handbook" located at http://www.cms.gov/Medicare/Medicare-Contracting/FFSProvCustSvcGen/downloads/Portal-handbook.pdf.

60 - PCSP Performance Management
(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

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. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

At 1 year after the date a contract was awarded, the number of subscribers to a contractor'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 contractor, the number of subscribers would be the combined total subscribed to its A/B and HH+H electronic mailing lists. This requirement does not apply to the subscribers of a contractor's targeted mailing list(s) as described in section 50.3.1 of this chapter. A contractor who is awarded the same 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, *contractors 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 contractors' electronic mailing lists to continue to* increase. As such, *contractors* shall increase the *number of subscribers by 2 percent per contract year, with the ultimate goal of having all of the providers in the jurisdiction subscribe.*

60.2 – Telephone *Standards*
(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

Each contractor'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. As mentioned in section 30.2.1 of this chapter, PCC toll-free numbers installed for general provider inquiry traffic may also be used for other program area applications in accordance with a contractor's SOW. Consequently, and as explained in section 30.2.1 of this chapter, all calls handled by a contractor's PCC contribute to that contractor's success or failure in meeting the standards described in this section.

60.2.1 – *Customer Service Representative (CSR) Callback Rate*
(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

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

Contractors 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. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

- 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 9*5* percent. This standard *is* measured quarterly and *is* cumulative for the quarter.

60.2.3 – Call Acknowledgment

***(Rev.* 18, Issued: 09-08-06, Effective: 10-01-06, Implementation: 10-02-06)**

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

60.2.4 – Average Speed of Answer (ASA)

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

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. Contractors 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. *Contractors shall maintain an ASA of 60 seconds or less.* This standard *is* measured quarterly and *is* cumulative for the quarter.

Contractors shall send an e-mail to the Service Reports mailbox at servicereports@cms.hhs.gov by 1 p.m. Eastern Time if the ASA on the PCC line(s) is higher than the applicable quarterly standard for the previous day, unless the previous day was a Friday or a holiday. In those cases, the e-mail shall be sent by 1 p.m. Eastern Time the next business day. The e-mail shall address any telecommunications issues that are contributing to the elevated ASA. The e-mails shall be sent with the subject line "ASA."

60.2.5 – Callbacks

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

Contractors shall make *three* attempts to reach a provider for a callback. The contractor 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)* should be left on the message. If the provider does not respond after *three* callbacks, the contractor has the discretion to prepare a written response, completed within 10 business days of *receipt of the* original inquiry. The contractor shall not close out the inquiry without any type of response to the caller. Contractors shall not leave the responses on provider voicemails. 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 contractor has informed the provider that the inquiry was escalated to a different unit within the contractor*

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. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

Contractors 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 *93* 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 *93* 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 *93* percent for Knowledge Skills. This standard *is* measured quarterly and *is* cumulative for the quarter.

60.3 – Written Inquiries

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

Contractors shall evaluate the responses to general 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. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

*Currently, c*ontractors 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 calls monitored is questioned. Contractors shall meet the following standards:

- For all provider responses monitored for the quarter, the percent scoring as "Pass" shall be no less than *93* percent for Adherence to the Privacy Act. This standard *is* measured quarterly and *is* cumulative for the quarter.

- For all provider responses monitored for the quarter, the percent scoring as "Achieves Expectations" or higher shall be no less than *93* percent for Customer Skills. This standard *is* measured quarterly and *is* cumulative for the quarter.

- For all provider responses monitored for the quarter, the percent scoring as "*Achieves Expectations*" *or higher* shall be no less than *93* percent for Knowledge Skills. This standard *is* measured quarterly and *is* cumulative for the quarter.

60.3.2 – Written Inquiries Timeliness

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

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 contractor was open for business every day during the reporting period. Days where the contractor is closed for business shall not count as business days.

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

60.3.2.1 - General Inquiries Timeliness

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

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 contractor and ends the day the contractor sends the final response. For those general inquiries that cannot be answered in final within 45 business days *of receipt*, contractors 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 contractor's overall allowance of no more than 5 percent of interim responses for the universe of written inquiries.

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

If the contractor is responsible for handling both Part A and Part B claims, inquiries requiring response from both of these areas share the same time frame for response (i.e., the 45-business-day period starts on the same day for both responses). Therefore, the contractor shall ensure that the inquiry is provided to both responding units as quickly as possible. The response to these inquiries may be combined or separate, depending on which procedure is most efficient for the contractor's conditions. If a contractor responds separately, each response shall refer to the fact that the other area of inquiry will be responded to separately.

60.3.2.2 - PRRS Timeliness – *Complex* Provider Inquiries

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

The PRRS staff shall provide clear and accurate answers 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 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 contractor and ends the day the contractor sends the final response. For those PRRS inquiries that cannot be answered in final within 45 business days *of receipt*, contractors 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 contractor's overall allowance of no more than 5 percent of interim responses for the universe of written inquiries.

60.3.2.3 - PRRS Timeliness - Complex Beneficiary Inquiries

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

PRRS staff shall provide clear and accurate responses within 25 business days *of receipt* for at least 75 percent of *beneficiary inquiries* referred by the BCC or the CMS *Regional Offices,* and *within* 45 business days *of receipt* for 100 percent of all *inquiries*.

This timeframe begins the day the inquiry is originally received in the NGD and ends the day the contractor sends the final response. For Benefit Integrity Unit escalations, the contractor should consider the action complete and close the Complex Inquiry in NGD when the Benefit Integrity Unit referral is placed into the 2nd level screening work flow, and not when the 2nd level screening is complete.

For those complex beneficiary inquiries that cannot be answered in final within 45 business days *of receipt*, contractors shall issue an interim response acknowledging receipt of the inquiry and explaining the reason for the delay. When possible, inform the beneficiary 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 for complex beneficiary inquiries will count toward the contractor's overall allowance of no more than 5 percent of interim responses for the universe of written inquiries. Responses to complex beneficiary inquiries shall be documented in the NGD.

60.3.2.4 - Congressional Inquiries Timeliness

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

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 contractor and ends the day the contractor sends the final response. For those Congressional inquiries that cannot be answered in final within 10 business days *of receipt*, contractors shall issue an interim response within 10 business days *of receipt* explaining the reason for the delay*, including indicating how the inquirer can contact the contractor 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 contractor's overall allowance of no more than 5 percent of interim responses for the universe of written inquiries.

70 - PCSP Data Reporting

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

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.

70.1 - Provider Inquiries Evaluation System (PIES)

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

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.

Contractors 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. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

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 (*i.e., A/B, HH+H, DME*). Contractors may assign the same person to more than one contract type. To request access to PIES, send the following information to the PIES mailbox at pie-system@cms.hhs.gov:

- Name
- *Telep*hone number
- E-mail address
- Contract (*i.e., A/B, HH+H, DME*)

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

70.1.2 - Due Date for Data Submission

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

Each *PCC* shall enter required *PCC* data elements into PIES between the 1st and 10th of each month for the prior month. CMS understands that data on the number of callbacks closed within 10 *business* days may not be available by the 10th of the month. Not having *these* data shall not prevent the *PCC* from entering all other available data into PIES in a timely manner. The *PCC* shall supply the missing data to CMS within *2* business days after it becomes available to the contractor.

After the 10th of the month, the data entry capability will no longer be available to the contractors. After the 10th of the month, the data will be considered late and the data will need to be entered into PIES by CMS staff. Also, if the contractor entered data timely but, after the 10th of the month, determined that the data needed to be changed, the contractor will not be able to change the data; the changed data will need to be entered by CMS staff. Contractors shall inform CMS of the data to be entered into PIES or, if data already entered needs to be changed, shall inform CMS of the data to be changed, the reason(s) for the change(s), and highlight the fields that are to be changed. This information shall be submitted to PIES at pie-system@cms.hhs.gov.

70.1.3 - Data to *b*e Reported Monthly

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

- Telephone inquiries data: Contractors shall capture and report *in PIES* the data elements appropriate for their contractor profile (i.e., CSR- and IVR-only lines or a combined CSR/IVR line).

- Written inquiries data: Contractors 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: Contractors 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. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

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

Contractors 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. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

The PCID 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 contractor to no more than two people per contract (*i.e., A/B, HH+H, DME*). Contractors may assign the same person to more than one contract type. To request access to PCID, send the following information to the PCID mailbox at p-cid@cms.hhs.gov:

- Name
- *Telep*hone number
- E-mail address
- Contract (*i.e., A/B, HH+H, DME*)

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

70.2.2 - Contract Data to *b*e Reported in PCID

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

Contractors shall be responsible for entering and maintaining the following data elements in PCID:

- Number of Active Providers Served *(see section 20.4.1 of this chapter for the definition of "active" provider)*
- Remote Monitoring Procedures
- IVR Information
- Contractor Mailing Address
- Contractor *Provider Education Website* Address
- Number of *Electronic Mailing List* Subscribers
- Location of Written Inquiries
- Emergency Contact Information
- Contractor Closures
- Contractor Points of Contact
  - PCSP Program Manager
  - POE Contact (Primary)

- *PCC* Contacts

Contractors shall populate the required data elements within 60 *calendar* days after *contract* award *or, i*f the data *are* not available at that time, within 7 calendar days after *the data become* available. Changes/updates to any of the data *described above, with the exception of the Number of Active Providers Served,* shall be made within 14 calendar days of the change. *Contractors shall report any changes/updates to the Number of Active Providers Served annually, within 14 calendar days after the beginning of each contract year.* In addition, contractors shall review the data in the system *(excluding the Number of Active Providers Served, as explained above)* at least monthly to determine if updates are necessary. Updates shall be entered *in PCID* by the 10th of the month for the prior month.

70.2.3 – *Other Data to be Reported in PCID*

(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

Contractors shall report in PCID the data described below in sections 70.2.3.1 – 70.2.3.5 of this chapter on a monthly basis by the 10th of the month for the previous month's data. After the 10th of the month, the data entry capability will no longer be available to the contractors. After the 10th of the month, any missing data will be considered late and the data will need to be entered into PCID by CMS staff. Also, if the contractor entered data timely but, after the 10th of the month, determined that the data needed to be changed, the contractor will not be able to change the data; the data will need to be changed by CMS staff. At that time, contractors shall inform CMS of the data to be entered into PCID or, if data that were already entered need to be changed, shall inform CMS of the changes to the data and the reason(s) for the change(s), and highlight the fields 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. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

A. Inquiry Tracking Monthly Report

Contractors shall report their monthly telephone and written inquiry tracking information in PCID within 10 calendar days after the end of the month for the previous month's data. Because the inquiry tracking reports are considered a formal Deliverable, contractors shall send a note to their respective Deliverables mailboxes after they submit their inquiry tracking data to PCID. This is to inform the COR that the required data have been submitted to CMS.

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

B. Reporting "Not Classified" Inquiries

PCID does not allow contractors 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 contractors 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

Contractors may also create contractor-specific subcategories for inclusion under every category (except "General Information"). Contractors 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. Currently, there is no place in the system for contractors to provide the definitions for these contractor-specific categories. (See section 30.6.D of this chapter.) For this reason, contractors who enter data in these fields shall, on a monthly basis and on the same day the contractor enters its inquiry tracking report in PCID, complete the Excel spreadsheet available from the PCID "Documentation" link,

and submit it to the Provider Services mailbox at providerservices@cms.hhs.gov with the subject line "Contractor-Specific Subcategories Report." A PDF version of the "Contractor-Specific Subcategories Report" is also available at http://www.cms.gov/Medicare/Medicare-Contracting/FFSProvCustSvcGen/Program-Support.html.

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

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. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

Contractors shall report the following PCC training closure information in PCID by the 10th of the month for training closures in the upcoming month and for training closures that occurred in the previous month:

- *Dates and times the PCC will be closed for CSR training during the upcoming month;*
- *Topics and subtopics of CSR training that occurred in the prior month; and,*
- *Categories and subcategories (from the Standardized Provider Inquiry Tracking Chart) that correspond to the CSR training that occurred in the prior month.*

For example, by July 10, contractors shall report planned training dates and times for the month of August. At the same time, contractors shall submit training topics and subtopics, and standardized provider inquiry categories and subcategories for training that occurred for the month of June.

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

70.2.3.3 – POE Data to be Reported in PCID
(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

Contractors shall enter POE event and self-paced education data in PCID by 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.

Contractors 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 (A/B MACs only) -- Part A, Part B, both Part A and Part 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) to which the POE event was offered (i.e., 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 (A/B MACs only) -- Part A, Part B, both Part A and Part 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 (i.e., is inactive)*
- *Topic(s)/Subtopic(s) – The topic(s)/subtopic(s) the self-paced education was designed to cover*

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

70.2.3.4 – Provider Electronic Mailing List (Listserv) Subscriber Data to be Reported in PCID
(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

Contractors shall be responsible for entering and maintaining provider electronic mailing list subscriber data in PCID by the 10th of the month for the previous month's data. To the extent possible, contractors shall report the number of unique (non-duplicated) subscribers. This reporting requirement does not apply to contractors' targeted mailing lists that are described in section 50.3.1 of this chapter.

If a contractor has more than one electronic mailing list, it shall combine the number of subscribers to both and report the total. However, HH+H contractors shall separately report the subscribers to their A/B and HH+H electronic mailing lists; these reportings shall not be combined.

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

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

70.2.3.5 – Special Initiatives to be Reported in PCID
(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

Contractors shall report their special initiatives to PCID by the 10th of the month for the previous month's data. Special initiatives may include direct mailings, electronic mailing list messages, POE events, website postings, and/or IVR messages.

70.2.4 – Emergency PCC Closure Data to be Reported in PCID
(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

Emergency PCC closures (see section 30.2.7.3 of this chapter) shall be reported to PCID by the 10th of the month for emergency PCC closures that occurred in the previous month. Reporting emergency PCC closures is not required for months in which there were no such closures.

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

70.2.5 – Telecommunications Service Interruptions to be Reported in PCID
(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

All telecommunications service interruptions (Verizon-related and in-house) shall be reported to PCID by the 10th of the month following the month in which the interruption occurred. Reporting service interruptions in PCID is not required for months in which there were no service 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 are as follows:

- *Date the service interruption occurred;*
- *Time of day (local time) the service interruption occurred;*
- *Date and time (local time) the service was restored;*
- *Program affected (A/B MACs only) -- Part A, Part B, both Part A and Part B, HH+H*
- *Impacted line(s) -- IVR-only, CSR-only, IVR and CSR, combined IVR/CSR*
- *Impacted location -- The PCC call center location impacted*
- *Source -- Internal or external problem*
- *Overview/Description -- A description of the problem*
- *Resolution -- How the interruption was resolved*

70.3 – QCM Data Reporting
(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

Contractors shall complete scorecards and enter data into the QCM database by the 10th of the month for the previous month's data. (See section 30.2.13 of this chapter for additional information.)

70.4 – QWCM Data Reporting
(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

Contractors shall complete scorecards and enter data into the QWCM database by the 10th of the month for the previous month's data. (See section 30.3.6 of this chapter for additional information.)

70.5 – Reporting Provider and Beneficiary Inquiry Workload Data in the Contractor Reporting of Operational Workload Data (CROWD)
(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

Contractors shall report to CROWD beneficiary and provider inquiry workload data relating to the volume of beneficiary or provider inquiries that were processed during the reporting month. See Pub. 100-06, Medicare Financial Management Manual, chapter 6, for information about CROWD.

80 - Disclosure of Information
(Rev. 28; Issued: 5-2-14; Effective: 7-2-14; Implementation: 7-2-14)

Contractors shall protect the confidentiality of Medicare beneficiary personally-identifiable information (PII) and protected health information (PHI) in accordance with the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act of 1996. To ensure compliance, contractors 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.