CMS Manual System

Pub 100-09 Medicare Contractor Beneficiary and Provider Communications

Transmittal 14

Department of Health & Human Services (DHHS)

Centers for Medicare & Medicaid Services (CMS)

Date: OCTOBER 14, 2005

Change Request 4048

SUBJECT: Provider Inquiry Reporting Standardization

I. SUMMARY OF CHANGES: Instructions for all contractors to report and track the nature of their inquiry types (reason of the calls) for telephone and written inquiries using the CMS Standardized Provider Inquiry Chart.

NEW/REVISED MATERIAL
EFFECTIVE DATE: January 01, 2006
IMPLEMENTATION DATE: January 03, 2006

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
N	3 / 20.5 / Provider Inquiry Reporting Standardization

III. FUNDING:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2006 operating budgets.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

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

Attachment - Business Requirements

Pub. 100-09	Transmittal: 14	Date: October 14, 2005	Change Request 4048

SUBJECT: Provider Inquiry Reporting Standardization

I. GENERAL INFORMATION

A. Background: CMS developed a Standardized Provider Inquiry Chart. This chart provides common inquiry categories and definitions for contractors to use when tracking and reporting on provider inquiries.

B. Policy: CMS requires all contractors to track and report the nature of their inquiry types (reason of the calls) for telephone and written inquiries.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4048.1	Contractors shall track and report the nature of their telephone and written inquiries (reason of their calls) using categories and subcategories listed according to definitions provided in the CMS Standardized Provider Inquiry Chart.	X	X	X	X					
4048.2	Contractors should log additional levels of inquiry types to assist in identification of provider education or CSR training needs.	X	X	X	X					
4048.3	Contractors shall track multiple issues raised by a provider during a single call or in a piece of written correspondence.	X	X	X	X					
4048.4	Contractors shall use categories and subcategories in the chart for inquiries reported to CMS, such as in the Quarterly Activity Report.	X	X	X	X					

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4048.5	Contractors' staff working with telephone and written inquiries shall be trained to log their inquiry types according to CMS Standardized Provider Inquiry Chart in the tracking system used by the contractor.	X	X	X	X					
4048.6	Contractors shall recommend changes to CMS Standardized Provider Inquiry Chart, including modifications to existing categories and subcategories and new inquiry categories and subcategories.	X	X	X	X					
4048.6.1	Contractors shall submit changes or comments related to the CMS Standardized Provider Inquiry Chart via the Provider Services mailbox, ProviderServices@cms.hhs.gov.	X	X	X	X					
4048.6.2	When submitting changes to the CMS Standardized Provider Inquiry Chart, contractors shall include 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.	X	X	X	X					

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	None.									

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions:

X-Ref Requirement #	Instructions
	N/A

B. Design Considerations:

X-Ref Requirement #	Recommendation for Medicare System Requirements
	N/A

C. Interfaces:

X-Ref Requirement #	Recommendation for Medicare System Requirements
	N/A

D. Contractor Financial Reporting /Workload Impact: N\A

E. Dependencies: N\A

F. Testing Considerations: N\A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: January 1, 2006 **Implementation Date:** January 3, 2006 **Pre-Implementation Contact(s):** **Lisandra** Torres Guzman 410)786-3415 **Post-Implementation Contact(s):** Lisandra Torres Guzman (410)786-3415	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.**

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

Medicare Contractor Beneficiary and Provider Communications Manual

Chapter 3 - Provider Customer Services

(Rev. 14, 10-14-05)

20.5 Provider Inquiry Reporting Standardization

(Rev. 14, Issued: 10-14-05; Effective date: 01-01-06; Implementation date: 01-03-06)

CMS requires all contractors to track and report the nature of their inquiry types (reason of the calls) for telephone and written inquiries using categories and subcategories listed according to definitions provided in the CMS Standardized Provider Inquiry Chart (Exhibit 2).

These categories are to be used to capture the reason for the inquiry, not the action taken. Contractors may use an additional level of detail, if necessary, to assist in identification of provider education or CSR training needs. However, inquiries reported to CMS, such as in the Quarterly Activity Report, must use categories and subcategories in the chart.

For all provider general telephone and written inquiries, contractors shall track multiple issues raised by a provider during a single call or in a piece of written correspondence.

A. Required Training

Contractors' staff working with telephone and written inquiries shall be trained to log their inquiry types according to CMS Standardized Provider Inquiry Chart in the tracking system used by the contractor.

B. Updates to Chart

Contractors shall recommend changes to CMS Standardized Provider Inquiry Chart, including modifications to existing categories and subcategories and new inquiry categories and subcategories. Contractors shall submit changes or comments related to the CMS Standardized Provider Inquiry Chart via the Provider Services mailbox, 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 on a quarterly basis, as needed. CMS will define categories to be tracked under the "Temporary Issues Category" and the reporting period for those subcategories through separate instructions.

Exhibit 2

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
Adjustments	Changing the information on a submitted claim to correct an error or the correction of a claim denied in error.	Cancellation of Claim/Return Claim/Billed in Error	Contact is asking to cancel a claim that was submitted in error. Includes "services not rendered."
		Claim Processing Error	Contact is asking for an adjustment of an incorrect payment due to a processing error by the local or shared systems, imaging errors, interest not paid or penalties applied in error.
		Claim Information Change	Contact is asking for change or correction of information on a submitted/processed claim; for example, contact asks to add or remove modifiers or procedure codes to correct the amount of units provided, etc.
		Medical Review	Contact is asking about corrections/changes in diagnosis/treatment on processed claim.
		MSP	Contact is asking about the adjustment process for changes in the beneficiary MSP or HMO record.
Administrative Billing Issues	The mechanism and processes of how to bill for Medicare Services, which includes the explanation of CMS instructions, procedures and decision-making criteria for claim review and payment decisions. This does not include an explanation of why a particular claim was denied.	1500/UB-92 Form	Contact is asking how to complete the claim form and/or where to find it, including an electronic equivalent of both 1500 and UB92 Forms.
		Advance Beneficiary Notice (ABN)	Contact is asking for general information on ABN, for example, When is it appropriate to use an ABN?, What do I have to do with an ABN?
		Claims Related Reports	Contact is asking for information about accessing and/or receiving reports produced by Medicare regarding to billing trends, history of Medicare payments, comparative billing reports, medical review reports, etc.
		Claim Documentation	Contact is asking what information is necessary to submit with a claim to allow processing and/or adjudication of the claim, for example, medical record, progress notes, physicians orders, x-rays, etc.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		Coinsurance	*Contact is asking for the amount of coinsurance and/or deductible that a beneficiary must pay before Medicare begins to pay for covered services and supplies. This subcategory applies to inquiries at a general level. Use "Deductible" subcategory under "Eligibility" for inquiries on annual deductible for a specific beneficiary.*
		Fraud and Abuse	*Contact is reporting a fraud and abuse allegedly done by a Medicare provider. This subcategory also includes providers calling for guidelines to assure compliance of Medicare rules and regulations against fraudulent and abusive practices.*
		Filing/Billing Instructions	*Contact is asking for instructions on filing a claim, type of bill necessary for a type of claim, how to correct a claim (adjust a claim), mandatory submission of claims, and time filing limits. Includes inquiries on "How to meet the 72 hr rule for dx services".*
		HPSA/PSA	*Contact is asking for information about Health Professional Shortage Area (HPSA) and/or Physician Scarcity Area (PSA) classification. This subcategory includes questions such as how to bill based on location class as urban vs. rural area, the use of appropriate modifiers and the amount of bonus payment applicable to them.*
Allowed Amount	*The amount that Medicare will pay for a certain procedure code according to the Medicare payment systems, fee schedules and locality rates applicable.*	*Ambulance Fee Schedule*	*Contact is asking for the Ambulance Fee Schedule payment amount for a particular item or service provided to a Medicare beneficiary.*
		Ambulatory Surgical Center	*Contact is asking for the Ambulatory Surgical Centers payment amount for a particular item or service provided to a Medicare beneficiary.*
		Anesthesia Fee Schedule	*Contact is asking for the Anesthesia Fee Schedule payment amount for a particular item or service provided to a Medicare beneficiary.*
		Critical Access Hospitals	*Contact is asking for the Critical Access Hospitals payment amount for a particular item or service provided to a Medicare beneficiary.*
		Clinical Lab Fee Schedule	*Contact is asking for the Clinical Laboratory Fee Schedule payment amount for a particular item or service provided to a Medicare beneficiary.*

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		Drug Average Sales Price (ASP) Resource	*Contact is asking about the Medicare Part B Drug Average Sales Price Resource payment amounts. This extensive listing of drugs is a guide. It may not include all drugs that could be considered for payment by Medicare.*
		ESRD Composite Rate	*Contact is asking for the ESRD Composite Rate payment amount for a particular item or service provided to a Medicare beneficiary.*
		Home Health PPS	*Contact is asking for the Home Health PPS payment amount for a particular item or service provided to a Medicare beneficiary.*
		Hospital Inpatient PPS	*Contact is asking for the Hospital Inpatient PPS payment amount for a particular item or service provided to a Medicare beneficiary.*
		Hospital Outpatient PPS	*Contact is asking for the Hospital Outpatient PPS payment amount for a particular item or service provided to a Medicare beneficiary.*
		Hospice Payment System	*Contact is asking for the Hospice Payment System payment amount for a particular item or service provided to a Medicare beneficiary.*
		Long Term Care Hospital PPS	*Contact is asking for the Long Term Care Hospital PPS payment amount for a particular item or service provided to a Medicare beneficiary.*
		Physician Fee Schedule	*Contact is asking for the Physician Fee Schedule payment amount for a particular item or service provided to a Medicare beneficiary.*
		DMEPOS Fee Schedule	*Contact is asking for the DMEPOS Fee Schedule payment amount for a particular item or service provided to a Medicare beneficiary.*
		Psychiatric Hospital PPS	*Contact is asking for the Psychiatric Hospital PPS payment amount for a particular item or service provided to a Medicare beneficiary.*
		Rehabilitation Hospital PPS	*Contact is asking for the Rehabilitation Hospital PPS payment amount for a particular item or service provided to a Medicare beneficiary.*
		Skilled Nursing Facility PPS	*Contact is asking for the Skilled Nursing Facility PPS payment amount for a particular item or service provided to a Medicare beneficiary.*

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
Appeals	Action initiated by the provider due to disagreement on a Medicare's claim determination.	Process/Rights	Contact is asking for general appeal information, appeal process instructions and/or appeal rights.
		Status/Explanation/Resolution	Contact is asking the status of the appeal. This involves whether an appeal has been received and/or whether the time to file an appeal has expired, an explanation of Medicare's determination with respect to the submitted appeal and requests for duplicates of Medicare Redetermination Notices (MRN).
		Qualified Independent Contractor (QIC) Contractor	Contact is asking about an appeal status or information related to appeals reviewed by the QIC.
Claim Denials	Claim that has been fully adjudicated and a non-payment determination has been made based on Medicare rules and regulations.	ABN	Contact is asking for clarification on a particular claim denial where the use of ABN applies and the patient is not required to pay the provider for a service.
		Claim Overlap	Contact is asking about claim(s) denied due to an overlap in service dates with a previously processed claim. This may include the denial of a Part B claim for physical therapy services that conflicted with a previously processed inpatient claim with overlapping dates of service.
		Coding Errors/Modifiers	Contact is asking about a claim(s) denied due to an invalid or incorrect code. Includes the absence or incorrect use of a modifier and global surgery denials.
		Contractor Processing Errors	Contact is asking about a claim(s) denied due to a contractor error (incorrect edit, shared systems issue, etc.), when processing the claim.
		Contractual Obligation Not Met	Contact is asking about a claim(s) denied because the provider did not comply with their Medicare contractual obligation (for example, the claim was submitted with missing information, the claim was not filed timely, etc).
		CWF Rejects	Contact is asking about a claim(s) denied because information on the claim does not match the CWF beneficiary information (for example, discharge status, name mismatch, female patient with a male procedure claimed). Log under this sub-category CWF issues that need to be corrected through SSA because the provider submitted correct information on the claim and CWF file needs to be updated. Please note that "frequency limit" issues identified by CWF should be categorized under "frequency limitation" (See below).

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		Denial Letter Request	*Contact is asking for a copy of the Medicare denial letter, establishing the reason for non payment of services in order to bill another insurer.*
		DME POS Issues	*Contact is asking about a claim(s) denied due to equipment, item or service not received by a beneficiary or returned to a supplier and other maintenance/services issues. Also, includes inquiries related to invalid CMNs.*
		Duplicate	*Contact is asking about a claim(s) denied due to same date of service, claim previously processed or paid for the same date and same provider.*
		Eligibility	*Contact is asking about a claim(s) denied due to incorrect patient information submitted by the provider that does not agree with CWF (for example, incorrect suffix, transposed numbers) and affects the patient's eligibility for Medicare Benefits. Log under this sub-category, issues were there is no need to update information on CWF files.*
		Evaluation & Management Services	*Contact is asking about a claim(s) where payment was denied or reduced due to a changed E&M code. E&M codes explain how the physician gathered and analyzed patient information, determined a condition and advised the best treatment. Includes services such as: office visits, hospital visits, consultation visits, and care plan oversight.*
		Frequency Limitation	*Contact is asking about a claim(s) that was denied because the allowable number of incidences for that service in a given time period has been exceeded or for a service that was previously billed. Also, includes inquiries related to billing frequency limits for durable medical equipment and supplies such as Capped Rental.*
		LCD	*Contact is asking about a claim(s) that was denied or reduced based on a local coverage determination (LCD) by the contractor. Coverage determinations reflect the local contractor decision as to whether a product, service, or device is reasonable and necessary.*
		Life Time Days Met	*Contact is asking about claim(s) denied because a particular benefit is disallowed for a Medicare beneficiary due to the lifetime days limit exhausted.*

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		Medical Necessity	*Contact is asking about a claim(s) denied because the information presented did not indicate services or supplies are reasonable and necessary for the diagnosis and treatment of the illness or injury.*
		MSP	*Contact is asking about a claim(s) denied due to other insurance existing on the beneficiary file that is primary to Medicare.*
		NCD	*Contact is asking about a claim(s) that was denied or reduced based on a national coverage determination (NCD) by CMS. Coverage determinations reflect national Medicare coverage policies governing specific medical service, procedure or device.*
		Statutory Exclusion	*Contact is asking about a claim(s) that items or services were denied by law.*
Claim Status	*Information about where the claim is in the process and whether it has been paid. Routine claim status questions are to be referred to the IVR.*	*Additional Development Request (ADR) Letters*	*Contact is asking about a Medicare letter received from the contractor that requests more information or documentation to process pending claim(s). Contact may also be providing a response to a written request.*
		Applied to Deductible	*Contact is asking about a processed claim where payment was not generated because the payment amount was applied to the beneficiary's annual deductible amount.*
		ATP Amount/Check Information	*Contact is asking for current Approved to Pay (ATP) amount, current pending claims totals and/or payment information on a claim (i.e., status of check, check number, check amount and issued date).*
		Crossover	*Contact is asking for information on a claim that is covered by a supplemental insurer, such as Medigap or other private insurance.*
		Not on File	*Contact is asking for a claim that Medicare does not have on file or that has not been received by the contractor.*
		Paid in Error	*Contact is asking about a claim that they believe was paid in error.*
		Payment Explanation/Calculation	*Contact is asking for explanation on how the claim was paid or how the payment amount was calculated. Includes "reimbursement" questions.*
		Suspended	*Contact is asking about the status of a claim that is pending while waiting for information needed to complete processing.*

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
Coding	*Any set of codes used to encode data elements, such as tables of terms, medical concepts, medical diagnostic codes or medical procedure codes. Includes the codes, their descriptions, and how to use them.*	*CCI Edits*	*Contact is asking about Correct Coding Initiative edits that identify types of inappropriate coding combinations, such as comprehensive and component code combinations and code combinations of services or procedures that could not be performed together.*
		Condition Codes	*Contact is asking about billing codes that indicate whether the claimant meets a condition of the service.*
		Procedure Codes	*Contact is asking about the numeric representation of a procedure code used to determine reimbursement for services rendered on a claim or for other medical documentation. Includes CPT-4 codes, which belong to the American Medical Association and indicate physician services, physical and occupational therapy services, radiology procedures, clinical laboratory tests, medical diagnostic services, and hearing and vision services. Also, includes HCPCS Codes Level II that determines reimbursement for equipment and medical supplies.*
		Diagnosis codes	*Contact is asking about the numeric representation of a disease, injury, impairment, or other health problem that providers must use to report the diagnosis for each service and /or item they provide.*
		Evaluation & Management Codes (E&M)	*Contact is asking about codes that explain how the physician gathered and analyzed patient information, determined a condition, and advised the best treatment. Examples are: care plan oversight, office visits, hospital visits and consultations. E&M codes are a part of the AMA's CPT-4 coding system.*
		Modifiers	*Contact is asking about two digit codes used in conjunction with a procedure code that provides additional information about the service. The modifier may affect the reimbursement rate of a service.*
		MSP Payer/Value Codes	*Contact is asking about codes used to designate that another insurer is responsible for full or partial payment where Medicare has no payment or secondary payment responsibility.*

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		Revenue Codes	*Contact is asking about codes that identify specific accommodations or ancillary charges that are provided in a hospital, (e.g., blood, cardiology, radiology, laboratory services, etc.*
		Patient Status Codes	*Contact is asking about codes that indicate the patient's status as of the "Through" date of the billing period. These codes reflect the destination of the patient not the service received at the ending date. Includes also inquiries related to source of admission codes and discharge status codes.*
		Place of Service Codes	*Contact is asking about codes on professional claims to identify where the service was rendered.*
		Specialty Codes	*Contact is asking about codes used on a claim form to indicate a provider's type or medical specialty.*
Complaints	*An expression of dissatisfaction with service from providers in regards to different aspects of the Medicare operation.*	*Contact Center Closure*	*Contact is expressing dissatisfaction due to hours of operation or call center closures for CSR training.*
		Medicare Contractor Operation	*Contact is expressing dissatisfaction due to contractor operational errors, procedures, policies, processes, and staff issues not addressed by other subcategories included in this section.*
		Medicare Program	*Contact is expressing dissatisfaction due to issues with the Medicare program. Includes provider expressions of intentions of leaving the Medicare program.*
		Provider Education and Outreach	*Contact is expressing dissatisfaction with educational activities, education staff performance or availability of educational resources or activities for Medicare providers.*
		Self Service Technology	*Contact is expressing dissatisfaction due to content, functionality, instability, formatting and processes related to Provider Self Service tools such as CMS or contractor website, online tools for eligibility inquiries or claim submissions, IVR, etc.*
		Staff	*Contact is expressing dissatisfaction due to CSR or Staff attitude, incorrect information given or non response to an inquiry.*

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
Direct Data Entry (DDE)	The Direct Data Entry system is an on-line application that allows direct on-line access to Medicare claims, such as: claim entry, error correction, eligibility inquiry, claims status, claim adjustment and roster billing.	Connectivity/Installment/Processing Issues	Contact is requesting assistance with the connection, installment, password resets, claim processing and adjustments through DDE.
		Orientation Package	Contact is requesting information or an orientation package related to DDE.
Electronic Data Interchange (EDI)	The system for submitting claims electronically and retrieving Electronic Remittance Advices.	Connectivity/Installment Issues	Contact is requesting assistance with the connection, installment and password resets through EDI.
		Front End or Vendor Editing	Contact is requesting information or assistance with errors in the transmission or status of claims submitted electronically.
		Information package/HIPAA Compliant Billing Software	Contact is requesting information or an orientation package related to EDI.
Eligibility/Entitlement	The qualification of an individual to receive Medicare, including various qualifying aspects of Medicare coverage (as described in the associated subcategories). If multiple sub-categories are discussed in the same inquiry, log main category for tracking purposes.	Beneficiary Demographic	Contact is asking to verify or update (within the contractor's ability) beneficiary personal information, such as HIC number, address, date of birth, date of death, etc.
		Benefit Days Available	Contact is asking for the number of days in a hospital or SNF that remain available for the beneficiary.
		Deductible	Contact is asking if the beneficiary's annual deductible amount has been met so that Medicare payment for providers' services or supplies can begin.
		HMO Record	Contact is asking whether the beneficiary is enrolled in an HMO, when HMO enrollment began, or for HMO contacts information.
		Hospice	Contact is asking if beneficiary has a hospice record open.
		MSP Record	Contact is asking for information related to other insurance coverage that the beneficiary might have that is primary to Medicare.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		Next Eligible Date	*Contact is asking when is the next eligible date for the beneficiary to receive one or more preventive services.*
		Part A Entitlement	*Contact is asking when the beneficiary became eligible for Part A benefits.*
		Part B Entitlement	*Contact is asking when the beneficiary became eligible for Part B benefits or whether the beneficiary is eligible for Part B benefits.*
Financial Information	*The financial responsibility of providers and/or Medicare. These types of inquiries normally involve the information that comes from the contractor's financial department or requests that are processed by the contractor's financial department.*	*Check Copies*	*Contact is requesting a copy of a check.*
		Cost Report	*Contact is asking about the annual report that institutional providers are required to submit in order to make proper determination of amounts payable under the Medicare program; for example, How do I submit a cost report? What supporting documents are needed for an acceptable cost report? Have you received my cost report?*
		Credit Balance/Account Receivable	*Contact is asking about a credit balance that is due to Medicare. A credit balance is an improper or excess payment made to a provider as the result of patient billing or claims processing errors. Examples of Medicare credit balances instances are: 1) Paid twice for the same service either by Medicare or another insurer; 2) Paid for services planned but not performed or for non-covered services; 3) Overpaid because of errors made in calculating beneficiary deductible and/or coinsurance amounts; or 4) A hospital that bills and is paid for outpatient services included in a beneficiary's inpatient claim. Also, includes inquiries to confirm if a payment was applied to an open receivable.*
		Do Not Forward (DNF) Initiative	*Contact is requesting information about CMS initiative that entails the use of "Return Service Requested" envelopes to preclude the forwarding of Medicare checks and remittance advices to locations other than those recorded on the Medicare provider files, and the provider is not receiving its checks.*

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		Electronic Fund Transfer	*Contact is asking about electronic transfer of Medicare payments directly to a provider's financial institution.*
		Offsets	*Contact is asking the reason that payment was withheld or for an explanation of the Financial Control Number (FCN#) that appeared on the Remittance Advice.*
		Overpayment	*Contact is asking about the notice that they have received due to Medicare funds in excess of amounts that are due and payable to them under the Medicare statute and regulation. The amount of the overpayment is a debt owed to the U.S. Government.*
		Refunds	*Contact is asking about a refund, such as, its status, notifying Medicare that a refund is needed, or asking about the process to request it.*
		Stop Payment / Check to Be Reissued	*Contact is requesting a stop payment, reissuance a check, asking how to request it or verifying the status of a previous request. Also, includes check reissue inquiries due to stale dated checks and checks sent to wrong provider.*
General Information	*Information that cannot be included in other categories.*	*Address /Phone/Fax/Web Address*	*Contact is asking for contractor's addresses including website, fax and phone numbers.*
		Issue Not Identified/Incomplete Information Provided	*Contact failed to explain the reason for the inquiry, or omitted a HIC number or provider number. This sub-category may apply to written correspondence only.*
		Misrouted Telephone Call/Written Correspondence	*Contact is asking a question that should be handled in another contractor area, by another contractor and or by another agency/program.*
		Reference Resources Referral/Request	*Contact is asking where to find or access information about specific topics or requesting information about resources available for provider education or self service options, such as, MEDPARD directory, online claim status availability, electronic remittance advice, IVR, etc.*
		Other Issues	*Contact is discussing subjects that are not classifiable into the defined categories or subcategories.*
HIPAA Privacy/ Privacy Act	*The statutory authorities that govern the protections for personally identifiable patient health information and the conditions of its release.*	*Authorizations*	*Contact is asking for a consent/authorization form or a copy of their patient's authorization, which is necessary to release the information requested.*
		Release of Information Request	*Contact is requesting a copy of patient history or record.*

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		Requirements	*Contact is asking about the HIPAA Privacy or Privacy Act requirements. Also, includes inquiries related to HIPAA contingency plans and the compliance with HIPPA transaction rules.*
MSP	*The term used when Medicare is not responsible for paying primary on a claim that is otherwise the primary responsibility of another payer.*	*COB/MSP Rules*	*Contact is asking about Coordination of Benefits Rules and/or Medicare Secondary Payer Rules.*
		Coordination of Benefits (COB) Contractor	*Contact is asking about the COB contractor responsibilities and contact information. Includes situations that require a referral to the COB contractor.*
		File Updates	*Contact is asking for beneficiary MSP/COB files information or providing information for MSP/COB file update.*
		Liens and Liabilities/Settlements	*Contact is asking about requesting or accepting a Medicare conditional payment, for services that would otherwise be covered under Workers Compensation, No Fault Insurance, Liability and Group Health Plans (GHP). Also, includes questions about settlement information and the status of a conditional payment.*
Policy/ Coverage Rules	*Includes inquiries related to policy questions, coverage rules and benefits information.*	*Benefits/Exclusions/ Coverage Criteria/Rules*	*Contact is asking for clarification of rules and criteria used by Medicare to cover and pay for services furnished to Medicare beneficiaries by Medicare providers.*
		Certifications Requirements	*Contact is asking about requirements, electronic submissions and/or status, when applicable, of certifications for Medicare Benefits. This may include Hospice certifications and/or Certificate of Medical Necessity.*
		Local Coverage Determination (LCD)	*Contact is asking about a local coverage policy developed by the Medicare contractor to describe the circumstances for Medicare coverage for a specific medical service, procedure or device within their jurisdiction.*
		National Coverage Determination (NCD)	*Contact is asking about a national coverage policy developed by the Centers for Medicare & Medicaid Services to describe the circumstances for Medicare coverage for a specific medical service, procedure or device.*
		Non-published Items	*Contact is asking about the coverage of items with no criteria published by contractor or CMS.*
		Pre-authorization	*Contact is asking about or requesting a pre-authorization for providing Medicare benefits.*

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		Statutes and Regulations	*Contact is asking about the Federal law and regulations that govern the Medicare Program and its operation.*
Provider Enrollment	*The forms and process by which an individual, institution or organization becomes a provider in the Medicare program, eligible to bill for their services.*	*National Provider Identifier*	*Contact is asking about the National Provider Identifier (NPI).*
		Provider Demographic Information Changes	*Contact is asking for verification of their provider demographic information or asking how to request a change/correction of its existing information.*
		Provider Eligibility	*Contact is asking about his or her status as a Medicare Program participant or not participant provider, and how to change it. Also, includes inquiries related to a provider alert/sanction status period.*
		Provider Enrollment Requirements	*Contact is asking about the requirements to become a participating provider of the Medicare Program. Also, includes inquiries from a provider not certified by Medicare, overview/orientation of the Provider Enrollment Forms (CMS 855 Form), where to find it and/or instructions on how to complete it.*
Provider Outreach	*The contractor's educational effort and activities with the provider community.*	*Education Referrals*	*Contact is requesting contact/visit from Professional Relations Staff to provide supplemental education, discuss an issue in-depth, or to request clarification of a confusing situation.*
		Workshop Information	*Contact is asking for information about provider outreach activities or educational opportunities for providers and their staff.*
Remittance Advice (Remit)	*The paper or electronic summary statement for providers, including payment information for one or more beneficiaries.*	*Duplicate Remittance Notice*	*Contact is asking for a duplicate remittance notice. Includes inquiries where provider did not received his/her remittance notice, needs to send it to the patient's second insurance, needs a single line or a no pay remittance notice.*
		ERA Election	*Contact is asking for information about how to access and/or receive remittance notices electronically.*
		How to read RA	*Contact is asking for assistance in reviewing and/or understanding their remittance notice. Includes explanation of the Claim Adjustment Reason Codes and Remittance Advice Remark Codes on the Remittance Notice.*

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
RTP/Unprocessable Claim	A claim(s) with incomplete, invalid, or missing information will be returned to the provider as unprocessable. This action cannot be appealed and the corrected claim(s) needs to be submitted as a new claim. Includes "W Status of Claim" and status of claims to be returned to provider.	1500 / UB-92 Form Item	Contact is asking about a claim(s) that was returned because the CMS claim form was not completed with the required information, such as, missing or invalid HICN, name, date of birth or sex. Includes the explanation of narrative of reason codes in the contractor's claims correction file, claims processing system and reports.
		Clinical Laboratory Improvement Act (CLIA)	Contact is asking about a claim(s) that was returned because the claim had a missing or incorrect CLIA number.
		Contractor Error	Contact is asking about a claim(s) that was returned to provider as unprocessable due to a contractor error.
		Contractual Obligation Not Met	Contact is asking about a claim(s) rejected because the provider did not comply with his or her Medicare contractual obligation. For example, the claim was presented with missing information (other than codes or modifiers), the billing was not timely, etc.
		Shared Systems	Contact is asking about a claim(s) that was returned because the patient information on the claim does not match information on CMS's shared systems (FISS, MCS, VMS and CWF).
		Missing/Invalid Codes	Contact is asking about a claim(s) that was returned because of a missing or invalid or changed code. Includes "Invalid CPT" inquiries.
		Place of Service	Contact is asking about a claim(s) that was returned due to invalid place of service or the place of service was not related to the procedure.
		Provider Information	Contact is asking about a claim(s) that was returned due to an incorrect or missing UPIN/NPI.
		Submitted to Incorrect Program	Contact is asking about a claim(s) that was returned because it was submitted to the incorrect program (FI, Carrier or DMERC).
		Truncated Diagnosis	Contact is asking about a claim(s) that was returned due to incorrect, invalid or missing diagnosis information.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
Systems Issues	*Medicare electronic systems, including the Medicare Claims Processing Systems and/or customer self-service applications (I.e. CMS website, contractor website, IVR, etc).*	*Medicare Claims Processing System Issues*	*Contact is presenting situation related to issues with the Medicare Processing Systems; for example, issues due to an aged claim, recycling claim and release of claims, etc.*
		Website Issues	*Contact is reporting problems with the functionality, stability or use of the CMS and contractor website.*
		IVR Issues	*Contact is reporting problems with the functionality or use of the contractor's IVR.*
Temporary Issues	*Includes inquiries that CMS would like to track temporarily due to special circumstances. CMS will provide specific timeframes for the monitoring of temporary issues. For contractor specific temporary issues, please follow instructions on IOM 100-9, Chapter 3, Section 20.5.*	*Part D Drug Coverage*	*Contact is presenting situation related to issues with the implementation of the Part D Medicare Prescription Drug Coverage.*
		CERT	*Contact is asking information related to the Comprehensive Error Rate Testing (CERT) Program.*