CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-09 Medicare Contract Beneficiary and Provider Communications	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 21	**Date: JANUARY 11, 2008**
	Change Request 5848

Subject: Instructions Related to the CMS Standardized Provider Inquiry Chart for FY 2008

I. SUMMARY OF CHANGES: Instructions on some of the most frequent issues identified in FY 2007 to improve the accuracy of data reported by Medicare Provider Contact Centers and to improve the overall reporting of the reasons of provider inquiries. In addition, this instruction incorporates some minor changes that affect the contractors monthly reporting in the Customer Service Assessment and Management System (CSAMS). CMS is removing from CSAMS, the reporting of the following metrics: the QCM Number of CSRs Available for Monitoring, the QCM Number of Completed Scorecards, QCM Trainee CSRs Available for Monitoring, QCM Customer Skills Assessment, QCM Knowledge Skills Assessment and QCM Privacy Act.

New / Revised Material
Effective Date: October 1, 2007
Implementation Date: February 11, 2008

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

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

R/N/D	Chapter / Section / Subsection / Title
R	3 / 20.1.6 / B / Data to be Reported Monthly
R	3 / 20.6 / Provider Inquiry Reporting Standardization
R	6 / 30.6 / Inquiry Tracking
R	6 / 30.6.1 / Updates to Chart
R	6 / 40.2.1 / General Requirements
R	6 / 70.2 / Data to Be Reported Monthly
R	6 / 90 / Provider Inquiry Standardized Categories

III. FUNDING:

SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

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

IV. ATTACHMENTS:

Manual Instruction

One-Time Notification

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

Attachment – One-Time Notification

Pub. 100-09	Transmittal: 21	Date: January 11, 2008	Change Request: 5848

SUBJECT: Instructions Related to the CMS Standardized Provider Inquiry Chart for FY 2008

Effective Date: October 1, 2007

Implementation Date: February 11, 2008

I. GENERAL INFORMATION

As a result of analyzing the inquiry tracking information submitted by the Medicare Provider Contact Centers (PCCs) in Fiscal Year 2007, CMS determined that additions to the CMS Provider Inquiry Chart and instructions on some of the most frequent issues identified are necessary. These instructions will allow CMS to improve the accuracy of data reported and to improve the overall reporting of the reasons of provider inquiries. In addition, this instruction incorporates some minor changes that affect the contractors' monthly reporting in the Customer Service Assessment and Management System (CSAMS). CMS is removing from CSAMS, the reporting of the following metrics: the QCM Number of CSRs Available for Monitoring, the QCM Number of Completed Scorecards, QCM Trainee CSRs Available for Monitoring, QCM Customer Skills Assessment, QCM Knowledge Skills Assessment and QCM Privacy Act.

A. Background:

The CMS Standardized Provider Inquiry Chart was originally implemented in the PCCs through CR 4048 – Provider Inquiry Reporting Standardization. This instruction addresses the following issues identified since the implementation of this instruction:

- Additions of categories and subcategories to the CMS Standardized Provider Inquiry Chart as well as updates to some of the existing definitions of the subcategories.
- Training for contractors' staff handling provider inquiries.
- Misrouted inquiries from Medicare beneficiaries in the Medicare PCCs.
- Reporting of a high volume of telephone inquiries and written inquiries under the "General Information" category that could be reported under a more specific category or subcategory.
- The need for improvement in the reporting of contractor-specific subcategories to assist CMS in identifying frequent inquiry types received by the Medicare PCCs that were not included in the CMS Standardized Provider Inquiry Chart.

In regard to CSAMS, CMS is removing some of the metrics that contractors are required to report monthly. The deleted metrics are being captured through other reporting mechanisms.

B. Policy:

Operational Policy Decision related to Section 921 of the Medicare Modernization Act.

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)

		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
5848.1	Contractors shall make necessary tracking system adjustments to allow the logging/tracking reflecting the new additions and modifications to the CMS Standardized Provider Inquiry Chart.	X	X	X	X	X					
5848.2	Contractors shall add the "Beneficiary Inquiries" category to their inquiry tracking system. The creation of this category shall not be interpreted as guidance that PCCs shall handle beneficiary inquiries or spend time identifying the reasons of beneficiaries' inquiries. Rather, CMS developed a category for beneficiary inquiries based on information provided by the Medicare PCCs about the types of misrouted beneficiary inquiries they receive, and to assist reporting these to CMS.	X	X	X	X	X					
5848.3	Contractors shall use the CMS Standardized Provider Inquiry Chart to capture the reason for the inquiry, not the status, the disposition or the action taken. Examples: The most common dispositions reported in error as reason of inquires were i.e. "Referrals to IVR," "Referrals to other departments," "Pending callback," "No further action needed."	X	X	X	X	X					
5848.4	Multi-Carrier System Desktop Tool (MCSDT) users shall list the name of the category in the subcategory listing too when finalizing the logging of an issue, as explained in the example below. Example: If the CSR or correspondent received a call or a letter related to a claim denied, they shall select the "Claim Denials" category and if the reason for the call fell outside of the 18 existing/predefined subcategories for "Claim Denials", the CSR or correspondent shall select "Claim Denials" again as a subcategory.	X			X						
5848.5	In regards to the tracking of general inquiries that belongs exclusively to the "General Information" category, contractors shall select the "Other Issues" subcategory to log an inquiry if the inquiry fell outside of the 5 existing/predefined subcategories of the "General Information" category.	X	X	X	X	X					
5848.6	Contractors shall not create contractor-specific subcategories under the "Temporary Issues" category that could be added as a contractor-specific subcategory under a more related category. Example: The addition of "HMO Refunds" as a contractor-specific subcategory that could be reported	X	X	X	X	X					

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	under "Financial Information" instead of "Temporary Issues."										
5848.7	Contractors shall not create a subcategory "Other" under any of the existing categories of the CMS Standardized Provider Inquiry Chart.	X	X	X	X	X					
5848.8	Contractors shall not report under "General Information" – "Others" inquiries that belong to other categories if those inquiries do not belong to "General Information."	X	X	X	X	X					
5848.9	Contractor staff working with telephone and written inquiries shall be trained to understand the CMS Standardized Inquiry Chart categories, subcategories and definitions.	X	X	X	X	X					
5848.9.1	Contractor staff working with telephone and written inquiries shall be trained to log their inquiry types according to the CMS Standardized Inquiry Chart in the tracking system used by the contractor.	X	X	X	X	X					
5848.9.2	By January 31, 2008, Medicare PCCs shall notify CMS of the date of their staff training in using the CMS Standardized Provider Inquiry Chart by submitting an e-mail with the information to the providerservices@cms.hhs.gov mailbox with the subject line "CMS Standardized Provider Inquiry Chart Training."	X	X	X	X	X					
5848.10	By January 1, 2008, Contractors shall use a new template of the Quarterly Contractor Inquiry Tracking Report that will be available, at http://www.cms.hhs.gov/FFSContReptMon/05_CMSStandardizedProviderInquiryChart.asp#TopOfPage to begin reporting all the changes communicated through this instruction to the ProviderServices@cms.hhs.gov on a quarterly basis.	X	X	X	X	X					
5848.11	Contractors shall assign a specific descriptive name to contractor-specific subcategories reported to CMS. The use of Sub-category 1, Sub-category 2 as names is unacceptable.	X	X	X	X	X					
5848.12	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-specific subcategory called "HCPCS" under "Coding" when the existing listing already provides "Procedure Codes" as one of the standard subcategories under "Coding."	X	X	X	X	X					

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
5848.13	Contractors shall create contractor-specific subcategories for issues that are significant to the contractor operation and represent a significant amount of inquiries related to a topic.	X	X	X	X	X					
5848.14	Contractors shall no longer report in CSAMS the following metrics: the QCM Number of CSRs Available for Monitoring, the QCM Number of Completed Scorecards, QCM Trainee CSRs Available for Monitoring, QCM Customer Skills Assessment, QCM Knowledge Skills Assessment and QCM Privacy Act.			X	X	X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	N/A										

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

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

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): Lisandra Torres Guzman (410-786-3415)

Post-Implementation Contact(s): Lisandra Torres Guzman (410-786-3415)

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Carriers, and Regional Home Health Carriers (RHHIs)* use the following statement:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *For Medicare Administrative Contractors (MACs)*, use the following statement:

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.

20.1.6 – *Customer Service Assessment and Management System (CSAMS) Reporting Requirements*

(Rev. 21, Issued: 01-11-08, Effective: 10-01-07, Implementation: 02-11-08)

The CSAMS is an interactive Web-based software tool used by CMS to collect and display call center telephone performance data. Each call center site shall enter required telephone customer service data elements into CSAMS between the 1st and 10th of each month for the prior month. To change data after the 10th of the month, users shall inform CO via CSAMS at csams@cms.hhs.gov. In those rare situations where one or more data elements are not available by the 10th of the month, the missing data shall not prevent the call center from entering all other available data into CSAMS timely. The call center shall supply the missing data to CMS within two workdays after it becomes available to the contractor. Definitions, calculations and additional information for each of the required telephone customer service data elements as well as associated standards are posted on the CMS' telephone customer service Web site at https://cms.hhs.gov/csams. Call centers shall use CSAMS call handling data to improve call center performance.

A. Definition of Call Center for CSAMS

All contractors shall ensure that monthly CSAMS data are being reported by individual call centers and that the data are not being consolidated. The CMS wants telephone performance data reported at the lowest possible physical location in order to address performance concerns. A call center is defined as a location where a group of CSRs is answering Medicare provider calls.

B. Data to Be Reported Monthly

Contractors shall capture and report the following data each month:

1. Number of Attempts - This is the total number of calls offered to the provider call center via the FTS Toll-Free during the month. This shall be taken from reports produced by FTS toll-free service provider. The current provider is Verizon and the reports are available at their Web site http://www.verizonbusiness.com/us/.

2. Number of Failed Attempts - This represents the number of calls unable to access the call center via the toll-free line. This data shall be taken from reports produced by FTS toll-free service provider. The current provider is Verizon and the reports are available at their Web site http://www.verizonbusiness.com/us/. Number of Attempts (TTY/TDD) - This is the total number of calls offered to the TTY/TDD line at the provider call center via the FTS Toll-Free during the month. This shall be taken from reports produced by FTS toll-free service provider. The current provider is Verizon and the reports are available at their Web site http://www.verizonbusiness.com/us/.

3. Number of Failed Attempts (TTY/TDD) - This represents the number of calls unable to access the call center via the TTY/TDD toll-free line. This data shall be

taken from reports produced by FTS toll-free service provider. The current provider is Verizon and the reports are available at their Web site http://www.verizonbusiness.com/us/.

4. Number of Attempts (for those call centers with IVR-only lines) - This is the total number of calls offered to the IVR-only line at the provider call center via the FTS Toll-Free during the month. This shall be taken from reports produced by FTS toll-free service provider. The current provider is Verizon and the reports are available at their Web site http://www.verizonbusiness.com/us/.

5. Number of Failed Attempts for those call centers with IVR-only lines) - This represents the number of calls unable to access the call center via the IVR-only toll-free line. This data shall be taken from reports produced by FTS toll-free service provider. The current provider is Verizon and the reports are available at their Web site http://www.verizonbusiness.com/us/.

6. Call Abandonment Rate - This is the percentage of provider calls that abandon from the ACD queue. This shall be reported as calls abandoned up to and including 60 seconds.

7. Average Speed of Answer - This is the amount of time that all calls waited in queue before being connected to a CSR. It includes ringing, delay recorder(s), and music. This time begins when the caller enters the CSR queue and includes both calls delayed and those answered immediately.

8. Total Sign-in Time (TSIT) - This is the amount of time the CSRs were available to answer telephone inquiries. This time includes the time that CSRs were plugged-in, logged-in, handling calls, making outgoing calls, in the after call work state or in an available state.

9. Number of Workdays - This is the number of calendar days for the month that the call center is open and answering telephone inquiries. For reporting purposes, a call center is considered open for the entire day even if the call center was closed for a portion of the day and/or not able to answer telephone inquiries for a portion of the day.

10. Total Talk Time - This is the total amount of time that all CSRs were connected to callers and includes any time the caller is placed on hold by the CSR during the conversation.

11. Available Time - Available time is the amount of time that CSRs were signed-in on the telephone system waiting for a call to be delivered (i.e., the CSR is not handling calls, making outgoing calls, or in the after call work (ACW) state).

12. After Call Work Time - This includes the time that CSRs need to complete any administrative work associated with a call after the customer disconnects.

13. Status of Calls Not Resolved at First Contact - Report as follows:

    a. Number of callbacks required. This number is based on calls received for the calendar month and represents the number requiring a callback as of the last workday of the month.

    b. Number of callbacks closed within 10 workdays. This number is based on calls received for the calendar month and represents the number closed within 10 workdays even if a callback is closed within the first 10 workdays of the following month.

14. IVR Handle Rate - Report data needed to calculate the IVR handle rate. For call centers with combined CSR and IVR lines this includes:

    a. The number of calls offered to the IVR (defined as the total number of calls receiving a prompt offering the use of the IVR during or after business hours.)

    b. The number of calls handled by the IVR.

    c. For call centers with separate CSR and IVR lines this includes:

        1) The number of calls offered to the IVR (defined as the total number of IVR-only calls receiving a prompt offering the use of the IVR during or after business hours plus the total number of CSR completed calls.)

        2) The number of calls handled by the IVR (defined as the number of calls where the caller selected and played at least one informational message.)

15. Calls in CSR queue - This is the total number of calls delivered to the CSR queue.

16. Calls Answered by CSRs - This represents the total number of calls answered by all CSRs for the month from the CSR queue.

17. Calls Answered <= 60 Seconds - This represents the total number of calls answered by all CSRs within 60 seconds from the CSR queue.

18. Calls Answered <= 120 Seconds - This represents the total number of calls answered by all CSRs within 120 seconds from the CSR queue.

19. Calls Abandoned <= 120 Seconds - This represents the total number of calls abandoned before or at 120 seconds from the CSR queue.

20. Training Hours – Normal Business Days - Report the number of hours (rounded to the nearest half-hour) that the provider contact center closed for CSR training per month. This indicator is used to measure the time the provider contact center is closed during normal business hours for staff development. The number of hours used each month can not exceed 8 hours per month.

21. Training Hours – Federal Holidays - Report the number of hours (rounded to the nearest half-hour) that the provider contact center closed for CSR training on a Federal holiday(s) per month. This indicator is to measure the time the contact center closed on a Federal Holiday for staff development.

20.6 - Provider Inquiry Reporting Standardization

(Rev. 21, Issued: 01-11-08, Effective: 10-01-07, Implementation: 02-11-08)

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

1. The type of inquiry (telephone, letter, e-mail, fax, walk-in.)
2. The person responsible for answering the provider inquiry (by name or other unique identifier.)
3. Category of the inquiry (using CM-provided categories listed in the chart.)
4. The disposition of the inquiry, including referral to other areas at the contractor (e.g., appeals, medical review, MSP.)
5. The timeliness of the response.

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

These categories are to be used to capture the reason for the inquiry, not the status, disposition or 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 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.

Contractors shall follow these additional requirements when tracking or logging their inquiry types:

1. Contractors shall not create a subcategory "Other" under any of the existing categories of the CMS Standardized Provider Inquiry Chart.

2. Contractors shall not report under "General Information" – "Others" inquiries that belong to other categories if those inquiries do not belong to "General Information."

3. Multi-Carrier System Desktop Tool (MCSDT) users shall list the name of the category in the subcategory listing too when finalizing the logging of an issue, as explained in the example below.

   Example: If the CSR or correspondent received a call or a letter related to a claim denied, they shall select the "Claim Denials" category and if the reason for the call fell outside of the 18 existing/predefined subcategories for "Claim Denials", the CSR or correspondent shall select "Claim Denials" again as a subcategory.

4. In regards to the tracking of general inquiries that belongs exclusively to the "General Information" category, contractors shall select the "Other Issues" subcategory to log an inquiry if it fell outside of the 5 existing/predefined subcategories of the "General Information" category.

Contractors shall use the Quarterly Contractor Inquiry Tracking Report template available, at http://www.cms.hhs.gov/FFSContReptMon/05_CMSStandardizedProviderInquiryChart.asp#TopOfPage when reporting to CMS their inquiry types. This report shall be submitted to the ProviderServices@cms.hhs.gov, and it is due at the end of the month following the end of each calendar quarter (January 31, April 30 July 31, and October 31.

A. Required Training

Contractor staff working with telephone and written inquiries shall be trained to understand the CMS Standardized Inquiry Chart categories, subcategories and definitions and shall be trained to log their inquiry types according to the CMS Standardized Inquiry Chart in the tracking system used by the contractor. By January 31, 2008, Medicare PCCs shall notify CMS of the date of their staff training in using the CMS Standardized Provider Inquiry Chart by submitting an e-mail with the information to the providerservices@cms.hhs.gov mailbox with the subject line "CMS Standardized Provider Inquiry Chart Training."

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:

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

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

C. Contractor-Specific Subcategories

Contractors shall follow the following requirements when adding contractor-specific subcategories to the Quarterly 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-specific subcategory called “HCPCS” under “Coding” when the existing listing already provides “Procedure Codes” as one of the standard subcategories under “Coding.”

2. Contractors shall assign a specific descriptive name to contractor-specific subcategories reported to CMS. The use of Sub-category 1, Sub-category 2 as names is unacceptable.

3. Contractors shall create contractor-specific subcategories for issues that are significant to the contractor operation 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 a contractor-specific subcategory under a more related category.

   Example: The addition of “HMO Refunds” as a contractor-specific subcategory that could be reported under “Financial Information” instead of “Temporary Issues.”

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-04 Form*	Contact is asking how to complete the claim form and/or where to find it, including an electronic equivalent of both 1500 and UB04 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

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
			claim, for example, medical record, progress notes, physicians orders, x-rays, etc.
		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.
		Provider Number	Contact is asking for information or requesting instructions on how to bill appropriately using the provider numbers or identifiers required by the Medicare program (i.e. UPIN, NPI, Group Number).
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.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		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.
		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.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		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.
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.
Beneficiary Inquiries	Contact initiated by a Medicare beneficiary or designated representative to a Medicare Provider Contact Center (PCC) to	*Claim Issues*	Contact is asking questions related to status of claims, including appeals, and questions related to information contained in the MSN. Also, include requests for a copy of an MSN, requests for reopening of claims due to processing

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
	inquire or complain about a variety of aspects of the Medicare operation. These types of inquiries are considered misrouted and belong to 1-800 Medicare or related partners, who are designated to provide customer service to Medicare beneficiaries. Each Medicare beneficiary inquiry received by a Medicare PCC must be logged using this category or any of the subcategories below, as appropriate.		errors, scanning errors and system errors, and/or requests to cancel or reissue a Medicare claim related check.
		Complaints	Contact (Medicare Beneficiary or designated representative) is presenting issue involving a Medicare beneficiary that reflects dissatisfaction with any aspect of the Medicare Program operation, its staff and its providers (i.e., about appointments with the MD, clearinghouse dismissals). Also, include complaints related to difficulty accessing 1-800 Medicare.
		Coverage/Benefits	Contact is asking questions related to services covered or excluded by the Medicare Program. Also, include inquiries related to diagnosis codes or procedure codes eligible for payment, prescription drug issues (i.e., requesting pre-authorization on a drug) and/or requests for Medicare publications (i.e., MEDPAR directory).
		Eligibility/Entitlement	Contact is asking questions related to Medicare beneficiary demographic information (i.e., date of birth, date of death, address), entitlement dates, benefit days, deductible or coinsurance. Also, include inquiries to confirm MSP information and/or a beneficiary enrollment to a Medicare Advantage plan and/or HIPAA/Privacy – third-party authorizations.
		Fraud and Abuse	Contact is reporting issues with providers related to possible abusive and/or fraudulent practices(i.e. , payment assignments and violations to them)

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		MSP	Contact is asking questions related to Medicare as primary or secondary insurance, and other coordination of benefits issues (i.e. coordination between Part A and Part B, files updates). It includes beneficiary inquiries attempting to update the MSP record due to issues with a Medicare Advantage Plan, co-insurance coordination with primary or secondary insurance, and/or issues due to a crossover claim.
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.
		Certification Requirements	Contact is asking about claim(s) denied due to certification requirements not being met. This includes Hospice certifications and/or Certificates of Medical Necessity (CMNs).
		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 modifiers, global surgery denials and denials due to CCI edits.
		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).

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		CWF Rejects	Contact is asking about a claim(s) denied because information on the claim does not match the CWF beneficiary information (for example, Managed Care/HMOs status, 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).
		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 break-in service denials.
		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.
		EMC Filing Requirements	Contact is asking about a claim(s) where payment was denied as not being covered unless they are submitted electronically.
		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.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		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 / Dollar Amount Limitation	Contact is asking about a claim(s) that was denied because the allowable number of incidences or dollar amount limit for that service in a given time period has been exhausted or exceeded due to a service that was previously billed. Also, includes inquiries related the outpatient therapy cap and to billing frequency limits for durable medical equipment and supplies (same or similar equipment denials) 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.
		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. Includes denials related to medically unbelievable edits.
		MSP	Contact is asking about a claim(s) denied due to other insurance existing on the beneficiary file that is primary to Medicare.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		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.
		Provider Number	Contact is asking about a claim(s) denied due to issues between the shared systems and the provider identification number (i.e. UPIN, NPI, Group Number).
		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.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		Suspended	Contact is asking about the status of a claim that is pending while waiting for information needed to complete processing.
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.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		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.
		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.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		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.
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.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
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.
		DME Same or Similar Equipment	Contact is asking if beneficiary has a DME Certificate of Medical Necessity (CMN) or DMERC Information Form (DIF) active, or if a beneficiary has same or similar equipment previously covered by Medicare on file.
		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.
		Next Eligible Date	Contact is asking when is the next eligible date for the beneficiary to receive one or more preventive services.
		Outpatient Therapy Cap	Contact is asking if the beneficiary's outpatient therapy cap amount has been reached.
		Part A Entitlement	Contact is asking when the beneficiary became eligible for Part A benefits.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		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.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
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.
		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.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		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.
		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.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
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. Include inquiries related to the Medicare Easy Print (MREP) software.
		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.
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-04 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.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		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.
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.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
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 or Chapter 6, Sections 30.1.1 – 30.1.1.2.	*CD-ROM Initiative*	Contact is requesting a hard-copy of the Annual Disclosure Statement, the "Dear Provider" letter and provider enrollment material in CD-ROM form, or asking for clarification of the CD-ROM content. Includes logging of CD-ROM related problems that providers encountered.
		CERT	Contact is asking information related to the Comprehensive Error Rate Testing (CERT) Program.
		Competitive Acquisition Program (CAP)	Contact is asking general questions about the CAP.
		HIGLAS	Contact is presenting a situation due to the implementation of HIGLAS, the new financial accounting system. Includes inquiries about HIGLAS's training material, its impact on claim processing, recoup overpayments, demand letters, settlements and penalty withholdings, HIGLAS changes on remittance advices and checks (voided/reissued).
		Part D Drug Coverage	Contact is presenting situation related to issues with the implementation of the Part D Medicare Prescription Drug Coverage.
		PQRI	Contact is asking for information about the Physician Quality Reporting Initiative.
		Recovery Audit Contractor (RACs)	Contact is asking information about a CMS initiative using RACs to identify underpayments and overpayments and to recoup overpayments. Includes inquiries related to demand letters and records requested by RACs.

30.6 - Inquiry Tracking

(Rev. 21, Issued: 01-11-08, Effective: 10-01-07, Implementation: 02-11-08)

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

1. The type of inquiry (telephone, letter, e-mail, fax, walk-in);
2. The person responsible for answering the provider inquiry (by name or other unique identifier);
3. Category of the inquiry (using CMS-provided categories listed in § 90);
4. The disposition of the inquiry, including referral to other PCSP areas or areas elsewhere at the contractor (e.g., appeals, medical review, MSP); and
5. The timeliness of the response.

Tracking information on referrals to the PRRS shall include details of the inquiry and information about how to reach the provider in case there is a need to clarify the question. Contractors have discretion to determine the additional minimum referral information needed by the PRRS. Data from the tracking system shall be used to analyze the number and types of inquiries in order to generate FAQs to be posted on the Web site, identify areas for telephone CSR training, and identify areas for broader provider education. The tracking system will also be used to generate quarterly reports for CMS use.

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, listed in § 90.

These categories are to be used to capture the reason for the inquiry, not the status, the disposition or 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 shall 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.

Contractors shall follow these additional requirements when tracking or logging their inquiry types:

1. Contractors shall not create a subcategory “Other” under any of the existing categories of the CMS Standardized Provider Inquiry Chart.

2. Contractors shall not report under “General Information” – “Others” inquiries that belong to other categories if those inquiries do not belong to “General Information.”

3. Multi-Carrier System Desktop Tool (MCSDT) users shall list the name of the category in the subcategory listing too when finalizing the logging of an issue, as explained in the example below.

   Example: If the CSR or correspondent received a call or a letter related to a claim denied, they shall select the "Claim Denials" category and if the reason for the call fell outside of the 18 existing/predefined subcategories for "Claim Denials", the CSR or correspondent shall select "Claim Denials" again as a subcategory.

4. In regards to the tracking of general inquiries that belongs exclusively to the "General Information" category, contractors shall select the "Other Issues" subcategory to log an inquiry if the inquiry fell outside of the 5 existing/predefined subcategories of the "General Information" category.

Contractors shall use the Quarterly Contractor Inquiry Tracking Report template available, at http://www.cms.hhs.gov/FFSContReptMon/05_CMSStandardizedProviderInquiryChart.asp#TopOfPage when reporting to CMS their inquiry types. This report shall be submitted to the ProviderServices@cms.hhs.gov, and it is due at the end of the month following the end of each calendar quarter (January 31, April 30 July 31, and October 31.

30.6.1 - Updates to Chart

(Rev. 21, Issued: 01-11-08, Effective: 10-01-07, Implementation: 02-11-08)

Contractors shall recommend changes to CMS Standardized Provider Inquiry Chart, listed in § 90, 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 as needed. CMS will define categories to be tracked under the "Temporary Issues Category" and the reporting period for those subcategories through separate instructions. Between updates, contractor may create and add contractor-specific temporary codes, if their call volume requires them to do so.

A. Contractor-Specific Subcategories

Contractors shall follow the following requirements when adding contractor-specific subcategories to the Quarterly 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-specific subcategory called "HCPCS" under "Coding" when the existing listing already provides "Procedure Codes" as one of the standard subcategories under "Coding."

2. Contractors shall assign a specific descriptive name to contractor-specific subcategories reported to CMS. The use of Sub-category 1, Sub-category 2 as names is unacceptable.

3. Contractors shall create contractor-specific subcategories for issues that are significant to the contractor operation 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 a contractor-specific subcategory under a more related category.

Example: The addition of “HMO Refunds” as a contractor-specific subcategory that could be reported under “Financial Information” instead of “Temporary Issues.”

40.2.1 - General Requirements

(Rev. 21, Issued: 01-11-08, Effective: 10-01-07, Implementation: 02-11-08)

Contractors shall provide training for all new CSR hires and refresher training updates for existing personnel. This training shall enable the CSRs to answer the full range of customer service inquiries. Contractors shall have a training evaluation process in place to certify that the trainee is ready to independently handle inquiries.

Upon receipt of CMS developed standardized CSR training materials, contractors shall implement these materials for all CSRs on duty and those hired in the future. Since the development of these materials will be done by CMS, it is not expected that there will be any costs to the contractors to use these training materials. Standardized training materials and other training information will be posted to the following Web site:

http://www.cms.hhs.gov/ContractorLearningResources/02_Training.asp#TopOfPage

Contractors may supplement the standard materials with their own materials as long as there is no contradiction of policy or procedures.

All contractors shall train their CSRs about how to find, navigate and fully use their Provider Web site and http://www.cms.hhs.gov/. CSRs shall be connected to and able to use the contractor's Web site and the CMS Web site to assist providers.

The contractor provider contact center staff shall be trained in the use of the contractor and CMS FAQs in order to maintain consistency of the information given to Medicare providers.

Contractor staff working with telephone and written inquiries shall be trained to understand the CMS Standardized Inquiry Chart categories, subcategories and definitions and shall be trained to log their inquiry types according to the CMS Standardized Inquiry Chart in the tracking system used by the contractor. By January 31, 2008, Medicare PCCs shall notify CMS of the date of their staff training in using the CMS Standardized Provider Inquiry Chart by submitting an e-mail with the information to the providerservices@cms.hhs.gov mailbox with the subject line "CMS Standardized Provider Inquiry Chart Training."

70.2- Data to Be Reported Monthly

(Rev. 21, Issued: 01-11-08, Effective: 10-01-07, Implementation: 02-11-08)

Contractors shall capture and report the following data each month:

Data Reported	Definition
Number of Attempts	This is the total number of calls offered to the provider contact center via the FTS Toll-Free during the month. This shall be taken from reports produced by FTS toll-free service provider. The current provider is Verizon and the reports are available at their Web site http://www.verizonbusiness.com/us/.
Number of Failed Attempts	This represents the number of calls unable to access the contact center via the toll-free line. This data shall also be taken from reports produced by FTS toll-free service provider. The current provider is Verizon and the reports are available at their Web site http://www.verizonbusiness.com/us/.
Number of Attempts (TTY/TDD)	This is the total number of calls offered to the TTY/TDD line at the provider contact center via the FTS Toll-Free during the month. This shall be taken from reports produced by FTS toll-free service provider. The current provider is Verizon and the reports are available at their Web site http://www.verizonbusiness.com/us/.
Number of Failed Attempts (TTY/TDD)	This represents the number of calls unable to access the contact center via the TTY/TDD toll-free line. This data shall be taken from reports produced by FTS toll-free service provider. The current provider is Verizon and the reports are available at their Web site http://www.verizonbusiness.com/us/.
Number of Attempts	(for those contact centers with IVR-only lines) - This is the total number of calls offered to the IVR-only line at the provider contact center via the FTS Toll-Free during the month. This shall be taken from reports produced by FTS toll-free service provider. The current provider is Verizon and the reports are available at their Web site http://www.verizonbusiness.com/us/.
Number of Failed Attempts for those contact centers with IVR-only lines)	This represents the number of calls unable to access the contact center via the IVR-only toll-free line. This data shall be taken from reports produced by FTS toll-free service provider. The current provider is Verizon and the reports are available at their Web site http://www.verizonbusiness.com/us/.

Call Abandonment Rate	This is the percentage of provider calls that abandon from the ACD queue. This shall be reported as calls abandoned up to and including 60 seconds.
Average Speed of Answer	This is the amount of time that all calls waited in queue before being connected to a CSR. It includes ringing, delay recorder(s), and music. This time begins when the caller enters the CSR queue and includes both calls delayed and those answered immediately.
Total Sign-in Time (TSIT)	This is the amount of time the CSRs were available to answer telephone inquiries. This time includes the time that CSRs were plugged-in, logged-in, handling calls, making outgoing calls, in the after call work state or in an available state.
Number of Business days	This is the number of calendar days for the month that the contact center is open and answering telephone inquiries. For reporting purposes, a contact center is considered open for the entire day even if the contact center was closed for a portion of the day and/or not able to answer telephone inquiries for a portion of the day.
Total Talk Time	This is the total amount of time that all CSRs were connected to callers and includes any time the caller is placed on hold by the CSR during the conversation.
Available Time	Available time is the amount of time that CSRs were signed-in on the telephone system waiting for a call to be delivered (i.e., the CSR is not handling calls, making outgoing calls, or in the after call work (ACW) state).
After Call Work Time	This includes the time that CSRs need to complete any administrative work associated with a call after the customer disconnects.
Status of Calls Not Resolved at First Contact	Report as follows: 1. Number of callbacks required. This number is based on calls received for the calendar month and represents the number requiring a callback as of the last workday of the month. 2. Number of callbacks closed within 10 workdays. This number is based on calls received for the calendar month and represents the number closed within 10 workdays even if a callback is closed within the first 10 workdays of the following month.
IVR Handle Rate	For contact centers with <u>combined</u> CSR and IVR lines , this includes: 1. The number of calls offered to the IVR (defined as the total

	number of calls receiving a prompt offering the use of the IVR during or after business hours); and 2. The number of calls handled by the IVR. For contact centers with separate CSR and IVR lines this includes: 1. The number of calls offered to the IVR (defined as the total number of IVR-only calls receiving a prompt offering the use of the IVR during or after business hours) plus the total number of calls offered to CSRs, and 2. The number of calls handled by the IVR (defined as the number of calls where the caller selected and played at least one informational message).
Calls in CSR queue	This is the total number of calls delivered to the CSR queue.
Calls Answered by CSRs	This represents the total number of calls answered by all CSRs for the month from the CSR queue.
Calls Answered <= 60 Seconds	This represents the total number of calls answered by all CSRs within 60 seconds from the CSR queue.
Training Hours – Normal Business Days	Report the number of hours (rounded to the nearest half-hour) that the provider contact center closed for CSR training per month. This indicator is used to measure the time the provider contact center is closed during normal business hours for staff development. The number of hours used each month can not exceed 8 hours per month.
Training Hours – Federal Holidays	Report the number of hours (rounded to the nearest half-hour) that the provider contact center closed for CSR training on a Federal holiday(s) per month. This indicator is to measure the time the contact center closed on a Federal Holiday for staff development

90 - Provider Inquiry Standardized Categories

(Rev. 21, Issued: 01-11-08, Effective: 10-01-07, Implementation: 02-11-08)

CMS requires all contractors to track and report the nature of their inquiry types (reason for the inquiry) for telephone and written inquiries using categories and subcategories listed according to definitions provided in the CMS Standardized Provider Inquiry Chart (See Inquiry Tracking, § 30.6).

These categories are to be used to capture the reason for the inquiry, not the status, the disposition or 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 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.

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-04 Form*	Contact is asking how to complete the claim form and/or where to find it, including an electronic equivalent of both 1500 and UB04 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

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
			claim, for example, medical record, progress notes, physicians orders, x-rays, etc.
		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.
		Provider Number	Contact is asking for information or requesting instructions on how to bill appropriately using the provider numbers or identifiers required by the Medicare program (i.e. UPIN, NPI, Group Number).
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.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		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.
		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.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		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.
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.
Beneficiary Inquiries	Contact initiated by a Medicare beneficiary or designated representative to a Medicare Provider Contact Center (PCC) to	*Claim Issues*	Contact is asking questions related to status of claims, including appeals, and questions related to information contained in the MSN. Also, include requests for a copy of an MSN, requests for reopening of claims due to processing

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
	inquire or complain about a variety of aspects of the Medicare operation. These types of inquiries are considered misrouted and belong to 1-800 Medicare or related partners, who are designated to provide customer service to Medicare beneficiaries. Each Medicare beneficiary inquiry received by a Medicare PCC must be logged using this category or any of the subcategories below, as appropriate.		errors, scanning errors and system errors, and/or requests to cancel or reissue a Medicare claim related check.
		Complaints	Contact (Medicare Beneficiary or designated representative) is presenting issue involving a Medicare beneficiary that reflects dissatisfaction with any aspect of the Medicare Program operation, its staff and its providers (i.e., about appointments with the MD, clearinghouse dismissals). Also, include complaints related to difficulty accessing 1-800 Medicare.
		Coverage/Benefits	Contact is asking questions related to services covered or excluded by the Medicare Program. Also, include inquiries related to diagnosis codes or procedure codes eligible for payment, prescription drug issues (i.e., requesting pre-authorization on a drug) and/or requests for Medicare publications (i.e., MEDPAR directory).
		Eligibility/Entitlement	Contact is asking questions related to Medicare beneficiary demographic information (i.e., date of birth, date of death, address), entitlement dates, benefit days, deductible or coinsurance. Also, include inquiries to confirm MSP information and/or a beneficiary enrollment to a Medicare Advantage plan and/or HIPAA/Privacy – third-party authorizations.
		Fraud and Abuse	Contact is reporting issues with providers related to possible abusive and/or fraudulent practices(i.e. , payment assignments and violations to them)

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		MSP	Contact is asking questions related to Medicare as primary or secondary insurance, and other coordination of benefits issues (i.e. coordination between Part A and Part B, files updates). It includes beneficiary inquiries attempting to update the MSP record due to issues with a Medicare Advantage Plan, co-insurance coordination with primary or secondary insurance, and/or issues due to a crossover claim.
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.
		Certification Requirements	Contact is asking about claim(s) denied due to certification requirements not being met. This includes Hospice certifications and/or Certificates of Medical Necessity (CMNs).
		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 modifiers, global surgery denials and denials due to CCI edits.
		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).

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		CWF Rejects	Contact is asking about a claim(s) denied because information on the claim does not match the CWF beneficiary information (for example, Managed Care/HMOs status, 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).
		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 break-in service denials.
		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.
		EMC Filing Requirements	Contact is asking about a claim(s) where payment was denied as not being covered unless they are submitted electronically.
		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.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		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 / Dollar Amount Limitation	Contact is asking about a claim(s) that was denied because the allowable number of incidences or dollar amount limit for that service in a given time period has been exhausted or exceeded due to a service that was previously billed. Also, includes inquiries related the outpatient therapy cap and to billing frequency limits for durable medical equipment and supplies (same or similar equipment denials) 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.
		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. Includes denials related to medically unbelievable edits.
		MSP	Contact is asking about a claim(s) denied due to other insurance existing on the beneficiary file that is primary to Medicare.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		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.
		Provider Number	Contact is asking about a claim(s) denied due to issues between the shared systems and the provider identification number (i.e. UPIN, NPI, Group Number).
		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.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		Suspended	Contact is asking about the status of a claim that is pending while waiting for information needed to complete processing.
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.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		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.
		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.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		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.
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.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
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.
		DME Same or Similar Equipment	Contact is asking if beneficiary has a DME Certificate of Medical Necessity (CMN) or DMERC Information Form (DIF) active, or if a beneficiary has same or similar equipment previously covered by Medicare on file.
		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.
		Next Eligible Date	Contact is asking when is the next eligible date for the beneficiary to receive one or more preventive services.
		Outpatient Therapy Cap	Contact is asking if the beneficiary's outpatient therapy cap amount has been reached.
		Part A Entitlement	Contact is asking when the beneficiary became eligible for Part A benefits.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		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.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
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.
		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.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		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.
		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.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
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. Include inquiries related to the Medicare Easy Print (MREP) software.
		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.
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-04 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.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		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.
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.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
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 or Chapter 6, Sections 30.1.1 – 30.1.1.2.	*CD-ROM Initiative*	Contact is requesting a hard-copy of the Annual Disclosure Statement, the "Dear Provider" letter and provider enrollment material in CD-ROM form, or asking for clarification of the CD-ROM content. Includes logging of CD-ROM related problems that providers encountered.
		CERT	Contact is asking information related to the Comprehensive Error Rate Testing (CERT) Program.
		Competitive Acquisition Program (CAP)	Contact is asking general questions about the CAP.
		HIGLAS	Contact is presenting a situation due to the implementation of HIGLAS, the new financial accounting system. Includes inquiries about HIGLAS's training material, its impact on claim processing, recoup overpayments, demand letters, settlements and penalty withholdings, HIGLAS changes on remittance advices and checks (voided/reissued).
		Part D Drug Coverage	Contact is presenting situation related to issues with the implementation of the Part D Medicare Prescription Drug Coverage.
		PQRI	Contact is asking for information about the Physician Quality Reporting Initiative.
		Recovery Audit Contractor (RACs)	Contact is asking information about a CMS initiative using RACs to identify underpayments and overpayments and to recoup overpayments. Includes inquiries related to demand letters and records requested by RACs.