

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.	<i>Cancellation of Claim/Return Claim/Billed in Error</i>	Contact is asking to cancel a claim that was submitted in error. Includes "services not rendered."
		<i>Claim Processing Error</i>	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.
		<i>Claim Information Change</i>	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.
		<i>Medical Review</i>	Contact is asking about corrections/changes in diagnosis/treatment on processed claim.
		<i>MSP</i>	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.	<i>1500/UB-04 Form</i>	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.
		<i>Advance Beneficiary Notice (ABN)</i>	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?
		<i>Claims Related Reports</i>	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.
		<i>Claim Documentation</i>	Contact is asking what information is necessary to submit with a claim to allow processing and/or adjudication of the claim, for example, medical record, progress notes, physicians orders, x-rays, etc.

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		<i>Coinsurance</i>	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.
		<i>Fraud and Abuse</i>	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.
		<i>Filing/Billing Instructions</i>	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".
		<i>HPSA/PSA</i>	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.
		<i>Provider Number</i>	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.	<i>Ambulance Fee Schedule</i>	Contact is asking for the Ambulance Fee Schedule payment amount for a particular item or service provided to a Medicare beneficiary.
		<i>Ambulatory Surgical Center</i>	Contact is asking for the Ambulatory Surgical Centers payment amount for a particular item or service provided to a Medicare beneficiary.
		<i>Anesthesia Fee Schedule</i>	Contact is asking for the Anesthesia Fee Schedule payment amount for a particular item or service provided to a Medicare beneficiary.

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		<i>Critical Access Hospitals</i>	Contact is asking for the Critical Access Hospitals payment amount for a particular item or service provided to a Medicare beneficiary.
		<i>Clinical Lab Fee Schedule</i>	Contact is asking for the Clinical Laboratory Fee Schedule payment amount for a particular item or service provided to a Medicare beneficiary.
		<i>Drug Average Sales Price (ASP) Resource</i>	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.
		<i>ESRD Composite Rate</i>	Contact is asking for the ESRD Composite Rate payment amount for a particular item or service provided to a Medicare beneficiary.
		<i>Home Health PPS</i>	Contact is asking for the Home Health PPS payment amount for a particular item or service provided to a Medicare beneficiary.
		<i>Hospital Inpatient PPS</i>	Contact is asking for the Hospital Inpatient PPS payment amount for a particular item or service provided to a Medicare beneficiary.
		<i>Hospital Outpatient PPS</i>	Contact is asking for the Hospital Outpatient PPS payment amount for a particular item or service provided to a Medicare beneficiary.
		<i>Hospice Payment System</i>	Contact is asking for the Hospice Payment System payment amount for a particular item or service provided to a Medicare beneficiary.
		<i>Long Term Care Hospital PPS</i>	Contact is asking for the Long Term Care Hospital PPS payment amount for a particular item or service provided to a Medicare beneficiary.
		<i>Physician Fee Schedule</i>	Contact is asking for the Physician Fee Schedule payment amount for a particular item or service provided to a Medicare beneficiary.
		<i>DMEPOS Fee Schedule</i>	Contact is asking for the DMEPOS Fee Schedule payment amount for a particular item or service provided to a Medicare beneficiary.

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		<i>Psychiatric Hospital PPS</i>	Contact is asking for the Psychiatric Hospital PPS payment amount for a particular item or service provided to a Medicare beneficiary.
		<i>Rehabilitation Hospital PPS</i>	Contact is asking for the Rehabilitation Hospital PPS payment amount for a particular item or service provided to a Medicare beneficiary.
		<i>Skilled Nursing Facility PPS</i>	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.	<i>Process/Rights</i>	Contact is asking for general appeal information, appeal process instructions and/or appeal rights.
		<i>Status/Explanation/Resolution</i>	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).
		<i>Qualified Independent Contractor (QIC) Contractor</i>	Contact is asking about an appeal status or information related to appeals reviewed by the QIC.

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Beneficiary Inquiries	<p>Contact initiated by a Medicare beneficiary or designated representative to a Medicare Provider Contact Center (PCC) to 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.</p>	<i>Claim Issues</i>	<p>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 errors, scanning errors and system errors, and/or requests to cancel or reissue a Medicare claim related check.</p>
		<i>Complaints</i>	<p>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.</p>
		<i>Coverage/Benefits</i>	<p>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).</p>
		<i>Eligibility/Entitlement</i>	<p>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.</p>

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		<i>Fraud and Abuse</i>	Contact is reporting issues with providers related to possible abusive and/or fraudulent practices(i.e. , payment assignments and violations to them)
		<i>MSP</i>	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.	<i>ABN</i>	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.
		<i>Certification Requirements</i>	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).
		<i>Claim Overlap</i>	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.
		<i>Coding Errors/Modifiers</i>	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.
		<i>Contractor Processing Errors</i>	Contact is asking about a claim(s) denied due to a contractor error (incorrect edit, shared systems issue, etc.), when processing the claim.
		<i>Contractual Obligation Not Met</i>	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).

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		<i>CWF Rejects</i>	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).
		<i>Denial Letter Request</i>	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.
		<i>DME POS Issues</i>	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.
		<i>Duplicate</i>	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.
		<i>EMC Filing Requirements</i>	Contact is asking about a claim(s) where payment was denied as not being covered unless they are submitted electronically.
		<i>Eligibility</i>	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 where there is no need to update information on CWF files.
		<i>Evaluation & Management Services</i>	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.
		<i>Frequency / Dollar Amount Limitation</i>	Contact is asking about a claim(s) that was denied because the allowable number of incidences or

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			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.
		<i>LCD</i>	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.
		<i>Life Time Days Met</i>	Contact is asking about claim(s) denied because a particular benefit is disallowed for a Medicare beneficiary due to the lifetime days limit exhausted.
		<i>Medical Necessity</i>	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.
		<i>MSP</i>	Contact is asking about a claim(s) denied due to other insurance existing on the beneficiary file that is primary to Medicare.
		<i>NCD</i>	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.
		<i>Provider Number</i>	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).
		<i>Statutory Exclusion</i>	Contact is asking about a claim(s) that items or services were denied by law.

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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.	<i>Additional Development Request (ADR) Letters</i>	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.
		<i>Applied to Deductible</i>	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.
		<i>ATP Amount/Check Information</i>	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).
		<i>Crossover</i>	Contact is asking for information on a claim that is covered by a supplemental insurer, such as Medigap or other private insurance.
		<i>Not on File</i>	Contact is asking for a claim that Medicare does not have on file or that has not been received by the contractor.
		<i>Paid in Error</i>	Contact is asking about a claim that they believe was paid in error.
		<i>Payment Explanation/Calculation</i>	Contact is asking for explanation on how the claim was paid or how the payment amount was calculated. Includes "reimbursement" questions.
		<i>Suspended</i>	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.	<i>CCI Edits</i>	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.
		<i>Condition Codes</i>	Contact is asking about billing codes that indicate whether the claimant meets a condition of the service.

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		<i>Procedure Codes</i>	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.
		<i>Diagnosis codes</i>	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.
		<i>Evaluation & Management Codes (E&M)</i>	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.
		<i>Modifiers</i>	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.
		<i>MSP Payer/Value Codes</i>	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.
		<i>Revenue Codes</i>	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.
		<i>Patient Status Codes</i>	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

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			admission codes and discharge status codes.
		<i>Place of Service Codes</i>	Contact is asking about codes on professional claims to identify where the service was rendered.
		<i>Specialty Codes</i>	Contact is asking about codes used on a claim form to indicate a provider's type or medical specialty.
DMEPOS Competitive Bidding Program	Inquiries related to the DMEPOS Competitive Bidding Program designed to improve the effectiveness of Medicare's DMEPOS payments, reduce beneficiary out-of-pocket costs, and save the Medicare program money while ensuring beneficiary access to quality DMEPOS items and services. It requires the suppliers to be accredited by a Medicare-recognized accreditation organization.	<i>Bidding Cycle</i>	Contact is asking questions regarding the DMEPOS bidding cycle i.e. application requirements, evaluation criteria and deadlines. Also, Includes question about the accreditation process.
		<i>Claim Denials</i>	Contact is asking about claim(s) denied due to issues related to DMEPOS items i.e. non-contract supplier billing, repair/service/replacement, misuse or missing modifiers.
		<i>Complaints</i>	Contact is expressing dissatisfaction with different aspects and/or processes of the DMEPOS Competitive Bidding Program.
		<i>Filing/Billing Instructions</i>	Contact is asking for instructions on i.e. how to file a claim for a DMEPOS item, modifiers to use, documentation required including an ABN.
		<i>Policy/Coverage Rules</i>	Contact is asking for clarification of Medicare contract and CBAs policy, to cover and pay DMEPOS items. Also, includes CBAs rules about repair and replacement of beneficiary-owned items, questions about product categories covered by the program, traveling beneficiary rules, grandfathering provisions, non-contract supplier issues and special rules for certain provider specialties and medical

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			facilities.
		<i>Provider Outreach & Education</i>	Contact is asking questions or requesting information about outreach opportunities and reference educational materials related to the DMEPOS Competitive Bidding Program including the directory of contract suppliers and the list of contract items.
		<i>Single Payment Amount</i>	Contact is asking for the allowed payment amount established by the DMEPOS Competitive Bidding Program.
Complaints	An expression of dissatisfaction with service from providers in regards to different aspects of the Medicare operation.	<i>Contact Center Closure</i>	Contact is expressing dissatisfaction due to hours of operation or call center closures for CSR training.
		<i>Medicare Contractor Operation</i>	Contact is expressing dissatisfaction due to contractor operational errors, procedures, policies, processes, and staff issues not addressed by other subcategories included in this section.
		<i>Medicare Program</i>	Contact is expressing dissatisfaction due to issues with the Medicare program. Includes provider expressions of intentions of leaving the Medicare program.
		<i>Provider Education and Outreach</i>	Contact is expressing dissatisfaction with educational activities, education staff performance or availability of educational resources or activities for Medicare providers.
		<i>Self Service Technology</i>	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.
		<i>Staff</i>	Contact is expressing dissatisfaction due to CSR or Staff attitude, incorrect information given or non response to an inquiry.

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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.	<i>Connectivity/Installation/Processing Issues</i>	Contact is requesting assistance with the connection, installation, password resets, claim processing and adjustments through DDE.
		<i>Orientation Package</i>	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.	<i>Connectivity/Installation Issues</i>	Contact is requesting assistance with the connection, installation and password resets through EDI.
		<i>Front End or Vendor Editing</i>	Contact is requesting information or assistance with errors in the transmission or status of claims submitted electronically.
		<i>Information package/HIPAA Compliant Billing Software</i>	Contact is requesting information or an orientation package related to EDI.
Electronic Health Record (EHR) Incentive Programs	The Medicare and Medicaid EHR Incentive Programs provide incentive payments to eligible professionals, eligible hospitals, and critical access hospitals (CAHs) as they adopt, implement, upgrade, or demonstrate meaningful use of certified EHR technology.	<i>Attestation</i>	Contact is asking about how to attest that the meaningful use requirements for the EHR Incentive Programs are met. Also, includes inquiries on where to find sample formats for the attestation.
		<i>Certified EHR Technology</i>	Contact is asking about the requirements of certified EHR technology. This includes where to find the list of certified EHR technology.
		<i>Eligibility</i>	Contact is asking about the eligibility requirements to participate in the EHR Incentive Programs. Also, includes inquiries related to eligibility status as a participant in the EHR program.
		<i>Meaningful Use</i>	Contact is asking about the requirements to demonstrate Meaningful Use.
		<i>Not Classified</i>	Contact is asking an EHR question not included in another subcategory.

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		<i>Payment</i>	Contact is asking about a payment related to the EHR Incentive Programs. This includes a request for payment or to confirm if a payment is in process or already made.
		<i>Registration</i>	Contact is asking about the registration process to participate in the EHR Incentive Programs. This includes questions related to the Registration System and other issues associated with it.
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.	<i>Beneficiary Demographic</i>	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.
		<i>Benefit Days Available</i>	Contact is asking for the number of days in a hospital or SNF that remain available for the beneficiary.
		<i>Deductible</i>	Contact is asking if the beneficiary's annual deductible amount has been met so that Medicare payment for providers' services or supplies can begin.
		<i>DME Same or Similar Equipment</i>	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.
		<i>HMO Record</i>	Contact is asking whether the beneficiary is enrolled in an HMO, when HMO enrollment began, or for HMO contacts information.
		<i>Hospice</i>	Contact is asking if beneficiary has a hospice record open.
		<i>MSP Record</i>	Contact is asking for information related to other insurance coverage that the beneficiary might have that is primary to Medicare.
		<i>Next Eligible Date</i>	Contact is asking when is the next eligible date for the beneficiary to receive one or more preventive services.

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		<i>Outpatient Therapy Cap</i>	Contact is asking if the beneficiary's outpatient therapy cap amount has been reached.
		<i>Part A Entitlement</i>	Contact is asking when the beneficiary became eligible for Part A benefits.
		<i>Part B Entitlement</i>	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.	<i>Check Copies</i>	Contact is requesting a copy of a check.
		<i>Cost Report</i>	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?
		<i>Credit Balance/Account Receivable</i>	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.

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		<i>Do Not Forward (DNF) Initiative</i>	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.
		<i>Electronic Fund Transfer</i>	Contact is asking about electronic transfer of Medicare payments directly to a provider's financial institution.
		<i>Offsets</i>	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.
		<i>Overpayment</i>	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.
		<i>Refunds</i>	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.
		<i>Stop Payment / Check to Be Reissued</i>	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.	<i>Address /Phone/Fax/Web Address</i>	Contact is asking for contractor's addresses including website, fax and phone numbers.
		<i>Issue Not Identified/Incomplete Information Provided</i>	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.
		<i>Misrouted Telephone Call/Written Correspondence</i>	Contact is asking a question that should be handled in another contractor area, by another contractor and or by another agency/program.
		<i>Reference Resources Referral/Request</i>	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,

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			MEDPARD directory, online claim status availability, electronic remittance advice, IVR, etc.
		<i>Other Issues</i>	Contact is discussing subjects that are not classifiable into the defined categories or subcategories.
H1N1 Vaccine	Contact initiated to inquire about H1N1 influenza vaccine and its administration.	<i>Claim Denials</i>	Contact is asking about claims denied for H1N1 vaccine administration.
		<i>Complaints</i>	Contact is expressing dissatisfaction such things as payment for or access to the H1N1 vaccine.
		<i>Filing/Billing Instructions</i>	Contact is asking for instructions on how to file a claim for the H1N1 vaccine/administration, including coding requirements and roster billing.
		<i>Payment Policy/Coverage Rules</i>	Contact is asking about Medicare's rules regarding the coverage of and payment for the H1N1 flu vaccine/administration.
		<i>Vaccine Supply</i>	Contact is asking where to get a supply of the H1N1 vaccine.
		<i>Not Classified</i>	Contact is asking an H1N1 question not included in another subcategory.
HIPAA Privacy/ Privacy Act	The statutory authorities that govern the protections for personally identifiable patient health information and the conditions of its release.	<i>Authorizations</i>	Contact is asking for a consent/authorization form or a copy of their patient's authorization, which is necessary to release the information requested.
		<i>Release of Information Request</i>	Contact is requesting a copy of patient history or record.
		<i>Requirements</i>	Contact is asking about the HIPAA Privacy or Privacy Act requirements. Also, includes inquiries related to HIPAA contingency plans and the compliance with HIPAA 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	<i>COB/MSP Rules</i>	Contact is asking about Coordination of Benefits Rules and/or Medicare Secondary Payer Rules.

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	payer.		
		<i>Coordination of Benefits (COB) Contractor</i>	Contact is asking about the COB contractor responsibilities and contact information. Includes situations that require a referral to the COB contractor.
		<i>File Updates</i>	Contact is asking for beneficiary MSP/COB files information or providing information for MSP/COB file update.
		<i>Liens and Liabilities/Settlements</i>	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.	<i>Benefits/Exclusions/ Coverage Criteria/Rules</i>	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.
		<i>Certifications Requirements</i>	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.
		<i>Local Coverage Determination (LCD)</i>	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.
		<i>National Coverage Determination (NCD)</i>	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.
		<i>Non-published Items</i>	Contact is asking about the coverage of items with no criteria published by contractor or CMS.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		<i>Pre-authorization</i>	Contact is asking about or requesting a pre-authorization for providing Medicare benefits.
		<i>Statutes and Regulations</i>	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.	<i>National Provider Identifier</i>	Contact is asking about the National Provider Identifier (NPI).
		<i>Provider Demographic Information Changes</i>	Contact is asking for verification of their provider demographic information or asking how to request a change/correction of its existing information.
		<i>Provider Eligibility</i>	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.
		<i>Provider Enrollment Requirements</i>	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.
		<i>Provider Revalidation</i>	Contact is asking about and/or requesting clarification on the provider revalidation process i.e., the revalidation letter, additional requirements, certification statement, application fees. Also, includes inquiries related to the hardship exception request for the application fee and appeals to hardship exceptions.
Provider Outreach	The contractor's educational effort and activities with the provider community.	<i>Education Referrals</i>	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.
		<i>Workshop Information</i>	Contact is asking for information about provider outreach activities or educational opportunities for providers and their staff.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
Remittance Advice (Remit)	The paper or electronic summary statement for providers, including payment information for one or more beneficiaries.	<i>Duplicate Remittance Notice</i>	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.
		<i>ERA Election</i>	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.
		<i>How to read RA</i>	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.
Quality Initiatives	Include inquiries about CMS quality initiatives, related reports, processes and timeframes.	<i>E-Prescribing</i>	Contact is asking for general information about E-Prescribing and the E-Prescribing Incentive Program, with the exception of a request for an E-Prescribing Feedback Report.
		<i>E-Prescribing Feedback Report Request</i>	Contact is requesting an E-Prescribing Feedback Report for their National Provider Identifier (NPI).
		<i>PQRS</i>	Contact is asking for information about the Physician Quality Reporting System, formerly known as Physician Quality Reporting Initiative, with the exception of a request for a PQRI Feedback Report.
		<i>PQRS Feedback Report Request</i>	Contact is requesting a Physician Quality Reporting System, formerly known as Physician Quality Reporting Initiative, Feedback Report for their NPI.
		<i>QRUR</i>	Contact is asking for general information about the Quality and Resource Use Report (QRUR) with the exception of a request for a QRUR.
		<i>QRUR Request</i>	Contact is requesting a QRUR for their NPI.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
RTP/Unprocessable Claim	A claim(s) with incomplete, invalid, or missing information will be returned to the provider as unprocessable. This action cannot be appealed and the corrected claim(s) needs to be submitted as a new claim. Includes "W Status of Claim" and status of claims to be returned to provider.	<i>1500 / UB-04 Form Item</i>	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.
		<i>Clinical Laboratory Improvement Act (CLIA)</i>	Contact is asking about a claim(s) that was returned because the claim had a missing or incorrect CLIA number.
		<i>Contractor Error</i>	Contact is asking about a claim(s) that was returned to provider as unprocessable due to a contractor error.
		<i>Contractual Obligation Not Met</i>	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.
		<i>Shared Systems</i>	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).
		<i>Missing/Invalid Codes</i>	Contact is asking about a claim(s) that was returned because of a missing or invalid or changed code. Includes "Invalid CPT" inquiries.
		<i>Place of Service</i>	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.
		<i>Provider Information</i>	Contact is asking about a claim(s) that was returned due to an incorrect or missing UPIN/NPI.
		<i>Submitted to Incorrect Program</i>	Contact is asking about a claim(s) that was returned because it was submitted to the incorrect program (FI, Carrier or DMERC).

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		<i>Truncated Diagnosis</i>	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).	<i>Medicare Claims Processing System Issues</i>	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.
		<i>Website Issues</i>	Contact is reporting problems with the functionality, stability or use of the CMS and contractor website.
		<i>IVR Issues</i>	Contact is reporting problems with the functionality or use of the contractor's IVR.
Temporary Issues	Includes inquiries that CMS would like to track temporarily due to special circumstances. CMS will provide specific timeframes for the monitoring of temporary issues. For contractor specific temporary issues, please follow instructions on IOM 100-9, Chapter 3, Section 20.5 or Chapter 6, Sections 30.1.1 – 30.1.1.2.	<i>CD-ROM Initiative</i>	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.
		<i>CERT</i>	Contact is asking information related to the Comprehensive Error Rate Testing (CERT) Program.
		<i>Competitive Acquisition Program (CAP)</i>	Contact is asking general questions about the CAP.
		<i>HIGLAS</i>	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).

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		<i>Part D Drug Coverage</i>	Contact is presenting situation related to issues with the implementation of the Part D Medicare Prescription Drug Coverage.
		<i>Recovery Audit Contractor (RACs)</i>	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.