CMS Standardized Provider Inquiry Chart

Provider Customer Service Program (PCSP)

The CMS Standardized Provider Inquiry Chart provides standard inquiry categories and definitions for Medicare Administrative Contractors (MACs) to track and to report the nature of Medicare Fee-For-Service (FFS) provider inquiry types for telephone and written inquiries. These categories and subcategories describe the reason of why providers contacted the Medicare Provider Contact Centers (PCCs). (CMS Internet Only Manual (IOM) 100-09, Chapter 6, Section 30.6)

Revised on March 2020

Inquiry	Definition	Sub-categories	Definition
Adjustments	The process of changing information on a submitted claim to correct an error or to correct a claim denied in error.	*Cancellation of Claim/Return Claim/Billed in Error*	Contact is requesting to cancel a claim that was submitted in error. Includes "services not rendered."
		Claim Information Change	Contact is requesting a change or correction of information on a submitted/processed claim (e.g., contact asks to add or to remove the amount of units provided, to correct dates of service, to correct provider information).
		Claim Processing Error	Contact is requesting an adjustment of an incorrect payment due to a processing error by the local or shared systems (e.g., imaging errors, interest not paid or penalties applied in error).
		Diagnosis Code Change	Contact is requesting a change or a correction of a diagnosis on a submitted/processed claim.
		Medical Review	Contact is requesting corrections/changes in the diagnosis/treatment information on a processed claim as a result of a program integrity initiative.
		Modifier Change	Contact is requesting a change or a correction of a modifier on a submitted/processed claim.
		MSP	Contact is requesting an adjustment of a claim due to changes in the beneficiary Medicare Secondary Payer (MSP) or Health Maintenance Organization (HMO) (e.g., Medicare Advantage (MA) record.
		Procedure Code Change	Contact is requesting a change or a correction of a procedure code on a submitted/processed claim.

Inquiry	Definition	Sub-categories	Definition
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 Medicare billing (i.e., claim submission items and/or claim reports and payment not applicable to other inquiry category). This does not include an explanation of why a particular claim was denied.	*1500/837P/1450(UB-04)/837I Forms*	Contact is asking how to complete the claim form and/or where to find it, including an electronic equivalent of both 1500/837P and 837I/1450 UB04 Forms.
		ABN	Contact is asking for general information on Advance Beneficiary Notice (ABN) (e.g., when to use an ABN, where to find an ABN).
		Claim Documentation	Contact is asking for the necessary information to submit for processing and/or for adjudication of a claim (e.g., medical record, progress notes, physician's orders, x-rays).
		Claims Related Reports	Contact is asking for information about accessing and/or receiving reports produced by Medicare (e.g., billing trends, history of Medicare payments, comparative billing reports, medical review reports).
		Coinsurance	Contact is asking for the amount of coinsurance and/or deductible that beneficiaries must pay before Medicare begins to pay for covered services and supplies. This subcategory applies to inquiries at a general level. Use the "Deductible" subcategory under "Eligibility" for inquiries on annual deductible for a specific beneficiary.

Inquiry	Definition	Sub-categories	Definition
		Filing/Billing Instructions	Contact is asking for instructions on filing a claim, the type of bill necessary for a type of claim, how to correct/adjust a claim, mandatory submission of claims, and time filing limits. Includes inquiries on the 72 hour rule for diagnostic services.
		MBI	Contact is requesting assistance to correctly report the Medicare Beneficiary Identifier (MBI) on claims.
		HPSA/PSA	Contact is asking for information about Health Professional Shortage Area (HPSA) and/or Physician Scarcity Area (PSA) classification (e.g., 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 number or identifier required by the Medicare program (e.g., National Provider Identifier (NPI), Tax Identification Number (TIN) – SSN or EIN).
		OTP	Contact is asking questions or requesting guidance to bill under the OTP. Provider inquiries may include inquiries on how to submit an OTP claim, the necessary documentation with the claim, methodology and payment.
Allowed Amount	The amount that Medicare will pay for a certain service/product/item 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.

Inquiry	Definition	Sub-categories	Definition
		Ambulatory Surgical Center	Contact is asking for the Ambulatory Surgical Center (ASC)'s 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.
		ASP Resource	Contact is asking about the Medicare Part B Drug Average Sales Price (ASP) Resource payment amounts. This extensive listing of drugs is a guide that may not include all drugs that could be considered for payment by Medicare.
		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.
		Critical Access Hospitals	Contact is asking for the Critical Access Hospitals (CAHs) payment amount for a particular item or service provided to a Medicare beneficiary.
		DMEPOS Fee Schedule	Contact is asking for the Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule payment amount for a particular item or service provided to a Medicare beneficiary.
		ESRD Composite Rate	Contact is asking for the End Stage Renal Disease (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 (HH) Prospective Payment System (PPS) payment amount for a particular item or service provided to a Medicare beneficiary.

Inquiry	Definition	Sub-categories	Definition
		Hospice Payment System	Contact is asking for the Hospice Payment System 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.
		Long Term Care Hospital PPS	Contact is asking for the Long Term Care Hospital (LTCH) 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.
		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 (SNF) 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 claim determination.	*Duplicates*	Contact is appealing a Medicare determination, which appeal is already in progress, and as a result, is considered a duplicate request. Use only for instances where an inquiry response was sent to the provider.

Inquiry	Definition	Sub-categories	Definition
		Explanation/Resolution	Contact is asking for an explanation of a Medicare's determination or for additional information on a Medicare appeal resolution (e.g., if the time to file an appeal has expired, and/or is requesting a duplicate of a Medicare Redetermination Notice (MRN) related to a processed appeal).
		Process/Rights	Contact is asking for general appeal information, appeal process instructions and/or appeal rights.
		QIC	Contact is asking about an appeal status or information related to appeals reviewed by the Qualified Independent Contractor (QIC).
		Status	Contact is asking for the status of a submitted appeal and/or to confirm if an appeal was received.
Beneficiary Inquiries	Medicare beneficiaries or designated representatives that contact the MAC 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 misrouted Medicare beneficiary inquiry received by a MAC PCC must be logged using the subcategories under this category, as appropriate.	*Claim Issues*	Contact is asking for the status of claims, including appeals, and questions related to information contained in the Medicare Summary Notice (MSN). Also, includes requests for a copy of a MSN, requests for reopening of claims due to processing errors, scanning errors and system errors, and/or requests to cancel or to reissue a Medicare claim related check.

Inquiry	Definition	Sub-categories	Definition
		Complaints	Contact (Medicare beneficiary or designated representative) is presenting an issue involving a Medicare beneficiary that reflects dissatisfaction with any aspect of the Medicare program operation, its staff and its providers (e.g., about appointments with the provider, clearinghouse dismissals). Also, includes 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, includes inquiries related to diagnosis codes or to procedure codes eligible for payment, prescription drug issues (e.g., requesting pre-authorization on a drug) and/or requests for Medicare publications (e.g., Medicare Participating Physicians and Suppliers Directory (MEDPARD) directory).
		Eligibility/Entitlement	Contact is asking questions related to Medicare beneficiary demographic information (e.g., date of birth, date of death, address), the beneficiary identifier, entitlement dates, benefit days, deductible or coinsurance. Also, includes inquiries to confirm MSP information, a beneficiary enrollment to a Medicare Advantage plan and/or a Health Insurance Portability and Accountability Act (HIPAA)/Privacy – third-party authorization.
		Fraud and Abuse	Contact is reporting issues with providers related to possible abusive and/or fraudulent practices (e.g., payment assignment violations).

Inquiry	Definition	Sub-categories	Definition
		MSP	Contact is asking questions related to Medicare as primary or secondary insurance, and other coordination of benefits issues (e.g., 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	Claims that have been fully adjudicated and a non-payment determination was made based on Medicare rules and regulations.	*ABN*	Contact is asking for clarification on a particular claim denial where the use of Advance Beneficiary Notice (ABN) applies and the patient is not required to pay the provider for a service.
		Certification Requirements	Contact is asking about a claim(s) denied due to certification requirements not met. This includes Hospice certifications and/or Certificate of Medical Necessity (CMNs).
		Claim Overlap	Contact is asking about a 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 modifiers, global surgery denials and denials due to Correct Coding Initiative (CCI) edits.
		Contractor Processing Errors	Contact is asking about a claim(s) denied due to a MAC claim processing error (e.g., incorrect edit, shared systems issue).

Inquiry	Definition	Sub-categories	Definition
		Contractual Obligation Not Met	Contact is asking about a claim(s) denied because the provider did not comply with their Medicare contractual obligation (e.g., the claim was submitted with missing information, the ordering/referring/attending provider is not identified, provider not validly opted out of the Medicare program, the claim was not filed timely).
		CWF/Rejects	Contact is asking about a claim(s) denied because the beneficiary information on the claim does not match the Common Working File (CWF) beneficiary record (e.g., Managed Care/HMOs (e.g., Medicare Advantage)) status, discharge status, name mismatch, female patient with a male procedure claimed). Also, includes CWF issues that need to be corrected through the Social Security Administration (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 no payment of services in order to bill another insurer.
		DME POS Issues	Contact is asking about a claim(s) denied due to point of service (POS) issues related 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.

Inquiry	Definition	Sub-categories	Definition
		Duplicate	Contact is asking about a claim(s) denied due to same date of service, claim previously processed or paid for the same date and same provider.
		Eligibility	Contact is asking about a claim(s) denied due to beneficiary information not matching the CWF (e.g., incorrect suffix, transposed numbers). Also, include eligibility issues were there is no need to update information on CWF files.
		EMC Filing Requirements	Contact is asking about a claim(s) denied because it was not submitted electronically; therefore, not complying with the Electronic Media Claims (EMC) requirement. This also includes questions about a claim(s) denied due to an expired (or non-existent) Administrative Simplification Compliance Act (ASCA) Waiver based on non-compliance with ICD-10.
		Evaluation & Management Services	Contact is asking about a claim(s) where payment was denied or reduced due to a changed Evaluation & Management (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.

Inquiry	Definition	Sub-categories	Definition
		Frequency / Dollar Amount Limitation	Contact is asking about a claim(s) denied because the allowable number of incidences or dollar limit/threshold amount for that service in a given time period has been exhausted or exceeded due to a service that was previously paid. Also, includes inquiries related the outpatient therapy dollar limit/threshold amount and billing frequency limits for DMEPOS (same or similar equipment denials) such as Capped Rental.
		LCD	Contact is asking about a claim(s) denied or reduced based on a Local Coverage Determination (LCD) issued by the MAC. LCDs reflect the local MAC decision as to whether a product, service, or device is reasonable and necessary, and/or reflect a lack of coding specificity (e.g., ICD-10 CM/PCS) consistent with the appropriate LCD.
		Lifetime Days Met	Contact is asking about a claim(s) denied because the lifetime days' limit for a particular benefit is exhausted.
		MBI	Contact is asking about a claim(s) denied due to issues with the MBI reported on the claim(s).
		Medical Necessity	Contact is asking about a claim(s) denied because the information presented did not indicate that services or supplies are reasonable and necessary for the diagnosis and treatment of the illness or injury. Also, includes denials related to medically unlikely edits (MUEs).
		MSP	Contact is asking about a claim(s) denied because there is other insurance reflected on the beneficiary's file that is primary to Medicare.

Inquiry	Definition	Sub-categories	Definition
		NCD	Contact is asking about a claim(s) denied or reduced based on a National Coverage Determination (NCD) issued by CMS. This includes claim(s) denials due to lack of coding specificity (e.g., ICD-10 Clinical Modification (CM)/Procedure Coding System (PCS)) consistent with the appropriate NCD.
		Provider Number	Contact is asking about a claim(s) denied due to issues between the shared systems' provider information, the provider number and /or identifiers (NPI, TIN – SSN or EIN) of the billing provider and/or any other provider who must be identified in the claim. Also, includes inquiries about claims denied due to providers (i.e., attending/ordering/referring) without an enrollment record in Provider Enrollment, Chain and Ownership System (PECOS).
		Statutory Exclusion	Contact is asking about a claim(s) denied for items or services that are excluded 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 Interactive Voice Response (IVR).	*ADR*	Contact is asking about a Medicare Additional Documentation Request (ADR) letter received from the MAC that asks for 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).

Inquiry	Definition	Sub-categories	Definition
		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 the MAC has not received.
		Paid in Error	Contact is asking about a claim that they believe was paid in error.
		Payment Explanation/Calculation	Contact is asking for explanation on how the claim was paid or how the payment amount was calculated. Includes "reimbursement" questions.
		Suspended	Contact is asking about the status of a claim that is pending while waiting for information needed to complete processing.
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 inquiries about the codes, their descriptions, and how to use them.	*CCI Edits*	Contact is asking about Correct Coding Initiative (CCI) 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.
		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.

Inquiry	Definition	Sub-categories	Definition
		E&Ms	Contact is asking about codes that explain how the physician gathered and analyzed patient information, determined a condition, and advised the best treatment (e.g., care plan oversight, office visits, hospital visits and consultations). E&M codes are part of the American Medical Association (AMA)'s Current Procedural Terminology (CPT) - 4 coding system.
		Modifiers	Contact is asking about two digit codes used in conjunction with a procedure code that provides additional information about the service. The modifier may affect the reimbursement rate of a service.
		MSP Payer/Value Codes	Contact is asking about codes used to designate that another insurer is responsible for a full or a partial payment where Medicare has no payment or secondary payment responsibility.
		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. Also, includes 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.

Inquiry	Definition	Sub-categories	Definition
		Procedure Codes	Contact is asking about the numeric representation of a procedure used to determine reimbursement for services rendered on a claim or for other medical documentation. Also includes CPT- 4 codes (which belong to the American Medical Association) that indicate physician services, physical and occupational therapy services, radiology procedures, clinical laboratory tests, medical diagnostic services, and hearing and vision services and Healthcare Common Procedure Coding System (HCPCS) Codes Level II that determines reimbursement for equipment and medical supplies.
		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).
		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 MACs with regard 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 about MAC operational errors, procedures, policies, processes, and staff issues not addressed by other subcategories included in this section.
		Medicare Program	Contact is expressing dissatisfaction about issues with the Medicare program. Also, includes provider expressions of intent about leaving the Medicare program.

Inquiry	Definition	Sub-categories	Definition
		Provider Education and Outreach	Contact is expressing dissatisfaction about educational activities, education staff performance or availability of educational resources or activities for Medicare providers.
		Self-Service Technology	Contact is expressing dissatisfaction about content, functionality, instability, formatting and/or 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 about CSR or staff attitude, incorrect information given or no response to an inquiry.
Direct Data Entry (DDE)	The DDE system is an on-line application that allows direct on-line access to Medicare claims information, such as: claim entry, error correction, eligibility, 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.
		MBI	Contact is requesting assistance with DDE issues believed to be caused by the MBI(s) used on a claim(s).
		Orientation Package	Contact is requesting information or an orientation package related to DDE.

Inquiry	Definition	Sub-categories	Definition
DMEPOS Competitive Bidding Program	Inquiries related to the DMEPOS Competitive Bidding (CB) Program designed to improve the effectiveness of Medicare's DMEPOS payments, to reduce beneficiary out-of-pocket costs, and to save the Medicare program money while ensuring beneficiary access to quality DMEPOS items and services. It requires the suppliers' accreditation by a Medicare-recognized accreditation organization.	*Bidding Cycle*	Contact is asking questions regarding the DMEPOS bidding cycle (e.g., application requirements, evaluation criteria and deadlines). Also, includes questions about the accreditation process.
		Claim Denials	Contact is asking about a claim(s) denied due to issues related to DMEPOS items (e.g., non-contract supplier billing, repair /service /replacement, misuse or missing modifiers).
		Complaints	Contact is expressing dissatisfaction with an aspect(s) and/or process(es) of the DMEPOS Competitive Bidding Program. Also, includes complaints related to contractor-supplier performance (e.g., beneficiary's difficulty in obtaining DMEPOS suppliers, incorrect information distributed by suppliers, refusal to accept Medicare patients).
		Filing/Billing Instructions	Contact is asking for instructions about how to file a claim for a DMEPOS item (e.g., which modifiers to use, what documentation is required or the use of an ABN).

Inquiry	Definition	Sub-categories	Definition
		Policy/Coverage Rules	Contact is asking for clarification of Medicare contract and Competitive Bidding Area (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 facilities.
		Provider Outreach & Education	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 contracted suppliers and the list of contracted items.
		Single Payment Amount	Contact is asking for the allowed payment amount established by the DMEPOS Competitive Bidding Program.
EHR Incentive Programs	The Medicare and Medicaid Electronic Health Record (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.	*Attestation*	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.
		Certified EHR Technology	Contact is asking about the requirements of certified EHR technology. This includes where to find the list of certified EHR technology.

Inquiry	Definition	Sub-categories	Definition
		Eligibility	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.
		Meaningful Use	Contact is asking about the requirements to demonstrate Meaningful Use.
		Payment	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.
		Registration	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.
Electronic Data Interchange (EDI)	The EDI system for electronic claim submission and retrieval of Electronic Remittance Advices (ERA).	*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.
		MBI	Contact is requesting assistance with EDI issues believed to be caused by the MBI(s) used on a claim(s).

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 the main category name for tracking purposes.	*Beneficiary Demographic*	Contact is asking to verify or update (within the MAC's ability) beneficiary personal information, such as the beneficiary identifier, the address, date of birth, date of death, etc.
		Benefit Days Available	Contact is asking for the number of hospital or SNF days 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 the beneficiary has an active DME CMN or DMERC Information Form (DIF), or if the beneficiary has a same or a similar equipment on file.
		Incarcerated Beneficiary	Contact is asking to verify or to update (within the MAC's ability) personal information of an incarcerated beneficiary.
		HMO Record	Contact is asking whether the beneficiary is enrolled in a Health Maintenance Organization (HMO) (e.g., MA), when the HMO enrollment began, or for the HMO's contact information.
		Hospice	Contact is asking if the beneficiary has an open hospice record.
		MBI	Contact is asking to verify or to update (within the MAC's ability) the beneficiary's MBI. This includes provider inquiries about the beneficiary's proof of eligibility in the absence of the new Medicare card.

Inquiry	Definition	Sub-categories	Definition
		MSP Record	Contact is asking for other health insurance coverage the beneficiary might have that is primary to Medicare.
		Next Eligible Date	Contact is asking about the next date the beneficiary is eligible to receive one or more preventive services.
		Outpatient Therapy Cap	Contact is asking if the beneficiary reached the outpatient therapy limit/threshold amount.
		Part A Entitlement	Contact is asking when the beneficiary became eligible for Part A benefits.
		Part B Entitlement	Contact is asking when the beneficiary became eligible for Part B benefits or whether the beneficiary is eligible for Part B benefits.
Financial Information	The financial responsibility of providers and/or Medicare normally involve information that comes from the MAC's financial department or requests that are processed by the MAC'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 (e.g., how to submit a cost report, documentation needed for an acceptable cost report, whether the MAC received the cost report).

Inquiry	Definition	Sub-categories	Definition
		Credit Balance/Account Receivable	Contact is asking about a credit balance that is due to Medicare due to 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) Medicare or another insurer paid twice for the same service; 2) Paid for non-covered services or services planned but not performed; 3) Overpayment due to mis-calculation of the beneficiary's deductible and/or coinsurance amounts; or 4) A hospital 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.
		DNF	Contact is requesting information about the CMS Do Not Forward (DNF) 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. May include inquiries about why a provider is not receiving its checks.
		EFT	Contact is asking about the Electronic Fund Transfer (EFT) transfer of Medicare payments directly to a provider's financial institution.
		HIGLAS	Contact is presenting a situation due to recent updates and/or presenting technical matters on a payment, payables, and receivables directly associated to Healthcare Integrated General Ledger Accounting System (HIGLAS), the fee-for-service Medicare Contractor accounting system.

Inquiry	Definition	Sub-categories	Definition
		Offsets	Contact is asking the reason for a withheld payment or for an explanation of the Financial Control Number (FCN) that appeared on the Remittance Advice.
		Overpayment	Contact is asking about a notice received due to Medicare funds paid in excess of amounts that are due and payable 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 (e.g., status, notifying Medicare that a refund is needed, or asking about the process to request a refund).
		Stop Payment / Check to Be Reissued	Contact is requesting a stop payment or a check reissuance (e.g., 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 the wrong provider.
General Information	Inquiries that cannot be included in other categories.	*Address /Phone/Fax/Web Address*	Contact is asking for a MAC's address, website address, fax and/or phone numbers.
		Incomplete Information Provided	Contact failed to provide or omitted relevant information for the evaluation/resolution of the inquiry (e.g., the beneficiary ID and/or the provider number). This sub-category may apply to written correspondence only.
		Issue Not Identified	Contact failed to identify/explain the reason for the inquiry. This sub-category may apply to written correspondence only.
		Misrouted Telephone Call/Written Correspondence	Contact is asking a question not intended for the MAC and/or not to be handled by the MAC. These inquiries should be handled by another MAC, a support contractor, and/or by another agency/program/organization.

Inquiry	Definition	Sub-categories	Definition
		Other Issues	Contact is discussing subjects that are not classifiable into the defined categories or subcategories.
		Reference Resources Referral/Request	Contact is asking where to find or to access information about specific topics or requesting information about resources available for provider education or self-service options (e.g., MEDPARD directory, online claim status availability, electronic remittance advice, IVR, etc.).
H1N1 Vaccine	Contact initiated to inquire about Influenza A Virus Subtype (H1N1) influenza vaccine and its administration.	*Claim Denials*	Contact is asking about claims denied for H1N1 vaccine administration.
		Complaints	Contact is expressing dissatisfaction with things such as payment for or access to the H1N1 vaccine.
		Filing/Billing Instructions	Contact is asking for instructions on how to file a claim for the H1N1 vaccine/ administration, including coding requirements and roster billing.
		Payment Policy/Coverage Rules	Contact is asking about Medicare's rules regarding the coverage of and payment for the H1N1 flu vaccine/administration.
		Vaccine Supply	Contact is asking where to get a supply of the H1N1 vaccine.
Health Insurance Portability and Accountability Act (HIPAA)	The statutory authorities that govern the protection and release of Personally Identifiable Information (PII) and Protected Health Information (PHI).	*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 a patient history or record.

Inquiry	Definition	Sub-categories	Definition
		Requirements	Contact is asking about the HIPAA or Privacy Act requirements. Also, includes inquiries related to HIPAA contingency plans and the compliance with HIPPA transaction rules.
ICD-10	The health care industry transitioned to the Tenth Revision of the International Classification of Diseases, (ICD-10) codes for diagnoses and hospital inpatient procedures. Everyone covered by the HIPAA must use ICD-10 codes for documentation, reporting and/or billing of health care services provided.	*CM Diagnosis Codes*	Contact is asking about the ICD-10 (3 to 7 digits) 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. This also includes questions about the ICD-10-CM claim submission audit/quality review flexibility using "family of codes", proper use and grouper logic of ICD-10-CM MS-DRG, and the use of the GEM tool that converts ICD-9-CM to ICD-10-CM data or vice versa.
		Filing/Billing Instructions	Contact is asking about ICD-10 Medicare related billing items/issues (e.g., claim forms, dual processing). This includes instructions on ICD-9 and ICD-10 billing beyond ICD-10 transition dates that may or may not need to Request an Anticipated Payment (RAP) or a conditional payment. Also, relates to questions about alternative submissions of claims, including guidance on billing paper claims.

Inquiry	Definition	Sub-categories	Definition
		Front End Technical Issues	Contact is requesting help desk technical assistance with electronic errors submitted in the transmission or status of claims due to non-compliance or format issues with ICD-10. ICD-10 format errors may include the use of invalid alpha numeric (AN) characters in ICD-10 diagnosis codes that are present on 5010 or paper inbound claims, and/or typographical errors. Also, includes inquiries about the free ICD-10 formatted billing software.
		PCS Procedure Codes	Contact is asking about the ICD-10 (7 alphanumeric digits) representation of an inpatient procedure code used to determine reimbursement for inpatient services on a claim or other medical documentation. Also, includes questions about the proper use and grouper logic for ICD-10-PCS Medicare Severity Diagnosis Related Groups (MS-DRG), the use of the General Equivalence Mapping (GEM) tool that converts ICD-9-PCS to ICD-10-PCS data or vice versa.
		Provider Education & Outreach	Contact is asking for information about outreach activities or educational opportunities for providers and their staff related to ICD-10. Training opportunities may include ICD-10 teleconferences, self-paced education, webinars, reference guides for electronic transactions, FAQs, MLN Matters articles and MLN Connects national provider calls, and/or fact sheets.

Inquiry	Definition	Sub-categories	Definition
		Readiness	Contact is asking about how to be ready for the ICD-10 implementation to avoid reimbursement issues and interruptions of workflow. Also, includes questions about the ICD-10 readiness letter, the Administrative Simplification Compliance Act (ASCA) Waiver, waiver criteria, submission of waiver requests, effective and expiration date of the waiver, attestation forms and corrective action plans for providers and entities not compliant with ICD-10.
		RTP/Unprocessable Claims	Contact is asking about a claim(s) that was/were returned due to incorrect, invalid ICD-10 coding or format. This action cannot be appealed and the corrected claim(s) needs to be submitted as a new claim. This applies to paper claims and electronic submitted claims.
		Testing	Contact is asking questions about ICD-10 testing opportunities, and who they may need to contact for questions. This includes testing questions from providers and/or entities completing a corrective action plan due to ICD-10 non-compliance.
Medicare Secondary Payer (MSP)	The term used when Medicare is not responsible for paying primary on a claim that is otherwise the primary responsibility of another payer.	*Benefits Coordination & Recovery Center*	Contact is asking about the Benefits Coordination & Recovery Center (BCRC) responsibilities and contact information. Also, includes situations of collection, management, and reporting of other insurance coverage for beneficiaries that are performed and need referral to the BCRC.
		COB/MSP Rules	Contact is asking about COB Rules and/or Medicare Secondary Payer Rules.

Inquiry	Definition	Sub-categories	Definition
		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 Plan (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 to pay for services furnished by Medicare providers to Medicare beneficiaries.
		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 Certificates of Medical Necessity.
		LCD	Contact is asking about a local coverage determination developed by the MAC to describe the Medicare coverage circumstances for a specific medical service, procedure or device within their jurisdiction.
		Medicare Part D Prescriber Enrollment and Prescription Drug Coverage	Contact is inquiring about the mandatory requirement that all physicians and other eligible professionals, who prescribe Part D drugs, enroll in the Medicare program. Contact may also be inquiring about the Part D Medicare Prescription Drug Coverage.

Inquiry	Definition	Sub-categories	Definition
		NCD	Contact is asking about a national coverage determination developed by CMS to describe the circumstances for Medicare coverage for a specific medical service, a procedure or a device.
		Non-published Items	Contact is asking about the coverage of items with no criteria published by the MAC or CMS.
		Pre-Claim Review	Contact is asking about or requesting information about the relevant coverage policy, process, and clinical documentation requirements for a pre-claim review. Use this subcategory to log provider inquiries regarding all pre-claim review for home health services issues.
		Prior-authorization	Contact is asking about or requesting a prior authorization for providing Medicare benefits. This includes questions related to the process associated with the prior authorization of services, the beneficiary's medical condition(s) and the necessary documentation to warrant the prior authorization. Use this subcategory to log DMEs Powered Mobility Device (PMD) Demonstration provider inquiries.
		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 Medicare Program provider.	*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.
		NPI	Contact is asking about the National Provider Identifier (NPI).

Inquiry	Definition	Sub-categories	Definition
		OTP	Contact is asking questions or requesting guidance on how to enroll as an OTP provider, necessary documentation with the enrollment application, enrollment timeframes, etc. Provider inquiries may include questions on how to be certified, and/or accredited by the Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Substance Abuse Treatment (CSAT) - Division of Pharmacologic Therapies (DPT), and its license by the state in which they operate, and its registration through the local Drug Enforcement Administration (DEA) office.
		PECOS	Contact is asking about how to access, to use, to find and/or to report an issue related to the Internet-based Provider Enrollment, Chain and Ownership System (PECOS) used in lieu of the Medicare enrollment application (i.e., paper CMS-855).
		Provider Demographic Information Changes	Contact is asking for verification of their provider demographic information or asking how to request a change/correction of their 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.

Inquiry	Definition	Sub-categories	Definition
		Provider Enrollment Requirements	Contact is asking about the requirements to become an enrolled provider in the Medicare Program. Also, includes inquiries from non-enrolled providers, and enrolled providers who do not have enrollment records in PECOS. Includes the overview/orientation of the Provider Enrollment Forms (CMS 855 Form), where to find it and/or instructions on how to complete it.
		Provider Revalidation	Contact is asking about and/or requesting clarification on the provider revalidation process (e.g.., the revalidation letter, additional requirements, certification statement, application fees). Also, includes inquiries related to the hardship exception including requests for the application fee and appeals to hardship exceptions.
Program Integrity	Includes inquiries about CMS Program Integrity Initiatives, processes and timeframes.	*CERT*	Contact is asking information related to the Comprehensive Error Rate Testing (CERT) Program.
		Fraud and Abuse	Contact is reporting fraud and abuse allegedly done by a Medicare provider. Also, includes providers calling for guidelines to assure compliance of Medicare rules and regulations against fraudulent and abusive practices.
		RAC	Contact is asking information about a CMS initiative using a Recovery Audit Contractor (RAC) to identify underpayments and overpayments and to recoup overpayments. Also, includes inquiries related to demand letters and records requested by the RAC.
Provider Outreach	The MAC's educational effort and activities with the provider community.	*Education Referrals*	Contact is requesting contact/visit from Professional Outreach and Education (POE) staff to provide supplemental education, discuss an issue in-depth, or to request clarification of a confusing situation.

Inquiry	Definition	Sub-categories	Definition
		MBI	Contact is requesting general education/information about the MBI and/or the New Medicare Card.
		Workshop Information	Contact is asking for information about provider outreach activities or educational opportunities for providers and their staff.
Quality Initiatives	Includes inquiries about CMS quality initiatives, related reports, processes and timeframes.	*E-Prescribing*	Contact is asking for general information about E-Prescribing and the E-Prescribing Incentive Program, including requests for an E-Prescribing Feedback Report.
		PCIP	Contact is asking for information about the Primary Care Incentive Program.
		PQRS	Contact is asking for information about the Physician Quality Reporting System (PQRS), formerly known as Physician Quality Reporting Initiative (PQRI), including requests for a PQRS Feedback Report.
		QRUR	Contact is asking for general information about the Quality and Resource Use Report (QRUR), including requests for a QRUR.
		QPP	Contact is seeking information or asking questions about the Quality Payment Program (QPP). A key provision of the MACRA, the goal is to pay clinicians for the value and quality of care they provide to Medicare patients. The QPP framework unifies the Physician Quality Reporting System, the Value Modifier Program, and the Medicare Electronic Health Record Incentive Programs into a single framework with two paths, the MIPS and APMs.

Inquiry	Definition	Sub-categories	Definition
Remittance Advice (RA)	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 RA. Also, includes inquiries where a provider did not received his/her remittance notice, needs to send it to the patient's secondary insurance, and/or needs a single line or a no pay RA.
		ERA Election	Contact is asking for information about how to access and/or to receive RAs electronically. Also, includes inquiries related to the MREP software.
		How to read RA	Contact is asking for assistance in reviewing and/or in understanding their RA. Also, includes explanation of the Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC).
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 Claims" and status of claims to be returned to the provider (RTP).	*1500/837P/1450(UB-04)/837I Form Item*	Contact is asking about a claim(s) that was(were) returned because the CMS claim form was not completed with the required information, such as, missing or invalid beneficiary ID, name, date of birth or sex. Also, includes the explanation of narrative of reason codes in the MAC's claims correction file, claims processing system and reports.
		CLIA	Contact is asking about a claim(s) that was(were) returned because the claim had a missing or incorrect Clinical Laboratory Improvement Act (CLIA) number.
		Contractor Error	Contact is asking about a claim(s) that was(were) returned to provider as unprocessable due to a MAC error.

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 (e.g., 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(were) returned because the patient information on the claim does not match information on CMS's shared systems (Fiscal Intermediary Shared System (FISS), Medicare Carrier System (MCS), VIPS Medicare Shared System (VMS), and CWF).
		Missing/Invalid Codes	Contact is asking about a claim(s) that was(were) returned due to a missing, an invalid or a changed code. Also, includes "Invalid CPT" inquiries.
		Place of Service	Contact is asking about a claim(s) that was(were) 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(were) returned due to an incorrect or missing provider information including the NPI and/or TIN (SSN or EIN).
		Submitted to Incorrect Program	Contact is asking about a claim(s) that was(were) returned because it was submitted to the incorrect program (AB MAC, HH+H MAC, or DME MAC and RRB SMAC).
		Truncated Diagnosis	Contact is asking about a claim(s) that was(were) returned due to incorrect, invalid or missing diagnosis information.

Inquiry	Definition	Sub-categories	Definition
Systems Issues	Medicare electronic systems, including the Medicare Claims Processing Systems and/or customer self-service applications (i.e. CMS website, MAC website, IVR, etc.).	*MAC Provider Portal*	Contact is presenting a situation related to the MAC's Internet-based provider portal, including issues with the functionality, stability and/or use of the Portal. Includes issues with password resets and multi-factor authentication.
		Medicare Claims Processing System Issues	Contact is asking about a situation related to issues with the Medicare Processing Systems; for example, issues due to an aged claim, recycling claim and release of claims, etc.
		MBI	Contact is presenting a technical issue with the use of the MBI in the MAC's Internet-based provider portal, the Interactive Voice Response (IVR) System, the MAC's website, and/or the claims processing systems (if the claims processing systems issue is not reportable in other MBI subcategories).
		Website Issues	Contact is reporting problems with the functionality, stability or use of the CMS and MAC website (i.e., interactive tools, online education).
		IVR Issues	Contact is reporting problems with the functionality or use of the MAC's IVR.
Temporary Issues	Includes inquiries that CMS would like to track temporarily due to special circumstances.	*2019-Novel Coronavirus*	Contact is seeking information or asking questions about the 2019-Novel Coronavirus or COVID-19. Inquiries may include questions about policy guidance, health reporting and documentation, billing instructions coding and payment, treatment and prevention, clinical management, care coordination, testing available, protective supplies for healthcare personnel, and/or any provider outreach and education initiatives, and/or reference materials (e.g., FAQs, Medicare Learning Network (MLN) products), and other related aspects of the virus.

Inquiry	Definition	Sub-categories	Definition
		MDPP	Contact is seeking information or asking questions about the Medicare Diabetes Prevention Program (MDPP) that may be related to important program deadlines and payment policy. Providers may also inquire about MDPP documentation requirements, program eligibility criteria, MDPP provider enrollment & compliance, provider education initiatives and/or education and/or reference materials, and other related aspects of the program.
		Opioids Misuse Prevention	Contact is seeking information about the CMS initiative to promote care coordination and safe use of prescription opioids. Provider inquiries may include questions about important initiative deadlines, Medicare opioids drug plan policies to prevent and treat the misuse of opioids, national and local coverage of alternative pain treatments, provider education initiatives and/or education and/or reference materials, and other related aspects of the initiative.

Acronyms used in the CMS Standardized Provider Inquiry Chart

ABN – Advance Beneficiary Notice	EHR – Electronic Health Record	MSP – Medicare Secondary Payer
ADR – Additional Documentation Request	ERA – Electronic Remittance Advice	MUEs – Medically Unlikely Edits
AMA – American Medical Association	ESRD - End Stage Renal Disease	NCD – National Coverage Determination
AN – Alpha Numeric	FAQ – Frequently Asked Question	NPI – National Provider Identifier
APM - Advanced Alternative Payment Models	FCN – Financial Control Number	OTP – Opioid Treatment Program
ASCA – Administrative Simplification Compliance Act	FI – Fiscal Intermediary	PCC – Provider Contact Center
ASP – Drug Average Sales Price	FISS - Fiscal Intermediary Shared System	PCIP – Primary Care Incentive Program
ATP – Approved to Pay	GEM - General Equivalence Mapping	PCS – Procedure Coding System
BCRC - Benefits Coordination & Recovery Center	GHP – Group Health Plan	PECOS – Provider Enrollment, Chain and Ownership System
CAH - Critical Access Hospital	H1N1 - Influenza A Virus Subtype	
CARC - Claim Adjustment Reason Code	HCPCS – Healthcare Common Procedure Coding System	PMD – Power Mobility Device
CBA – Competitive Bidding Area	HIGLAS - Healthcare Integrated General Ledger Accounting System	POE – Provider Outreach and Education
CCI – Correct Coding Initiative		POS – Place of Service
CERT – Comprehensive Error Rate Testing	HIPPA - Health Insurance Portability and Accountability Act	PPS – Prospective Payment System
CHIP - Children's Health Insurance Program		PQRI - Physician Quality Reporting Initiative
CLIA – Clinical Laboratory Improvement Act	HMO – Health Maintenance Organization	PQRS – Physician Quality Reporting System, formerly known as PQRI.
CM - Clinical Modification	HPSA - Health Professional Shortage Area	
CMN – Certificate of Medical Necessity	ICD - International Classification of Diseases	PSA - Physician Scarcity Area
CMS – Centers for Medicare & Medicaid Services	IVR – Interactive Voice Response	QIC – Qualified Independent Contractor
COB - Coordination of Benefits	LCD – Local Coverage Determination	QPP – Quality Payment Program
COVID – Coronavirus Disease	MA – Medicare Advantage	QRUR – Quality and Resource Use Report
CPT - Current Procedural Terminology	MAC – Medicare Administrative Contractor	RA - Remittance Advice
CSAT- Center for Substance Abuse Treatment	MACRA - Medicare Access and CHIP Reauthorization Act of 2015	RAC – Recovery Audit Contractor
CWF - Common Working File		RAP - Request an Anticipated Payment
DDE – Direct Data Entry	MBI – Medicare Beneficiary Identifier	RARC – Remittance Advice Remark Code
DEA - Drug Enforcement Administration	MCS - Multi-Carrier System	RTP – Return to Provider
DIF – DMERC Information Form	MDPP - Medicare Diabetes Prevention Program	SAMHSA - Substance Abuse and Mental Health Services Administration
DMEPOS – Durable Medical Equipment, Prosthetics, Orthotics and Supplies	MEDPAR – Medicare Provider Analysis and Review	
	MEDPARD – Medicare Participating Physicians and Suppliers Directory	SNF – Skill Nursing Facility
DMERC – Durable Medical Equipment Regional Carrier		SSA – Social Security Administration
DNF – Do Not Forward	MIPS - Merit-based Incentive Payment System	SSN – Social Security Number
DPT - Division of Pharmacologic Therapies	MLN – Medicare Learning Network®	SSNRI - Social Security Number Removal Initiative, currently known as the New Medicare Card
E&M - Evaluation and Management	MREP – Medicare Easy Print Software	
EDI – Electronic Data Interchange	MRN – Medicare Redetermination Notice	TIN - Tax Identification Number
EIN - Employer Identification Number	MS-DRG - Medicare Severity Diagnosis Related Groups	VIPS - Viable Information Processing Systems
EMC – Electronic Media Claims	MSN - Medicare Summary Notice	VMS – VIPS Medicare Shared System