# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. INTRODUCTION</td>
<td></td>
<td>11</td>
</tr>
<tr>
<td>1.1</td>
<td>First Coast’s Secure Provider Online Tool (SPOT)</td>
<td>11</td>
</tr>
<tr>
<td>1.2</td>
<td>Scope of The SPOT: User Guide</td>
<td>11</td>
</tr>
<tr>
<td>1.2.1</td>
<td>Conventions</td>
<td>12</td>
</tr>
<tr>
<td>2</td>
<td>OVERVIEW</td>
<td>13</td>
</tr>
<tr>
<td>2.1</td>
<td>SPOT: Capabilities and Limitations</td>
<td>13</td>
</tr>
<tr>
<td>2.1.1</td>
<td>Capabilities</td>
<td>13</td>
</tr>
<tr>
<td>2.1.2</td>
<td>Limitations</td>
<td>13</td>
</tr>
<tr>
<td>2.1.3</td>
<td>SPOT: System Requirements</td>
<td>13</td>
</tr>
<tr>
<td>2.1.4</td>
<td>SPOT: Integration with CMS’ EIDM system</td>
<td>14</td>
</tr>
<tr>
<td>2.1.5</td>
<td>Acceptance of EIDM Terms and Conditions</td>
<td>14</td>
</tr>
<tr>
<td>2.1.6</td>
<td>Compliance with federal regulations</td>
<td>14</td>
</tr>
<tr>
<td>3</td>
<td>GETTING STARTED</td>
<td>15</td>
</tr>
<tr>
<td>4</td>
<td>SPOT: New User Registration</td>
<td>15</td>
</tr>
<tr>
<td>4.1</td>
<td>Part I: Create EIDM Account</td>
<td>15</td>
</tr>
<tr>
<td>4.1.1</td>
<td>Part II: Requesting access to SPOT</td>
<td>21</td>
</tr>
<tr>
<td>4.2</td>
<td>Part III – Registering a multifactor authentication (MFA) device</td>
<td>29</td>
</tr>
<tr>
<td>4.2.1</td>
<td>Tips for registering</td>
<td>29</td>
</tr>
<tr>
<td>4.2.2</td>
<td>How to register your MFA device</td>
<td>29</td>
</tr>
<tr>
<td>EIDM ACCOUNT/ACCESS MANAGEMENT</td>
<td></td>
<td>37</td>
</tr>
<tr>
<td>4.3</td>
<td>EIDM Account: ‘My Profile’</td>
<td>37</td>
</tr>
<tr>
<td>4.3.1</td>
<td>EIDM Account: ‘My Profile’ -- Change Password</td>
<td>37</td>
</tr>
<tr>
<td>4.3.2</td>
<td>EIDM Account: ‘My Profile’ -- Forgot Password</td>
<td>41</td>
</tr>
<tr>
<td>4.3.3</td>
<td>EIDM Account: ‘My Profile’ -- Forgot User ID</td>
<td>44</td>
</tr>
<tr>
<td>4.3.4</td>
<td>EIDM Account: ‘My Profile’ -- View Profile</td>
<td>45</td>
</tr>
<tr>
<td>4.3.5</td>
<td>EIDM Account: ‘My Profile’ -- Change Profile Information</td>
<td>46</td>
</tr>
<tr>
<td>4.3.6</td>
<td>EIDM Account: ‘My Profile’ -- Change Security Questions &amp; Answers</td>
<td>48</td>
</tr>
<tr>
<td>4.3.7</td>
<td>EIDM Account: ‘My Access’ -- View and Manage My Access</td>
<td>49</td>
</tr>
<tr>
<td>4.3.8</td>
<td>EIDM Account: ‘My Access’ -- View Existing Role Details</td>
<td>53</td>
</tr>
<tr>
<td>4.3.9</td>
<td>EIDM Account: ‘My Access’ -- Add Role</td>
<td>54</td>
</tr>
<tr>
<td>4.3.10</td>
<td>EIDM Account: ‘My Access’ -- Remove Role</td>
<td>55</td>
</tr>
<tr>
<td>5</td>
<td>ACCESSING THE ‘SPOT’ APPLICATION</td>
<td>57</td>
</tr>
<tr>
<td>5.1</td>
<td>Accessing the SPOT Application: EIDM Registered/Approved Users</td>
<td>57</td>
</tr>
</tbody>
</table>
### 5.2 ‘SPOT’: Organization and Navigation

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organization</td>
<td>59</td>
</tr>
<tr>
<td>Navigation</td>
<td>59</td>
</tr>
</tbody>
</table>

### 6 USING THE ‘SPOT’ APPLICATION

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appeals</td>
<td>61</td>
</tr>
<tr>
<td>Appeals: Correcting a claim</td>
<td>61</td>
</tr>
<tr>
<td>Appeals: Reopening a claim - overview</td>
<td>63</td>
</tr>
<tr>
<td>Claim reopenings submitted through the ‘SPOT’</td>
<td>65</td>
</tr>
<tr>
<td>Claim Reopening Requests: Eligibility Criteria</td>
<td>66</td>
</tr>
<tr>
<td>Request Types: Primary and Secondary Fields</td>
<td>67</td>
</tr>
<tr>
<td>Request Types: Information tooltips</td>
<td>68</td>
</tr>
<tr>
<td>Request Types: Hospice</td>
<td>69</td>
</tr>
<tr>
<td>Request Types: History Correction</td>
<td>70</td>
</tr>
<tr>
<td>Request Types: Entitlement</td>
<td>70</td>
</tr>
<tr>
<td>Request Types: MSP</td>
<td>71</td>
</tr>
<tr>
<td>Request Types: DOS Category</td>
<td>72</td>
</tr>
<tr>
<td>Claim Reopening Request Types: Diagnosis Code Category</td>
<td>74</td>
</tr>
<tr>
<td>Claim Reopening Request Types: Procedure Code Category</td>
<td>75</td>
</tr>
<tr>
<td>Request Types: Modifier Category</td>
<td>76</td>
</tr>
<tr>
<td>Claim Reopening Request Types: Units Billed Category</td>
<td>77</td>
</tr>
<tr>
<td>Claim Reopening Request Types: Billed Amount</td>
<td>78</td>
</tr>
<tr>
<td>Claim Reopening Requests: Accessing the Claim</td>
<td>78</td>
</tr>
<tr>
<td>Claim Reopening Requests: Access through Claim Status</td>
<td>78</td>
</tr>
<tr>
<td>Claim Reopening Requests: Access through Claim Reopenings</td>
<td>80</td>
</tr>
<tr>
<td>Claim Reopening Requests: Completing the Request Form</td>
<td>82</td>
</tr>
<tr>
<td>Claim Reopening Requests: Checking Status</td>
<td>85</td>
</tr>
<tr>
<td>Appeals: Submitting an appeal (claim redetermination)</td>
<td>86</td>
</tr>
<tr>
<td>Appeals: Appeals outcome</td>
<td>88</td>
</tr>
<tr>
<td>Claims</td>
<td>90</td>
</tr>
<tr>
<td>Claim: Check Claims Status</td>
<td>90</td>
</tr>
<tr>
<td>Claim Status: Part A</td>
<td>90</td>
</tr>
<tr>
<td>Claim Status: Part B -- Assigned Claims</td>
<td>91</td>
</tr>
<tr>
<td>Claim Status: Part B -- Non-assigned Claims</td>
<td>94</td>
</tr>
<tr>
<td>Claims: MR ADR Status</td>
<td>96</td>
</tr>
<tr>
<td>Eligibility</td>
<td>99</td>
</tr>
<tr>
<td>Eligibility: MBI Lookup</td>
<td>99</td>
</tr>
<tr>
<td>Figure</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
<td>------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>1</td>
<td>EIDM: New User Registration - CMS Enterprise Portal</td>
</tr>
<tr>
<td>2</td>
<td>EIDM: New User Registration - 'Choose Your Application'</td>
</tr>
<tr>
<td>3</td>
<td>EIDM: New User Registration – Register Your Information</td>
</tr>
<tr>
<td>4</td>
<td>EIDM: New User Registration – Create User ID, Password &amp; Security</td>
</tr>
<tr>
<td>5</td>
<td>EIDM: New User Registration – Registration Summary</td>
</tr>
<tr>
<td>6</td>
<td>EIDM: New User Registration – Confirmation Message</td>
</tr>
<tr>
<td>7</td>
<td>Request/Add Apps</td>
</tr>
<tr>
<td>8</td>
<td>EIDM: Request SPOT Access -- Access Catalog</td>
</tr>
<tr>
<td>9</td>
<td>EIDM: Request SPOT Access -- Access Catalog: Search</td>
</tr>
<tr>
<td>10</td>
<td>EIDM: Request SPOT Access -- Role Selection</td>
</tr>
<tr>
<td>11</td>
<td>EIDM: Identity Verification</td>
</tr>
<tr>
<td>12</td>
<td>RIDP Terms and Conditions</td>
</tr>
<tr>
<td>13</td>
<td>RIDP: Your Personal Information</td>
</tr>
<tr>
<td>14</td>
<td>RIDP Verify Identity</td>
</tr>
<tr>
<td>15</td>
<td>RIDP Success Confirmation</td>
</tr>
<tr>
<td>16</td>
<td>RIDP Identity Verification Incomplete</td>
</tr>
<tr>
<td>17</td>
<td>Experian Proofing Complete</td>
</tr>
<tr>
<td>18</td>
<td>EIDM: Find your organization</td>
</tr>
<tr>
<td>19</td>
<td>EIDM: Request submitted</td>
</tr>
<tr>
<td>20</td>
<td>EIDM Home Page</td>
</tr>
<tr>
<td>21</td>
<td>EIDM My Profile</td>
</tr>
<tr>
<td>22</td>
<td>EIDM Register MFA</td>
</tr>
<tr>
<td>23</td>
<td>SPOT Login Page</td>
</tr>
<tr>
<td>24</td>
<td>Choose MFA Device</td>
</tr>
<tr>
<td>25</td>
<td>MFA code entry options</td>
</tr>
<tr>
<td>26</td>
<td>Example of a send text message MFA entry button</td>
</tr>
<tr>
<td>27</td>
<td>Example of a send MFA code success through email with send entry button</td>
</tr>
<tr>
<td>28</td>
<td>SPOT Homepage</td>
</tr>
<tr>
<td>29</td>
<td>EIDM Account Profile: Change Password -- My Profile</td>
</tr>
<tr>
<td>30</td>
<td>EIDM Account Profile: Change Password</td>
</tr>
<tr>
<td>31</td>
<td>EIDM Account Profile: Change Password -- (Confirmation)</td>
</tr>
<tr>
<td>32</td>
<td>EIDM Account Profile: CMS Enterprise Portal Welcome page -- Forgot Password?</td>
</tr>
<tr>
<td>33</td>
<td>EIDM Account Profile: Forgot Password? -- Enter User ID</td>
</tr>
<tr>
<td>34</td>
<td>EIDM Account Profile: Forgot Password? -- Identity Authentication</td>
</tr>
<tr>
<td>35</td>
<td>EIDM Account Profile: Forgot Password? -- Confirmation</td>
</tr>
</tbody>
</table>
Figure 72: Request Types: MSP ................................................................. 72
Figure 73: Request Types: DOS Category -- Editable Fields .................. 73
Figure 74: Request Type: Edit Diagnosis Code -- Editable Field ........... 74
Figure 75: Request Type: Edit Procedure Code -- Editable Fields ......... 75
Figure 76: Modifier Category -- Editable Fields ...................................... 76
Figure 77: Request Type: Edit Units Billed -- Editable Fields ................ 77
Figure 78: Request Type: Billed Amount ................................................ 78
Figure 79: Claim Status Path: Line Item Detail with eligibility indicators 79
Figure 80: Claim reopening request form (Part A) ................................. 80
Figure 81: Claim Reopening Path: Claim Reopening Inquiry (Part B) ...... 81
Figure 82: Claim Reopening Path: ICN Query Error ............................... 81
Figure 83: Claim Reopening Path: Claim Reopening: Request Form ...... 82
Figure 84: Select Claim Reopening Request Type ................................. 83
Figure 85: Claim Reopening: Request Form -- Editable Fields .............. 83
Figure 86: Claim Reopening Request: Tooltip ........................................ 84
Figure 87: Claim Reopening Request: Review Changes .......................... 84
Figure 88: Claim Reopening Request: Error .......................................... 85
Figure 89: Claim redetermination form – Part B ...................................... 87
Figure 90: Secure Documentation: Electronic Signature .......................... 88
Figure 91: Appeals Outcome Search ..................................................... 89
Figure 92: Appeals Search Results ....................................................... 89
Figure 93: Claim Status: Query - Part A form ........................................ 90
Figure 94: Claim Status: Results - Part A .............................................. 91
Figure 95: View claim details ............................................................... 91
Figure 96: Claim Status: Query - Part B (Assigned) form ...................... 92
Figure 97: Claim Status: Results - Part B (Assigned) .............................. 93
Figure 98: Claim Status: Results - Part B (Assigned): Pending Claims Message .................................................................................. 93
Figure 99: Claim Status: Results - Part B (Assigned): Line Item Detail .................................................................................. 94
Figure 100: Claim Status: Query - Part B (Non-assigned) form .......... 95
Figure 101: Claim Status: Results - Part B (Non-assigned) .................. 96
Figure 102: MR ADR Status Search ..................................................... 97
Figure 103: Search Results ................................................................. 97
Figure 104: ADR Information Tab ........................................................ 98
Figure 105: ADR Review Tab .............................................................. 98
Figure 106: ADR Education Tab .......................................................... 99
Figure 107: Select MBI Lookup ........................................................... 99
Figure 108: MBI Lookup Search .....................................................................................................................100
Figure 109: MBI Lookup Search Results ........................................................................................................100
Figure 110: Eligibility/Benefits Inquiry Form -- Part B ..............................................................................101
Figure 111: Eligibility/Benefits Inquiry Results ..........................................................................................102
Figure 112: Deductible/Caps Results ............................................................................................................105
Figure 113: Preventive Information/History Results (Female) .........................................................................109
Figure 114: MSP Results ............................................................................................................................111
Figure 115: Plan Coverage Information Results ..........................................................................................112
Figure 116: Hospice/Home Health Information Results ..............................................................................116
Figure 117: Inpatient Information Results ..................................................................................................117
Figure 118: QMB information results .........................................................................................................119
Figure 119: Payments: Query - Part A form ...................................................................................................122
Figure 120: Payment History: Results - Part A: Payment Detail (Check/EFT Number) ......................................122
Figure 121: Payment History: Results - Part A: Summary Table ..................................................................123
Figure 122: Payments: Query - Part B form ..................................................................................................123
Figure 123: Payment History: Results - Part B: Payment Detail (Check/EFT Number) .....................................124
Figure 124: Payment History: Results - Part B: Summary Table ..................................................................124
Figure 125: Payment History: Results - Part B: Payment Details ..................................................................125
Figure 126: Remittance advice request form .............................................................................................125
Figure 127: Remittance Advice Request Status ...........................................................................................126
Figure 128: Remittance Advice Request Status Complete .............................................................................126
Figure 129: Sample remittance advice .......................................................................................................126
Figure 130: Access remittances through claim details ................................................................................127
Figure 131: Access remittances through Payment Details window ..............................................................127
Figure 132: Secure Documentation: Part A Selection Form ........................................................................129
Figure 133: Secure Documentation: Part B Selection Form ........................................................................129
Figure 134: Additional Development Response (ADR) form – Part A .......................................................130
Figure 135: Additional Development Response (ADR) form – Part B .......................................................131
Figure 136: Part A – Additional Development Response (ADR) – initial view ...........................................131
Figure 137: ADR Letter Example – Part A ...................................................................................................132
Figure 138: ADR Letter Example – Part B ...................................................................................................133
Figure 139: Part A – ADR Form – Select Documentation Type .................................................................133
Figure 140: Part A -- ADR Form – Sign form electronically .........................................................................134
Figure 141: Part A – ADR Form – Submit Form ..........................................................................................134
Figure 142: Secure Documentation: ADR Confirmation Email ....................................................................135
Figure 143: Medical Review ADR Response Form – Part A ......................................................................136
Figure 144: Support Documentation................................................................................................................136
Figure 145: MR ADR Confirmation..................................................................................................................137
Figure 146: PARD Document Types ...........................................................................................................137
Figure 147: Credit Balance Report Submission Form ....................................................................................139
Figure 148: Part B -- MSP Overpayment Form ............................................................................................140
Figure 149: Part B – Non-MSP Overpayment Form ....................................................................................141
Figure 150: Part B – Overpayment Redetermination Request .....................................................................143
Figure 151: Part A/B EDI Enrollment Form ..................................................................................................144
Figure 152: Request Secure Documentation ................................................................................................145
Figure 153: Overpayment Demand Letter request form .............................................................................146
Figure 154: 1099 request form .......................................................................................................................147
Figure 155: PDS Request Page -- Part A .......................................................................................................147
Figure 156: PDS Request Results Page -- Part A .........................................................................................148
Figure 157: PDS Request Comparative Data Table -- Part A ......................................................................149
Figure 158: PDS Request Message Code Table -- Part A ........................................................................154
Figure 159: PDS Request Page -- Part B .......................................................................................................155
Figure 160: PDS Request Results Page -- Part B .........................................................................................156
Figure 161: PDS Request Comparative Data Table -- Part B ......................................................................156
Figure 162: PDS Request Message Code Table -- Part B ........................................................................161
Figure 163: Provider-specific CBR Request Form -- Part B Page ...............................................................163
Figure 164: Provider-specific CBR Request: Request Status -- Part B ........................................................164
Figure 165: Part B – Provider-specific CBR: Report descriptors .................................................................164
Figure 166: Part B – Provider-specific CBR: Section one, page one .........................................................167
Figure 167: Part B – Provider-specific CBR: Section one, page two .........................................................167
Figure 168: Part B – Provider-specific CBR: Section two ........................................................................167
Figure 169: Retrieve secure documentation ..............................................................................................168
Figure 170: Enter 1099 form confirmation number ....................................................................................169
Figure 171: 1099 form pending ......................................................................................................................169
Figure 172: Secure Documentation: Check Status: Query Form ...............................................................170
Figure 173: 401 Permission Error ................................................................................................................171
1. INTRODUCTION

1.1 First Coast’s Secure Provider Online Tool (SPOT)

First Coast Service Options Inc. (First Coast) developed its provider internet portal application -- Secure Provider Online Tool (SPOT) -- to offer secure, online access to Medicare data, including claim status, payment information, benefits/eligibility, and data reports for members of its provider community in Florida, Puerto Rico, and the U.S. Virgin Islands.

SPOT is also an alternative channel for the electronic submission of various forms through Secure Documentation.

SPOT is a web-based application (https://thespot.fcso.com) hosted by CMS’ Enterprise Identity Management (EIDM), which is managed by the Centers for Medicare & Medicaid Services (CMS).

Note: The use of First Coast’s provider internet portal (i.e., SPOT) is not required and is at the discretion of the user in accordance with guidelines established by CMS’ change request (CR) 7420.

1.2 Scope of The SPOT: User Guide
The SPOT: User Guide furnishes procedural information and representative screen prints that are common to most users. On-screen help and contextual error messages will help guide users when completing procedures not illustrated in this manual.

1.2.1 Conventions

The SPOT: User Guide provides procedural information and representative screen prints, as appropriate, to describe how users may access and utilize the features of SPOT.

The following conventions will be utilized in this manual:

- Navigation labels will be presented in **bold** (e.g., Claim Status, Benefits/Eligibility, Payment History, Data Reports).
- Labels of entry fields, buttons, or menus (e.g., OK button, Medicare ID, Adjacent Count) that require user interaction (e.g., Click, Enter, Select) will be presented in **bold italics** in the action statement; links to be acted upon are indicated as links in underlined blue text in the action statement.
- Hyperlink labels will be presented as **underlined blue text** in the action statement.

**Note:** The term “user” is used throughout this document to refer to an individual who requires and/or has acquired access SPOT.
2 OVERVIEW

2.1 SPOT: Capabilities and Limitations

2.1.1 Capabilities
SPOT has the following capabilities:

- Offers secure, online access to Medicare data, including claim status, payment information, benefits/eligibility, and data reports for members of its provider community in Florida, Puerto Rico, and the U.S. Virgin Islands.
- Offers a secure, online channel for the submission of electronic forms and Part B claim reopenings
- Registered users may access Medicare data through the portal free-of-charge
- To protect proprietary and beneficiary data, users are automatically logged off after 15 minutes of inactivity. There are no limitations to periods of active use.

2.1.2 Limitations
SPOT has the following system limitations:

- As a web-based application, users of the SPOT must have internet access
- Access to SPOT website is dependent upon the availability of EIDM
- Access to Medicare data through the SPOT website is dependent upon the availability of CMS’ systems (i.e., EIDM, FISS, MCS, PECOS, HETS, and SAS)
- Access to previous queries submitted through the SPOT is limited to each individual session
- SPOT may only display claims status information and payment information related to claims that have been processed by First Coast
- The availability of the SPOT may be adversely affected by weather-related events that could disrupt business and access to necessary servers
- The availability of the SPOT may be adversely affected by high transaction volumes or simultaneous access by multiple users that exceed system’s load limitations
- The availability of the SPOT may be adversely affected by system intrusions or unauthorized access (e.g., hackers) to system resources
- The availability of the SPOT may be compromised by the insertion of malicious code, software, or modifications, which could result in portal unavailability
- The availability of the SPOT or access to required resources may be adversely affected by routine or unscheduled maintenance
- The availability of the SPOT or access to required data systems may be limited due to business operating hours and holidays
- Data updates to the SPOT application occur between 6:00-7:30 a.m. ET each weekday. Users may experience slower response times to claim and payment data queries or an interruption in access during these time periods.

2.1.3 SPOT: System Requirements
SPOT website is optimized for the following operating systems and browsers:
- **Operating system:**
  - Windows Vista (or later)
  - MAC OSx v10.8 (or later)
- **Screen resolution:** 1024 x 768 or higher
- **Internet browsers:**
  - Explorer v10 and higher (*Compatibility View must be turned off*) – for more information, please review the [Compatibility View FAQ](#)
  - Firefox v31 (or later)
  - Chrome v35 (or later)
  - Safari v6.1 (or later)
  
  **Note:** SPOT will *automatically determine* if your browser meets [minimum requirements](#).

- **Plug-ins:** Verify that you have the latest versions of JAVA and ActiveX
- **Pop-up blockers:** Disable pop-up blockers prior to access
  - *Compatibility View -- Disable Compatibility View prior to access*

### 2.1.4 SPOT: Integration with CMS’ EIDM system

To mitigate risk to all stakeholders, access to SPOT requires the existence of an EIDM account and a registration process to request access to the portal application. Although users do not need a separate EIDM account for each application, they must request access to each application separately.

### 2.1.5 Acceptance of EIDM Terms and Conditions

Users of U.S. government computer systems must be aware of warnings regarding unauthorized access to those systems, computer usage and monitoring, and local system requirements.

- Required before registration
- Required before log on

### 2.1.6 Compliance with federal regulations

The sensitivity of Medicare data combined with increased accessibility to claims, eligibility, and benefit information poses potential security risks to CMS, Medicare administrative contractors (MAC), and beneficiaries.

Therefore, First Coast’s provider internet portal is designed to ensure compliance with all federal legislation, including the Health Insurance Portability and Accountability Act (HIPAA), federal standards published by the National Institute of Standards and Technology (NIST), and CMS’ policies established to control risk.
GETTING STARTED

SPOT is one of several web-based applications hosted through CMS’ Enterprise Identity Management (EIDM). Although you do not need a separate account for each EIDM application, you must request access to each application separately. **EIDM accounts may not be shared.**

4  SPOT: New User Registration

**NOTE:** Before a SPOT end user can request access, a designated approver must FIRST submit a new organization form and be approved as an approver for their organization. After receiving an approval communication from the SPOT Help Desk, the approver can complete their registration in SPOT. Once the approver has completed their process, end users may use the following instructions to gain access to SPOT.

4.1  Part I: Create EIDM Account

The following instructions pertain to applicants who do not have an existing EIDM account to access another application:


![EIDM: New User Registration - CMS Enterprise Portal](image)

Select link for ‘**New User Registration**’.
2. The ‘Choose Your Application’ portion will appear. Choose SPOT, check I agree to the terms and conditions, and click Next.
2. The ‘Register Your Information’ portion will appear. Enter your full name, email address, Social Security number (optional) date of birth, home address, and your primary contact telephone number. Click Next.

3. The Create ‘UserID, Password & Security’ page will appear:
4. Create a ‘User ID’, for your EIDM account, which must meet the following parameters:
   - **Required**: Be a minimum of six and a maximum of 74 alphanumeric characters
   - **Required**: At least one letter
   - **Optional**: It may contain any of the following special characters: Dashes (-), Underscores (_), Apostrophes (‘), @, Periods (.) -- followed by alphanumeric characters.
   - Your ‘User ID’ may not contain your SSN or any nine consecutive numbers

5. Create your ‘Password’ for your EIDM account, which must be changed every 60 days and meet the following parameters:
   - Be a minimum of eight (8) and a maximum of 20 characters long.
   - Contain at least one number.
   - Contain at least one lower case letter.
   - Contain at least one upper case letter.
   - Contain at least one special character.
   - Be different from the previous six (6) passwords.
   - Not contain the User ID.
- **Not** contain any words consisting of three (3) letters or more (ex. 12Cat34@).
- **Not** contain any commonly used words (ex. Password1234).
- **Not** contain any digits in year format (ex. 2017).
- **Not** contain the following special characters: ? < > ( ) ‘ “ / \ &.

**Note:** Passwords may only be changed **once per day**.

6. Complete the ‘Select Your Challenge Questions and Answers’ section, which may be used to verify your identity.

7. Click the ‘Next’ button.

8. The ‘Registration Summary Page’ will appear:

![Image of Registration Summary Page]

**Figure 5:** EIDM: New User Registration – Registration Summary

9. Review your information and click Submit User. A Confirmation message will appear:
10. Although your EIDM account has been created, you must wait at least five minutes before logging in and beginning the process for requesting access to a specific application (e.g., SPOT).

Note: Having an EIDM account by itself does not automatically grant access to the SPOT application. You must request access to SPOT separately, and your request must be approved.
Part II: Verifying your identity

1. Return to the EIDM Enterprise Portal home page by clicking on the CMS Enterprise Portal logo at the top left of the page.
2. Although your EIDM account has been created, you must wait at least five minutes before beginning the identity verification process. This process is known as Remote Identity Proofing (RIDP).
3. In the center of the home page, click on the ‘Request/Add Apps’ button

![Request/Add Apps](image)

*Figure 7: Request/Add Apps*

4. The ‘Access Catalog’ page will appear.
5. Type “SPOT” in the ‘Start typing to filter apps’ … field

6. A close-up of the application’s access panel will move to the top of the page.

7. Click the ‘Request Access’ button at the bottom of SPOT’s catalog entry.
8. The ‘Request New Application Access’ page will appear:

![Image](EIDM: Request SPOT Access -- Role Selection)

9. SPOT will be listed in the ‘Application Description’ drop-down menu; however, you must select the proper role.

   Select ‘FCSO Portal User’ from the ‘Select a Role’ drop-down menu. Do not select any other role.

   Note: If you select the incorrect role (i.e., FCSO Help Desk User), your application will be denied, and you will need to begin the registration process from the beginning.

10. Review ‘Identify Verification’ information and then click ‘Next.’

![Image](EIDM: Identity Verification)

11. Review information about ‘Terms and Conditions’

   CMS uses the Experian identity verification service to confirm your identity when you need to access a protected CMS Application.

   If you have not previously been through CMS Enterprise Portal’s required identity verification, you may be prompted for RIDP when requesting access to SPOT.
You will be asked to provide a set of core credentials, which include full name, current address, residential phone number, and social security number.

The Experian identity verification service will use your core credentials to locate your personal information in the Experian database and generate a set of questions.

Figure 12: RIDP Terms and Conditions

12. Check ‘I agree to the terms and conditions’ box to proceed
13. Fill out the requested information under ‘Your Information.’

- Full legal name
- Social Security number
- Date of birth
- Current residential address
- Personal phone number
- You must use your full legal name. Refer to your driver’s license or financial account information.
- Your surname and other information such as date of birth has to match the information Experian has for you on file.
- Do not use nicknames.
- If you have a two-part name, enter the second part in the middle name field. (i.e., Mary Beth would have Mary in the first name field and Beth in the middle name field)
  - Enter your current residential address:
  - Address where you receive financial statements including credit cards and/or utilities
  - Address you most consistently use for billing purposes
  - Address associated with your credit report
  - If you have a recent change in address, you can try to ID proof with a prior address.

  Click ‘Next’
14. Complete the ‘Verify Identity’ questions from your Experian data base records by clicking on the radio button next to each correct answer. Click ‘Next’

15. If your information is verified you will see the graphic above and you are now ready to request access to SPOT. Congratulations, you have completed the RIDP process. Click ‘Next’ and proceed to request access to SPOT.
16. In the event your information cannot be verified through RIDP, you will be asked to contact Experian Verification Support Services. You may return to this application once you have resolved the issue with the Experian database.

17. Once Experian has reviewed your ticket number and proofed your identity, return to your EIDM profile and complete the request for access to SPOT. Be sure to check the box at the top of the ‘Your Information’ screen to confirm your contact with Experian.

18. If Experian is not able to resolve the issue, please call the SPOT Help Desk and request manual verification.
19. For manual verification, you will be asked to complete this application and submit a copy of your driver's license, an ID card issued by the federal, state, or local government or a U.S. passport.

20. After you have established your EIDM account and your identity has been verified, you may request access to the SPOT application.

21. Before you begin, please verify the billing provider’s official enrollment record in internet-based PECOS. The information submitted in your application will be compared to the corresponding information in the PECOS enrollment record. If any information does not match your official enrollment record, your access request will be denied.

If you require assistance during registration, you may email FCSOSpotHelp@fcso.com or call 855-416-4199. (Press 1 general assistance, press 2 for enrollment)

4.1.1 Part II: Requesting access to SPOT

1. Enter your organization’s legal business name and select the state/territory. Then, click the Search button. Locate your organization in the drop-down menu.

   **NOTE:** If your organization is not found, it has not been created by an approver yet. Your organization must have a designated approver who has created your organization in EIDM.

2. Add your Reason for Request, which can be something like “access to Medicare data.”

3. Click Next, review your information, and click Submit.
4. The final screen will confirm that your EIDM request has been submitted. You will receive an email confirmation once your request has been processed.

![Request Additional SPOT-First Coast Service Options Internet portal (FCSOv2) Role Acknowledgement](image)

4. Make note of your **tracking number** (e.g., 167539), and click the **OK** button.

5. Your organization’s designated approver is then responsible for approving or rejecting your access request.

### 4.2 Part III – Registering a multifactor authentication (MFA) device

Multifactor authentication (MFA) registration begins with your Enterprise Identity Management (EIDM) portal system profile. EIDM is a system that hosts SPOT and other web-based applications for the Centers for Medicare and Medicaid services (CMS).

**Reminder:** EIDM accounts **may not be shared. Each MFA device must be used for the SPOT account for which it’s registered.**

#### 4.2.1 Tips for registering

1. Register **more than one** MFA device to ensure your access to SPOT goes uninterrupted.

2. If you already use an MFA passcode to access other CMS EIDM applications, you do not need to register another for SPOT.

3. Don’t share accounts. MFA devices and the access codes produced by them may not be shared. In fact, they will not work otherwise.

4. Work with your information technology providers to find the best solution for you.

5. Review these [frequently-asked questions](#) regarding MFA registration.

#### 4.2.2 How to register your MFA device

1. If you are already logged into your EIDM account, click the [CMS.GOV Enterprise Portal logo](#) at the top right of the page. This will bring you back to the ‘Home’ screen.

3. Enter your **User ID** and **Password** and Click on Agree to our terms and conditions

4. Click **Login**

5. If you are not able to recall your SPOT user ID, click on the ‘**Forgot User ID**’ link below the ‘**Login**’ button. You will be asked a series of questions based on the information you registered when you opened your SPOT account. Once you have completed the questions, your user ID will be emailed to you.

6. Click at the top of the page to access **My Profile**, then **Register MFA** on the menu to the left
Figure 22:  
**EIDM Register MFA**

7. Choose your MFA device from the drop-down menu and click Submit. Follow the remaining instructions to complete registration.
Login to SPOT after you have secured your account

After you have completed the three-part SPOT registration process you may login to SPOT. To review, the registration process consists of the following steps:

- Part I: Create an EIDM (Enterprise Identity Management) account.
- Part II: Request access to SPOT
- Part III: Register for multifactor authentication

After all parts of the registration process are complete, view the following steps to login to SPOT:


Figure 23: SPOT Login Page
2. Enter your SPOT account user ID and password.
3. Check agree to terms and conditions.
4. You will see a box that says ‘Choose MFA Device’

![Choose MFA Device](image)

*Figure 24: Choose MFA Device*

5. Select the MFA device you registered in the Step III of the SPOT account registration process.
Figure 25: **MFA code entry options**

Options are:

- Phone/Tablet/PC/Laptop (for Symantec VIP users) – Open downloaded application and enter the passcode.
- Text message – Short Message Service (SMS) - Click ‘Send’
- Interactive Voice Response (IVR) – Click ‘Send’
- E-mail – Click ‘Send’
- One-Time Security Code (through helpdesk or ‘Unable to access security code?’ link)

**Note:** SMS, IVR, and E-mail all require you hit the ‘Send’ button to have a passcode delivered to you. Once the code has been sent, ‘Success’ will be displayed under the MFA dropdown box.
Figure 26: Example of a send text message MFA entry button

Note: You may experience delivery issues during peak business hours using email. If you have attempted to obtain passcodes through a variety of MFA devices, and are unsuccessful, click the ‘Unable to Access Security Code?’ link for assistance.

6. Click Send MFA Code. Once you receive your MFA passcode, enter it into the security field. You will receive the ‘Success’ message below the ‘Device Type’ menu.
7. Click the ‘Log In’ button. You will now be logged into SPOT

**NOTE:** You must log in to SPOT at least once every 30 days to retain access. If you do not, your account will face termination.

If you are unable to login to SPOT, please view the following help documents for further assistance:

- SPOT error message
- Oracle Access manager – Internal error – View instructions on how to clear your browser’s cache.
- If you continue to have difficulties logging in, please contact the SPOT Help Desk at FCSOSpotHelp@fcso.com or 855-416-4199 (press 1 for general assistance; press 2 for enrollment).
4.3 EIDM Account: ‘My Profile’

Your EIDM Account: My Profile contains personal information about you. You may view and make to changes to your personal information through the My Profile section of the EIDM website.

4.3.1 EIDM Account: ‘My Profile’ -- Change Password

You must log in to the EIDM portal once every 60 days to change your password. You may change your Password as well as personal information associated with your Enterprise Identity Management (EIDM) account through the My Profile menu on the EIDM website.

2. Click Login to CMS Secure Portal
3. Click the I Accept button to accept Terms and Conditions
4. Enter EIDM account User ID and Password, and click the Log in button
5. Select **My Profile** from the **My Portal** menu

6. The **View My Profile** page will appear

7. Select **Change Password** from the **Change My Profile** left-navigation menu
8. Enter appropriate values in the following fields:

9. **Old Password**

10. **New Password** -- with the following requirements:

    The password **must**:
    
    - Be a minimum of eight (8) and a maximum of 20 characters long.
    - Contain at least one number.
    - Contain at least one lower case letter.
    - Contain at least one upper case letter.
    - Contain at least one special character.
    - Be different from the previous six (6) passwords.
    - Not contain the User ID.
    - Not contain any words consisting of three (3) letters or more (ex. 12Cat34@).
    - Not contain any commonly used words (ex. Password1234).
    - Not contain any digits in year format (ex. 2017).
    - Not contain the following special characters: ? < > ( ) ‘ “ / \ &.

**Note:** Passwords may only be changed **once per day**.

11. **Confirm New Password**

12. Click the **Submit** button, and the confirmation page will appear

---

*Figure 30: EIDM Account Profile: Change Password*

*Figure 31: EIDM Account Profile: Change Password – (Confirmation)*
13. Click the **OK** button. **Note:** A notification email will be sent to the email associated with the EIDM account.
4.3.2 EIDM Account: ‘My Profile’ -- Forgot Password

You may create a new Password by accessing corresponding links on either the CMS Enterprise Portal home page or login page after you have authenticated your identity. If your account is locked, you may call the SPOT Help Desk to initiate a Password Reset.

If you can’t remember your EIDM account Password, and your account has not been locked, follow these steps:


![CMS Enterprise Portal Welcome page -- Forgot Password?](image1)

*Figure 32: EIDM Account Profile: CMS Enterprise Portal Welcome page -- Forgot Password?*

2. Click Forgot Password? link

   **Note:** You may also access the Forgot Password? link on the Welcome to CMS Enterprise Portal login page:

![CMS Enterprise Portal login page](image2)

*Figure 33: EIDM Account Profile: Forgot Password? -- Enter User ID*
3. Enter your User ID
4. Click the **Next** button
5. Enter answers to **Challenge Questions**
6. Enter appropriate values in the following fields:

7. **New Password**
   i. The password **must**:
      1. Be changed *at least* every 60 days.
      2. Be a *minimum* of eight (8) and a *maximum* of 20 characters long.
      3. Contain *at least* one number.
      4. Contain *at least* one lower case letter.
      5. Contain *at least* one upper case letter.
      6. Contain *at least* one special character.
      7. Be *different* from the previous six (6) passwords.
      8. **Not** contain the User ID.
      9. **Not** contain any words consisting of three (3) letters or more (ex. 12Cat34@).
      10. **Not** contain any commonly used words.(ex. Password1234).
      11. **Not** contain any digits in year format (ex. 2017).
      12. **Not** contain the following special characters: ? < > ( ) ‘ “ / \ &.

   ii. **Note:** Passwords may only be changed *once per day*.

8. **Confirm New Password**
9. Click the **Next** button, and the confirmation page will appear.

10. Click the **OK** button

**Note:** A notification email will be sent to the email associated with the EIDM account.

*Figure 35: EIDM Account Profile: Forgot Password? – Confirmation*
EIDM Account: ‘My Profile’ -- Forgot User ID
If you have forgotten your EIDM account User ID, you may recover it by following these steps:


   ![EIDM Account Profile: Application Login Page – Forgot User ID?](image1.png)

   **Figure 36:** EIDM Account Profile: Application Login Page – Forgot User ID?

2. Click **Forgot User ID?** link

   **Note:** You may also access the **Forgot User ID?** link on the Welcome to CMS Enterprise Portal Welcome page:

   ![EIDM Account Profile: Forgot User ID? – Identity Authentication](image2.png)

   **Figure 37:** EIDM Account Profile: Forgot User ID? – Identity Authentication

3. Enter the following **personal information:**

   4. **First Name**
5. **Last Name**
6. **Email address**
7. **Zip code** (home address)
8. **Date of Birth**
9. Click the **Next** button, and the confirmation page will appear

![Confirmation](image)

**Figure 38: EIDM Account Profile: Forgot User ID? – Confirmation**

10. Click the **OK** button

Note: A notification email will be sent to the email associated with the EIDM account

### 4.3.3 EIDM Account: ‘My Profile’ – View Profile

2. Enter your User ID and Password
3. Check to agree to **Terms and Conditions** and click **Login**
4. Select **My Profile** from the **My Portal** menu
5. The **View My Profile** page will appear
If you would like to make changes to your EIDM profile, select the option you wish to change in the left-navigation menu.

### 4.3.4 EIDM Account: ‘My Profile’ -- Change Profile Information

2. Enter your User ID, Password, and MFA information
3. Check to agree to **Terms and Conditions**
4. Click **Login**
5. Select **My Profile** from the **My Portal** menu
6. The **My Profile** page will appear
7. Select **Change Profile** from the **My Profile** menu
**Figure 40: EIDM Account: ‘My Profile’ – Change Profile**

8. Enter new information

9. Click **Submit**
EIDM Account: ‘My Profile’ -- Change Security Questions & Answers

2. Enter your User ID and Password, Check Terms and Conditions, enter your MFA information and click Login
3. Select My Profile from the My Portal menu. The ‘View My Profile’ page will appear
4. Select Change Security Questions from the My Profile menu

5. Select new Security Questions and provide answers in corresponding fields
6. Click the Submit button, and the confirmation page will appear
7. Click the **OK** button

**Note:** A notification email will be sent to the email associated with the EIDM account

Your **EIDM Account: My Access** profile for the SPOT contains information about the **billing provider**. You may view and make changes to your billing provider’s information through the **My Access** section of the EIDM website.

### 4.3.5 EIDM Account: ‘My Access’ -- View and Manage My Access

2. Enter your User ID and Password
3. Check to agree to **Terms and Conditions**
4. Click **Login**
5. Select **My Access** from the **My Portal** menu

*Figure 43: EIDM Account: ‘My Access’*

6. The **My Access** page will appear.
7. Scroll down until you reach the **My Access** information box.
8. Select Other actions from the Available actions navigation menu

9. The View and Manage My Access page will appear
10. Select **Modify Business Contact Information** from the left navigation menu.

11. The Modify Business Contact Information form will appear:

12. Enter changes to **Business Contact Information**

13. Click the **Next** button

14. Review your changes
15. If changes are complete, click the **Submit** button, and the confirmation page will appear.

16. You will also receive an email notification.
4.3.6 EIDM Account: ‘My Access’ -- View Existing Role Details

2. Enter your User ID and Password
3. Check to agree to Terms and Conditions
4. Click Login
5. Select My Access from the My Portal menu
7. Scroll down until you reach the My Access information box.
8. Select Other Actions from the Available Actions navigation menu
9. The View and Manage My Access page will appear

![EIDM Account: ‘My Access’ -- View and Manage My Access](image1.png)

Figure 50: EIDM Account: ‘My Access’ -- View and Manage My Access

10. Select View/Modify Role from the Take an Action menu, and role information will be displayed.

![EIDM Account: ‘My Access’ -- View/Modify Role](image2.png)

Figure 51: EIDM Account: ‘My Access’ -- View/Modify Role
4.3.7 EIDM Account: ‘My Access’ – Add Role

2. Enter your User ID and Password
3. Check to agree to Terms and Conditions
4. Click Login
5. Select My Access from the My Portal menu
7. Find the My Access information box at the top right
8. Click Add Role under Available Actions

![My Access Page](image)

**Figure 52: EIDM Account: ‘My Access’—Add Role**

9. In the Select a Role drop-down menu, choose your role

   - If you select **SPOT end user**, search for your organization, select your organization, add your reason for request (e.g., access to Medicare data), click Next, then click Submit
If you select Approver or Backup Approver, you can either associate to an existing organization, or create a new organization. If you create a new organization, you must have already submitted the new organization form and received your submitter ID from the SPOT Help Desk. If you have not already done so, please follow these instructions to submit your new organization form.

10. You will receive a confirmation screen and number. If you are an end user requesting a new role, the approver for that organization will receive a notification of your request via email, which they can then approve. If you are an approver, the SPOT Help Desk will review your request and you will receive an email notification once processed. Approvers, learn how to approve end user requests by viewing this guide.

### 4.3.8 EIDM Account: ‘My Access’ -- Remove Role

2. Enter your User ID and Password
3. Check to agree to Terms and Conditions
4. Click Login
5. Select My Access from the My Portal menu
7. Click Remove Role
8. The Request to Remove Role page will appear

![Request to Remove Role](image)

**Figure 56: EIDM Account ‘My Access’ – Remove Role**

9. Click the **Remove** link in the **Remove a Role** column

10. The request for confirmation message box will appear

11. Click the **OK** button to confirm
12. The confirmation page will appear:

Figure 57: EIDM Account: ‘My Access’ – Remove Role Confirmation

5 ACCESSING THE ‘SPOT’ APPLICATION

5.1 Accessing the SPOT Application: EIDM Registered/Approved Users

1. Navigate to https://thespot.fcso.com

2. The EIDM Login page will appear.

Figure 58: EIDM Portal Login

Note: If you have your EIDM account and attempt to log on to SPOT before your SPOT application access request has been approved (i.e., no request submitted, request in pending status, or request in denied status), a 401 permission error message will be returned:
Note: If you have acquired an EIDM account and have approved access to the SPOT, you may also encounter the 401 permission error message if you have not cleared your internet browser’s cache between logins to either the EIDM or SPOT websites.

3. Enter EIDM account [User ID, Password], and MFA information and click the Login button to proceed.
4. Select your organization, PTAN, and NPI from the drop-down menus. Click Submit.
5. Arrive at the SPOT homepage

![SPOT: Homepage](image)

**Figure 61: SPOT: Homepage**

5.2 ‘SPOT’: Organization and Navigation

5.2.1 Organization

SPOT is organized based upon categories, which include **Appeals, Claims, Eligibility, Payment Data, and Secure Documentation**. Users will find navigation links at the top of the portal as well as at the center of the homepage screen.

In addition, SPOT offers users links to important content on the First Coast provider website such as fee schedules and local coverage determinations. These links are located in the gray box at the bottom of each screen.

![Additional resources on medicare.fcsco.com](image)

**Figure 62: SPOT: Additional resources**

5.2.2 Navigation

Users may access any category by clicking on its corresponding tab label, or they may view all site locations by selecting the **Site Map** icon at the top of every page. To exit the portal, the user may either click **Log Off** or close...
the browser window. For helpful resources, including the SPOT Help Desk email address and phone number, click Help.

Figure 63:  *SPOT: Top navigation*
6 USING THE ‘SPOT’ APPLICATION

NOTE: You must log in to SPOT at least once every 30 days to retain access. If you do not, your account will face termination.

6.1 Appeals

The Appeals feature allows users to perform three tasks: reopen/correct a claim, submit an appeal, and find the outcome of an appeal.

6.1.1 Appeals: Correcting a claim

SPOT allows Part B users to correct a claim, specifically, to make overpayment corrections. To make an overpayment correction in SPOT, select Appeals, then Reopen/correct a claim.

1. The Claims Correction Inquiry page will appear. Select the radio button next to “overpayment correction.”

Figure 64: Claims Correction Inquiry

2. After selecting “overpayment correction,” enter the claim’s 13-digit ICN in the form.
3. Then, select your request type from the drop-down menu.

4. Once the claim lines appear, select the line(s) you wish to submit for an overpayment correction request. You can also submit the entire claim by selecting all lines. Then, click Review.
5. Your request will appear. Review, then click Submit.


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### 6.1.2 Appeals: Reopening a claim - overview

A **Claim Reopenings Request** allows a provider to submit corrections to a previously submitted claim with the goal of changing the initial determination of the claim, which may have resulted in an overpayment or an underpayment.

Although a claim reopening request may be initiated in response to an unanswered additional documentation request (ADR), the most common type of claim reopening request submitted by providers is often called a “clerical reopening” (based on the types of corrections requested). Clerical reopenings may include corrections to clerical errors, minor errors, or omissions.
The claim reopening process is **not** a part of the five-level appeals process and should not be confused with a claim redetermination, which is the first level of the appeals process.

- Submitting a claim reopening request is **not** the same as filing an adjustment claim, and the timely filing requirements of each differ greatly:
  - **Claim reopenings**: Must be filed within *one year of the receipt of the initial determination*
    - Claim reopening requests may be submitted for *any reason* within one year of the *receipt of the initial determination*. However, with a *showing of good cause*, claim reopening requests may be submitted (*in writing*) up to four years from the receipt of the initial determination.
  - **Adjustment claims**: Must be filed within *one year of the date of service*
  - **Claim redetermination**: Must be filed within *120 days from initial claim determination*
  - The submission of a claim reopening request *does not* guarantee its acceptance, ensure that the initial claim determination will be revised, or extend the timeframe in which to request an appeal
  - Granting a claim reopening request is at the discretion of the Medicare administrative contractor (MAC), and a contractor’s refusal to reopen a claim does *not* initiate new appeal rights.
  - Claim reopening requests will **not** be granted if an appeals decision is pending or in process
  - The decision to not reopen a claim determination is not an initial determination and is not appealable
  - For more information about claim reopenings, please refer to Medicare Claims Processing Manual, Chapter 34 - Reopening and Revision of Claim Determinations and Decisions
  - **Claim Reopening Requests** submitted after 6 p.m. ET during weekdays, at any time during a weekend, or on First Coast Service Options’ corporate holidays, will receive a receipt date that reflects First Coast’s next business day.
6.1.3 Claim reopenings submitted through the ‘SPOT’

SPOT offers providers the opportunity to make online corrections to eligible Part B claims at the line-item level and to submit their clerical reopening requests through SPOT.

- There are five request types available:
  - Entitlement
  - Hospice
  - History Correction
  - MSP
  - Other Corrections

- If a line item of a claim is considered eligible for reopening, corrections may be made to the following fields in Other Corrections:
  - Date of Service (DOS)
  - Diagnosis Code (primary)
  - Procedure Code
  - Modifier
  - Units Billed
  - Billed Amount

- Users may access claims they wish to reopen through two different paths on SPOT:
  - Claim Status: Search for the claim based on its Dates of Service
  - Claim Reopening: Search for the claim based on its ICN

- The validity and eligibility of any procedure codes, modifiers, or diagnosis codes will be verified automatically by SPOT. Eligibility refers to values that are permissible for clerical reopening.

- Once a claim reopening request has been submitted through SPOT, no additional requests for that ICN may be submitted.

Limitations to claim reopenings on the SPOT

- Multiple request types (e.g., Edit Procedure Code and Add Modifier) may not be utilized for the same eligible line item.
- Line items may not be added or removed.
- Certain corrections (e.g., updates to beneficiary information or status) may not be submitted.
- Rendering provider’s NPI may not be changed.
- Claim reopening requests submitted through SPOT must be filed within one year of the receipt of the initial determination.
- Multiple modifiers, procedure codes, or diagnosis codes may not be added through SPOT.
- Internet Explorer users must turn off Compatibility View to use the Claim Reopening Request Form.
- Claim Reopening Requests submitted after 6 p.m. ET during weekdays, at any time during a weekend, or on First Coast Service Options’ corporate holidays, will receive a receipt date that reflects First Coast’s next business day.
6.1.4 Claim Reopening Requests: Eligibility Criteria

After the claim has been accessed, the initial eligibility of any of its line items for claim reopening will be determined automatically by SPOT. For example, line items associated with pending and adjusted claims are ineligible.

SPOT determines eligibility of a particular line item for submission of a Claim Reopening Request through SPOT based upon specific criteria at the claim or line-item level, which includes:

- Claim may not be an adjustment claim
- Claim may not be a non-assigned claim (Note: If the claim is non-assigned, SPOT will display a message that the claim cannot be reopened and the user should refer to the reason code and/or remark code for direction on how to correct the claim)
- Claim/line item may not be in pending status
- Claim may not be an adjusted claim (Note: If the claim as been adjusted, SPOT will display a message that a redetermination is possible)
- Claim may not have been returned as unprocessable (RUC)
- Claim cannot contain the following modifiers: 21, 22, 24, 51, 52, 53, 56, 62, 66, 99, CC, GA, GY, GZ, SQ, WU
  
  Note: If one of these modifiers is present on a claim line, SPOT will display a message saying the claim cannot be reopened and should be submitted as a redetermination through secure messaging

- Claim cannot contain the following procedure codes: J0200, J0390, J0395, J0520, J0735, J1094, J1700, J1710, J1885, J1960, J1990, J2323, J2440, J2670, J2760, J3490, J3590, J7130, J7184, J7199, J7310, J7326, J7628, J7629, J7648, J7658, J7659, J7683, J7684, J8499, J9165, J9201, J9217, J9219, J9270, J9357, J9999, Q0144, Q027, Q2034, Q2035, Q2036, Q2037, Q2038, Q2039, Q2045, Q2046, Q2049, 90654, 90655, 90656, 90657, 90658, 90659, 90660, 90666, 90669, 90695, 90715, 90724, 90779, 96549
  
  Note: If any of these procedure claims are present in a claim, SPOT will display a messaging saying the claim cannot be reopened and should be submitted as a redetermination through secure messaging

- Claim/line item may not have been denied with any of the following denial codes: 043, 074, 083, 127, 135, 226, 227, 233, 299, 300, 309, 310, 324, 346, 387, 394, 395, 406, 413, 483, 512, 513, 552, 573, 581, 590, 596, 602, 633, 634, 636, 637, 638, 650, 791, 792, 883, 889, A59, A61, A60, A62, A63, A64, A67, D01, D03, D04, D05, D06, D07, D051, D083, D117, D118, D181, D382, D458, D504, D538, D908, D224, D225, D627, DA18, DA75, DA76, DA82, DC09, DC10, DC38, DC39, DC78, K74, K78, K81, K88, K90, J61, J85, J86, J87, J89, H06, H82

  Note: Denial codes may be added or removed at the discretion of the contractor

- A previous claim reopening request for the ICN has not been submitted through SPOT or IVR

- The claim’s ICN must begin with one of the following two-digit combinations, which indicates whether the ICN is a claim, an adjustment, or a correspondence as well as the provider’s location:
  
  - Florida: Regions 01 through 19 -- Exceptions: Region 05 and Region 13
  - Puerto Rico: Regions 01 through 10 -- Exception: Region 05
  - U.S. Virgin Islands: Regions 11 through 19 -- Exception: Region 13

  Note: The first two digits of an ICN represent its “region,” which indicates whether the ICN is a claim, an adjustment, or a correspondence

  Note: If the ICN does not fall within one of these regions above, or has been adjusted, SPOT will display a message saying the claim cannot be reopened
Only one claim reopening request type per line item may be submitted; however, multiple line items may be included in the same request.

Even if a claim is potentially eligible to initiate a reopening request, some or all of its associated line items may still be ineligible:

- If a line item is eligible, SPOT will display the hyperlink: View line items eligible for claim reopening above that line item.
- If a line item is ineligible, the hyperlink will not display above that line item.

### 6.1.5 Request Types: Primary and Secondary Fields

Only one Claim Reopening Request type may be selected for each eligible line item, and the type of request is determined by the primary field to be corrected. Some types of requests may allow the editing of more than one field (i.e., primary and secondary fields). However, the primary field is based upon the request type selected.

**Table 1: Claim Reopening Request Types**

<table>
<thead>
<tr>
<th>Claim reopening request type</th>
<th>Primary field(s) (required)</th>
<th>Secondary field (optional)</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospice</td>
<td>Add Modifier</td>
<td>N/A</td>
<td>Modifier GV or GW is required</td>
</tr>
<tr>
<td>History Correction</td>
<td>N/A</td>
<td>N/A</td>
<td>Submitting with no changes</td>
</tr>
<tr>
<td>Entitlement</td>
<td>Beneficiary full name</td>
<td>N/A</td>
<td>Coverage is based on date of service</td>
</tr>
<tr>
<td>MSP</td>
<td>Beneficiary full name</td>
<td>N/A</td>
<td>Coverage is based on date of service</td>
</tr>
</tbody>
</table>

To access the following reopenings, select Other Corrections from the drop-down menu:

- **Edit DOS From**
  - DOS From
  - N/A
  - **DOS From** date may **not be later** than **DOS To** date.

- **Edit DOS To**
  - DOS To
  - N/A
  - **DOS To** date may **not be earlier** than **DOS From** date.

- **Edit DOS Both**
  - DOS From and DOS To
  - N/A
  - Both fields must be changed.

- **Edit Diagnosis Code**
  - Diagnosis Code
  - N/A
  - The **primary diagnosis code** may be changed.

- **Edit Procedure Code**
  - Procedure Code
  - Billed Amount
  - The replacement code must be one that may be used in a claim reopening request.

- **Add Modifier**
  - Modifier (first available field)
  - N/A
  - Only one modifier may be added, and it must be one that may be used for a reopening request.

- **Edit Modifier**
  - Modifier (any modifier field that contains a value)
  - N/A
  - Only one modifier may be replaced, and it must be one that may be used for a reopening request.
### Claim Reopening Request Types

<table>
<thead>
<tr>
<th>Claim Reopening Request Type</th>
<th>Primary Field(s) (required)</th>
<th>Secondary Field (optional)</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delete Modifier</td>
<td>Modifier (any modifier field that contains a value)</td>
<td>N/A</td>
<td>Only one modifier may be deleted.</td>
</tr>
<tr>
<td>Edit Units Billed</td>
<td>Units Billed</td>
<td>Optional fields: DOS From, DOS To, Billed Amount</td>
<td>Anesthesia providers must use units and not minutes when adjusting units billed. The conversion factor is 1 unit = 15 minutes. For example, 75 minutes would be entered as 5 units (75/15=5 units).</td>
</tr>
<tr>
<td>Edit Billed Amount</td>
<td>Billed Amount</td>
<td>N/A</td>
<td>Note: An adjusted billed amount that is less than the allowed amount for the service is not accepted as it may result in an overpayment.</td>
</tr>
</tbody>
</table>

Note: Permissible values and correct formatting will be validated by SPOT.

#### 6.1.6 Request Types: Information Tooltips

Each field type has a unique set of formatting criteria. When completing the Claim Reopening Request Form, users may view the information tooltip for the field they wish to edit by hovering over the tooltip next to the column label:

**Table 2: Claim Reopening Tooltips**

<table>
<thead>
<tr>
<th>Claim Reopening Form Fields</th>
<th>Information Tooltip</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Service (DOS)</td>
<td>![Tooltip Image]</td>
</tr>
<tr>
<td>Diagnosis Code</td>
<td>![Tooltip Image]</td>
</tr>
<tr>
<td>Procedure Code</td>
<td>![Tooltip Image]</td>
</tr>
</tbody>
</table>
Claim Reopening Form Fields | Information Tooltip
---|---
Modifier | ![Modifier Information Tooltip]
Units Billed | ![Units Billed Information Tooltip]
Billed Amount | ![Billed Amount Information Tooltip]

Note: Permissible values and correct formatting will be validated by SPOT.

6.1.7 Request Types: Hospice

There is one type of claim reopening request for hospice.

**Table 3: Claim Reopening Request Types: Hospice**

<table>
<thead>
<tr>
<th>Claim reopening request type</th>
<th>Primary field(s) (required)</th>
<th>Secondary field (optional)</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospice</td>
<td>Add Modifier</td>
<td>N/A</td>
<td>Modifier GV or GW is required</td>
</tr>
</tbody>
</table>
6.1.8 Request Types: History Correction

There is one type of claim reopening request for history correction.

Table 4: Claim Reopening Request Types: History Correction

<table>
<thead>
<tr>
<th>Claim reopening request type</th>
<th>Primary field(s) (required)</th>
<th>Secondary field (optional)</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>History Correction</td>
<td>N/A</td>
<td>N/A</td>
<td>Submitting with no changes</td>
</tr>
</tbody>
</table>

6.1.9 Request Types: Entitlement

There is one type of claim opening request for entitlement.
### Table 5: Claim Reopening Request Types: Entitlement

<table>
<thead>
<tr>
<th>Claim reopening request type</th>
<th>Primary field(s) (required)</th>
<th>Secondary field (optional)</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Entitlement</td>
<td>Beneficiary full name</td>
<td>N/A</td>
<td>Coverage is based on date of service</td>
</tr>
</tbody>
</table>

**Figure 71: Request Types: Entitlement**

6.1.10 Request Types: MSP

There is one type of claim reopening for MSP.

### Table 6: Claim Reopening Request Types: MSP

<table>
<thead>
<tr>
<th>Claim reopening request type</th>
<th>Primary field(s) (required)</th>
<th>Secondary field (optional)</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>MSP</td>
<td>Beneficiary full name</td>
<td>N/A</td>
<td>Coverage is based on date of service</td>
</tr>
</tbody>
</table>
6.1.11 Request Types: DOS Category

There are three types of Claim Reopenings Requests that fall into the *Dates of Service* (DOS) category:

- Edit DOS From
- Edit DOS To
- Edit DOS Both

<table>
<thead>
<tr>
<th>Claim Reopening Request Type</th>
<th>Primary Fields (Required)</th>
<th>Secondary Field (Optional)</th>
<th>Required Format</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Edit DOS From</td>
<td>DOS From</td>
<td>N/A</td>
<td>MM/DD/YYYY</td>
<td>DOS From date may not be later than DOS To date</td>
</tr>
<tr>
<td>Edit DOS To</td>
<td>DOS To</td>
<td>N/A</td>
<td>MM/DD/YYYY</td>
<td>DOS To date may not be earlier than DOS From date</td>
</tr>
<tr>
<td>Edit DOS Both</td>
<td>DOS From and DOS To</td>
<td>N/A</td>
<td>MM/DD/YYYY</td>
<td>Both fields must be changed</td>
</tr>
</tbody>
</table>
Figure 73: Request Types: DOS Category – Editable Fields

Note: Although edits to the primary field are required, edits to secondary fields are optional. Once the type of claim reopening request has been selected, editable fields will be presented on a background of white.
6.1.12 Claim Reopening Request Types: Diagnosis Code Category

There is only one type of Claim Reopenings Request that falls into the Diagnosis Code category:

- Edit Diagnosis Code

Table 8: Claim Reopening Request Types: Edit Diagnosis Code

<table>
<thead>
<tr>
<th>Claim Reopening Request Type</th>
<th>Primary Field (Required)</th>
<th>Secondary Field (Optional)</th>
<th>Required Format</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Edit Diagnosis Code</td>
<td>Diagnosis Code</td>
<td>N/A</td>
<td>Format is contingent upon whether the code is an ICD-9 or ICD-10 code -- please refer to Table 5</td>
<td>The primary diagnosis code may be changed. Only one code set will be accepted on a single claim.</td>
</tr>
</tbody>
</table>

Note: The Edit Diagnosis Code request adds the replacement code; it does not remove the original diagnosis code from the claim.

Table 9: Diagnosis Codes: Required Formatting (ICD-10)

| ICD-10 Format Guidelines (Outpatient Claims with a DOS on or after October 1, 2015) |
|-------------------------------|-----------------------------|-----------------------------|---------------------|---------|
| Three to seven digits         | Note: All letters used except U |
| Character 1: Alpha            | Note: Numeric               |
| Characters 3-7: Alphanumeric  | Decimal Placement: After first 3 characters |
| Placeholder Character: “X” is used as a placeholder character to allow for future expansion. |

Figure 74: Request Type: Edit Diagnosis Code – Editable Field
6.1.13 Claim Reopening Request Types: Procedure Code Category

There is only one type of Claim Reopenings Request that falls into the *Procedure Code* category:

- **Edit Procedure Code**

**Table 10: Claim Reopening Request Types: Edit Procedure Code**

<table>
<thead>
<tr>
<th>Claim Reopening Request Type</th>
<th>Primary Field (Required)</th>
<th>Secondary Field <em>(Optional)</em></th>
<th>Required Format</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Edit Procedure Code</td>
<td>Procedure Code</td>
<td>Optional field: Billed Amount xx,xxx.xx</td>
<td>Five characters: Letters, numbers, or a combination of both</td>
<td>The replacement code must be one that may be used in a claim reopening request. An error message will be returned if an invalid or inappropriate code is used.</td>
</tr>
</tbody>
</table>

---

**Figure 75: Request Type: Edit Procedure Code – Editable Fields**

---

The SPOT: User Guide, Version 17.2
6.1.14 Request Types: Modifier Category

There are three types of Claim Reopenings Requests that fall into the Modifier category:

- Add Modifier
- Edit Modifier
- Delete Modifier

Table 11: Claim Reopening Request Types: Modifier Category

<table>
<thead>
<tr>
<th>Claim Reopening Request Type</th>
<th>Primary Field (Required)</th>
<th>Secondary Field (Optional)</th>
<th>Required Format</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Add Modifier</td>
<td>Modifier (first available modifier field)</td>
<td>N/A</td>
<td>Two characters: Letters, numbers, or combination</td>
<td>Only one modifier may be added, and it must be one that may be used for a reopening request.</td>
</tr>
<tr>
<td>Edit Modifier</td>
<td>Modifier (any modifier field that contains a value)</td>
<td>N/A</td>
<td>Two characters: Letters, numbers, or combination</td>
<td>Only one modifier may be replaced, and it must be one that may be used for a reopening request.</td>
</tr>
<tr>
<td>Delete Modifier</td>
<td>Modifier (any modifier field that contains a value)</td>
<td>N/A</td>
<td>N/A</td>
<td>Only one may be deleted.</td>
</tr>
</tbody>
</table>

Note: The new or replacement modifier must be among those that may be used in a claim reopening request. An error message will be returned if an invalid or inappropriate modifier is used.

Figure 76: Modifier Category – Editable Fields
6.1.15 Claim Reopening Request Types: Units Billed Category

There is only one type of Claim Reopenings Request that falls into the *Units Billed* category:

- **Edit Units Billed**

<table>
<thead>
<tr>
<th>Claim Reopening Request Type</th>
<th>Primary Field (Required)</th>
<th>Secondary Field 1 (Optional)</th>
<th>Secondary Field 2 (Optional)</th>
<th>Secondary Field 3 (Optional)</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Edit Units Billed</td>
<td>Units Billed: x.0 (e.g., 1 Unit=1.0)</td>
<td>DOS From MM/DD/YYYY</td>
<td>DOS To MM/DD/YYYY</td>
<td>Billed Amount xx,xxx.xx&lt;br&gt;Note: The Billed Amount field may only be edited in conjunction with the Units Billed field.</td>
<td>Anesthesia providers must use units and not minutes when adjusting units billed. The conversion factor is 1 unit = 15 minutes. For example, 75 minutes would be entered as 5 units (75/15=5 units).</td>
</tr>
</tbody>
</table>

**Table 12: Claim Reopening Request Types: Edit Units Billed**

![Figure 77: Request Type: Edit Units Billed – Editable Fields](image)

**Note:** Although edits to the *primary field* are required, edits to *secondary fields* are optional. Once the type of claim reopening request has been selected, *editable fields* will be presented on a background of white.
6.1.16 Claim Reopening Request Types: Billed Amount

There is one type of claim reopening request for billed amount.

Table 13: Claim Reopening Request Types: Billed Amount

<table>
<thead>
<tr>
<th>Claim reopening request type</th>
<th>Primary field(s) (required)</th>
<th>Secondary field (optional)</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Edit Billed Amount</td>
<td>Billed Amount</td>
<td>N/A</td>
<td>Note: An adjusted billed amount that is less than the allowed amount for the service is not accepted as it may result in an overpayment.</td>
</tr>
</tbody>
</table>

Figure 78: Request Type: Billed Amount

6.1.17 Claim Reopening Requests: Accessing the Claim

Before you may initiate the Claim Reopening Request process, you must first access the claim and any of its eligible line items that you wish to correct. Users may access claims they wish to reopen through two different paths on SPOT:

1. Check Claim Status: Search for the claim based on its dates of service
2. Reopen a Claim: Search for the claim based on its ICN

6.1.18 Claim Reopening Requests: Access through Claim Status

If you do not know the ICN of the claim you wish to open, you may find the claim by searching for it in Check Claims Status.

1. Select the menu tab labeled Claims
2. Select Check Claim Status from the submenu
3. The **Check Claims Status** form will appear

4. Select Date of Service and enter from and to dates

5. Select either Assigned or Non-Assigned

   **Note:** Part B claim status information will be accessible for up to 12 months from the finalization date. Data associated with pending claims may change prior to finalization.

6. The **Check Claim Status: Results - Part B** results summary page will appear.

7. Locate the claim you wish to reopen within the **Summary Table**, and click the corresponding **More** hyperlink in the **View** column.

8. The claim detail details pertaining to the selected assigned claim will display beneath the summary table:

9. Click the **View** hyperlink in the **Claim Details** table to view details at the **line-item level** and determine which line items are available for claim reopening.

10. The **Line Item Detail** page will appear.

   - If a line item is eligible, SPOT will display the hyperlink: **View line items eligible for claim reopening** above that line item.
   - If a line item is ineligible, the hyperlink will not display

---

![Claim Status: Line Item Detail](image)

**Figure 79:** Claim Status Path: Line Item Detail with eligibility indicators

11. To begin the **Claim Reopening Request** process, click any of hyperlinks labeled: **View line items eligible for claim reopening**, which will be displayed over any eligible line items.

12. The **Claim Reopening: Request Form** will appear. Only those line items that are eligible for reopening will display in the form
Note: Internet Explorer users must turn off Compatibility View to use the Claim Reopening Request Form.

6.1.19 Claim Reopening Requests: Access through Claim Reopenings

Select Reopen/Correct a Claim from the Appeals menu.

Part A instructions

1. For Part A, the Claim Reopening Request Form will appear. The provider’s name, PTAN, telephone number, and state are pre-populated:

![Claim Reopening Request Form](image)

Figure 80: Claim reopening request form (Part A)

2. Complete the required fields and upload the CMS-1450 (UB-04) form and any additional documentation needed to support your request. Add your electronic signature.

3. Click Submit

How to check the status of a Part A claim reopening request

1. Part A providers may check the status of their reopening requests by going to the Secure Documentation menu, then Check Status

2. Search by date of submission or confirmation number (received after you submitted the request)
NOTE: Part A providers may also check the direct data entry (DDE) system.

Part B instructions

Select *Reopen/Correct a Claim* from the *Appeals* menu, then select the radio button next to “claims reopening.”

1. For Part B, the Claim Reopening Inquiry page will appear:

![Claim Reopening Inquiry](image1)

*Figure 81: Claim Reopening Path: Claim Reopening Inquiry (Part B)*

1. Enter the claim’s ICN
2. Select the Reopening Type
3. Click the *Search* button
4. If no line items associated with the ICN are eligible to be reopened, the following error message will appear:

![Claim Reopening: Query](image2)

*Figure 82: Claim Reopening Path: ICN Query Error*
5. If one or more of the line items associated with the ICN are eligible to be reopened and you have selected Other Corrections, the **Claim Reopening: Request Form** will appear. **Only those line items that are eligible for reopening will display in the form:**

![Claim Reopening Request Form](image)

**Figure 83: Claim Reopening Path: Claim Reopening: Request Form**

### 6.1.20 Claim Reopening Requests: Completing the Request Form

**Tips:**

- Internet Explorer users must **turn off Compatibility View** to use the **Claim Reopening Request Form**.
- Editable fields on the **Claim Reopening Request Form** are based upon the claim reopening request selected (example image below is based on the Other Corrections selection)
- Primary fields, which are also based upon the request type selected, are required.

1. Select the **Request Type** for each of the line items you wish to edit from its corresponding drop-down menu:
2. Once you have selected Request Type for a particular line item, editable fields for that type will have a white background:

![Claim Reopening Request Form](image)

**Figure 85:** Claim Reopening: Request Form – Editable Fields

- **Note:** Internet Explorer users must turn off Compatibility View to use the Claim Reopening Request Form.

3. Add, edit, or remove values (as applicable). If a Request Type has more than one editable field (e.g., Edit Procedure Code), only the primary field must be changed. The primary field(s) will vary based upon request type.

4. SPOT will validate all entries in the Claim Reopening Request: Form. Users may notice a slight delay after entering new values for fields that require the portal to not only check the formatting of the value but also its validity and acceptability for claim reopenings.
5. To view formatting guidelines for any field, place your cursor on the ▪ next to the column heading for that field:

Figure 86: Claim Reopening Request: Tooltip

6. Once you have made your changes, click the Review button, and the Claim Reopening Request: Review Changes page will appear.

   Note: Do not click the Enter key -- it will be unresponsive. If you click the Cancel button, you will be redirected to the Claim Reopening: Query page. You must click the Review button to proceed to the Claim Reopening Request: Review Changes page.

7. Only the line items that have been edited will display on the Claim Reopening Request: Review Changes page. Edited fields will display with a green background:

   Figure 87: Claim Reopening Request: Review Changes

8. Review your changes, which will be highlighted by a green background.

   Note: No fields may be edited on the Claim Reopening Request: Review Changes page.

9. Click the Submit button to submit your Claim Reopening Request. Do not click the Enter key -- it will be unresponsive.

   Note: If you click the Cancel button, you will be returned to the Claim Reopening: Request Form page to begin the process again. You must click the Submit button to submit your request.

Claim Reopening Requests submitted after 6 PM ET during weekdays, at any time during a weekend, or on First Coast Service Options’ corporate holidays, will receive a receipt date that reflects First Coast’s next business day.
10. If you have already submitted a request for the ICN, the Claim Reopening Request: Error page will appear:

![Claim Reopening Request: Error](image)

**Figure 88: Claim Reopening Request: Error**

Note: Once you have successfully submitted a claim reopening request through SPOT, you may not submit additional claim reopening requests for the same ICN through SPOT or by any other method (i.e., IVR, fax, or Messaging).

For more information about claim reopenings, please refer to *Medicare Claims Processing Manual, Chapter 34 - Reopening and Revision of Claim Determinations and Decisions*.

11. If your submission was successful, the Claim Reopening Request: Confirmation page will appear:

Note: Claim Reopening Requests submitted after 6 p.m. ET during weekdays, at any time during a weekend, or on First Coast Service Options’ corporate holidays, will receive a receipt date that reflects First Coast’s next business day.

12. You will also receive a confirmation email, which will be sent to the email listed in your SPOT account profile. The email will specify which ICN was affected, and it will list any changes submitted in the request.

### 6.1.21 Claim Reopening Requests: Checking Status

If your claim reopening request was submitted successfully:

- Please allow *48-72 hours* before checking its status
- **Do not** submit additional claim reopening requests for the same ICN through the portal, IVR, fax, or Messaging.

  Note: Submission of additional claim reopening requests for the same ICN will **not** expedite your initial claim reopening request for the claim.

- Claim reopening requests may take up to *60 business days* to process (based on date of submission)
Note: Although the majority of claim reopening requests will be processed within the 60-day timeframe, some requests may take longer.

- **Claim Reopening Requests** submitted after 6 p.m. ET during weekdays, at any time during a weekend, or on First Coast Service Options’ corporate holidays, will receive a receipt date that reflects First Coast’s next business day.

- Whether your claim reopening request is approved or denied, additional claim reopening requests for the same **ICN** will not be accepted by SPOT or IVR.
  - If your claim reopening request is approved, an adjustment claim will be created, which will be assigned a new **ICN** and will not be eligible for a claim reopening request.
  - If your claim reopening request is denied, you may not submit a new claim reopening request for the same **ICN**.

**How to know if your request has been approved or denied**

- If your request to reopen the claim has been **approved**, you will receive a **new remittance advice** notification, which will list the adjusted claim amount and the new **ICN** for the adjusted claim. **Note:** The **ICN** of the adjusted claim will be **different** from the **ICN** of the original claim.

- If your request to reopen the claim was **not approved**, you will receive a letter or telephone call notifying you of the decision.

**How to check the status of a Part B claim reopening request**

To check on the status of your Part B claim reopening request, you may call the **IVR (1-877-847-4992)** and follow these steps:

- Indicate your location:
  - For providers in Florida or U.S. Virgin Islands – **press 1**
  - For providers in Puerto Rico – **press 2**

- Indicate you wish to use touchtone – **press any key**

- Select **Check status information** – **press 2**
  - Select **Correspondence and appeal status** – **press 2**

- When prompted, use the telephone keypad to enter the required information: **NPI**, **PTAN**, **TIN**, and the **ICN** of the original claim. If you need to enter any letters, use the **touchtone converter**. The interactive voice response system (IVR) will give you the status of your claim reopening request. For more information, please review the [Claim Reopening: Check status FAQ](#).

**6.1.22 Appeals: Submitting an appeal (claim redetermination)**

To submit a first-level appeal (redetermination), choose **Submit an appeal** from the **Appeals** menu. The claim redetermination form will appear:
Claim Redetermination Request: Submission Requirements:

- The **Claim Redetermination Request** form is to be used to file first-level appeals.
- You must file the **Claim Redetermination Request** within 120 days of the initial claim determination.
- This form may not be used for a claim adjustment.
- You must upload documentation to support your claim. All documents must be submitted in PDF format (6MB maximum).
- The processing of your request will be based solely on the information included in your submission.
- Submissions on weekends, holidays or after 6 p.m. ET weekdays will receive a receipt date that reflects the next business day.

Completing the form

1. Enter data in all required sections and fields.
   
   **Note:** You may enter up to three CPT®/HCPCS codes (separated by commas).

   **Note:** You may enter a **maximum of 1000 characters** (including punctuation and spaces) in the **Reason for Request** and **Description of Appealed Services** fields.

2. Upload **Support Documentation** in PDF format (6MB maximum).
a. Click the **Add file** button, and an additional line will appear. Repeat the process listed above to navigate to the file. **Note:** To remove the first file, click the **Clear** button

**Note:** To remove any additional files, click the **Delete** button located next to the file you wish to remove

2. Enter your electronic signature:

   ![Secure Documentation: Electronic Signature](secure_documentation.png)

   **Figure 90:** *Secure Documentation: Electronic Signature*

3. Check to make sure that you have completed all required fields and that you have uploaded your support documentation. If you click the **Submit** button, and any error is identified by the application (e.g., formatting error, required field data missing), you will need to reload any support documentation as well as correct the error before clicking the **Submit** button again.

4. Click the **Submit** button

5. If your submission was successful, a confirmation page will appear, and you will receive a notification email specifying the form filed and your confirmation number.

### 6.1.23 Appeals: Appeals outcome

To check the outcome of your first-level appeal (redetermination), select **Appeals outcome** from the **Appeals** menu. The “Find the outcome of appeals” form will appear. Enter information into the search form, which includes the beneficiary’s Medicare ID and the date of service from and to dates.

![Find the outcome of appeals](appeals_outcome.png)

**Find the outcome of appeals**

Please complete the following form to locate the outcome of your first-level appeals. You may search by the beneficiary’s Medicare ID, the date of service, or both. Please be aware that you will receive correspondence from First Coast for all finalized appeals where the outcome was misfiled, dismissed, partially favorable or unfavorable. Please use the date of this correspondence to plan any additional steps in the appeal process.

**Note:** Please allow at least 60 days after the appeal submission date to search for the outcome. You may search for appeals with a date of service up to **four years** prior to the current date. Outcome details for an appeal will be available for up to 90 days from the date it is finalized.

**Required**

- **Beneficiary’s Medicare ID:**
  - 55566777A1AC2DE3FG45

- **DOS From Date:**
  - MM/DD/YYYY

- **DOS To Date:**
  - MM/DD/YYYY

[Search] [Reset Form]
Once you have entered the required information, click Search. Results will appear, showing the outcome. The possible outcomes are:

Part A
- Favorable
- Unfavorable
- Partially favorable
- Pending

Part B
- Fully favorable
- Unfavorable
- Partially Favorable
- Dismissal
- Dismissal – incomplete redetermination
- Change in liability – unfavorable
- Withdrawal
- Pending

Figure 92: Appeals Search Results
To begin a new query, click New Query.
6.2 Claims

6.2.1 Claim: Check Claims Status

The Claim Status feature allows users to check the status of their claims. To access claims information, the user should select the Claims tab, then Check claims status. Specify the parameters of the query, and submit the query. Due to the nature of the systems source, the Claim Status query form as well as the information available will differ based upon the provider’s line of business (i.e., Part A or Part B) and the type of claim (i.e., assigned or unassigned).

Note: Data updates to SPOT application occur between 6-7:30 a.m. each weekday. Users may experience slower response times to claim and payment data queries or an interruption in access during these time periods.

6.2.2 Claim Status: Part A

To access claims information for a Part A provider, please take the following steps:

1. Select the menu tab labeled Claims
2. Select Claim Status from the submenu
3. The Claim Status: Query - Part A form will appear:

![Check Claims Status](image)

Figure 93: Claim Status: Query - Part A form

4. Specify the parameters of your query by selecting the month and year in which the date(s) of service occurred. To narrow your search, you may also select the exact date of service and/or enter a specific beneficiary’s Medicare ID. If you are looking for a specific claim, you may enter its Document Control Number (DCN).

Note: To access data for a previously submitted query -- during the same session -- you may click the corresponding Resubmit Query hyperlink in the Claim Status: Previous Queries table.

5. Click the Search button.

Note: Part A claim status information will be accessible for up to 12 months from the processed date.

6. The Claim Status: Results - Part A results summary page will appear:
To customize your summary display results, you may select the number of records that you would like to view per page as well as sort records by date, patient’s last name, or by claim status. Click the PDF or Excel icon to export the claim data summary.

Note: If you would like to store the summary of data displayed in the table, you may export the data to either Microsoft Excel or Acrobat Reader -- just click the corresponding icon at the bottom of the summary table.

To view additional details regarding a particular claim, click on the DCN number in the last column.

In both Part A and Part B claim status, once you click on the corresponding DCN or ICN number, ‘Claim Details’ will appear below the query results.

### Claim Details:

- **Last Name:** Holmes
- **First Name:** S
- **Date of Service From:** 05/31/2019
- **Date of Service To:** 05/31/2019
- **Total Charges:** $123,456,789
- **Type of Bill:** 138
- **Provider Reimbursement:** $0.00
- **Claim Status:** Pending
- **Reason Code:** 30919
- **Message:** This is an adjustment to a previous claim. For more information, please refer to your remittance advice.
- **Narrative Message:** THIS CLAIM IS A DUPLICATE OF A PREVIOUSLY REJECTED CLAIM
- **DCN:** 111111111111FLA
- **ICN:** 999999999999FLA

**Figure 94:** Claim Status: Results - Part A

7. To customize your summary display results, you may select the number of records that you would like to view per page as well as sort records by date, patient’s last name, or by claim status.

8. To view additional details regarding a particular claim, click on the DCN number in the last column.

8. In both Part A and Part B claim status, once you click on the corresponding DCN or ICN number, ‘Claim Details’ will appear below the query results.

**Figure 95:** View claim details

### 6.2.3 Claim Status: Part B -- Assigned Claims

To access assigned claims information for a Part B provider, please take the following steps:
1. Select the menu tab labeled **Claims**

2. Select **Claim Status** from the submenu

3. The **Claim Status: Query - Part B** form will appear:

   ![Image of Claim Status: Query - Part B (Assigned) form]

   **Figure 96: Claim Status: Query - Part B (Assigned) form**

4. Specify the parameters of your query by entering a date range and selecting the type of claim (i.e., **Assigned**) in the form. If you would like to search for claims associated with a specific beneficiary, please enter the Medicare ID as well. **Date range may not exceed 12 months.** If you are looking for a specific claim, you may enter its Internal Control Number (ICN). **Note:** To access data for a previously submitted query -- during the same session -- you may click the corresponding **Resubmit Query** hyperlink in the **Claim Status: Previous Queries** table.

5. Click the **Search** button. **Note:** **Part B** claim status information will be accessible for up to 12 months from the finalization date. **Data associated with pending claims may change prior to finalization.**

6. The **Claim Status: Results - Part B** results summary page will appear:
7. To customize your summary display results, you may select the number of records that you would like to view per page as well as sort records by date, patient’s last name, or by claim status.

**Note:** If you would like to store the summary of data displayed in the table, you may export the data to either Microsoft Excel or Acrobat Reader -- just click the corresponding icon at the bottom of the summary table.

8. To view additional details regarding a particular assigned claim, please click the corresponding hyperlink in the View column. **Claim-level** details pertaining to the selected assigned claim will display beneath the summary table.

9. To view details at the **line-item level**, click the **View** hyperlink in the **Claim Details** table.

10. Click the **OK** button to proceed to the **Line Item Detail** page:

    **Note:** If the claim’s status is **pending**, the following message will appear before the **Line Item Detail** page will display:

    ![Message from webpage]

    **Data associated with pending claims may change prior to finalization.**

    ![OK button]

**Figure 97:** Claim Status: Results - Part B (Assigned)

**Figure 98:** Claim Status: Results - Part B (Assigned): Pending Claims Message
11. To customize your display results, you may select the number of line items that you would like to view per page.

12. To return to Claim Status Results, please click the corresponding hyperlink labeled Back of any line item displayed.

   Note: If any line items are eligible to be reopened, the hyperlink: View line items eligible for claim reopening will display above that line item. If the line item is ineligible, the link will not display. Pending and adjusted claims are ineligible for claim reopening.

6.2.4 Claim Status: Part B -- Non-assigned Claims

To access non-assigned claims information for a Part B provider, please take the following steps:

1. Select the menu tab labeled Claims
2. Select Claim Status from the submenu
3. The Claim Status: Query - Part B form will appear:
13. Specify the parameters of your query by entering a date range and selecting the type of claim (i.e., Non-assigned) in the form. If you would like to search for claims associated with a specific beneficiary, please enter the Medicare ID as well. If you are looking for a specific claim, you may enter its Internal Control Number (ICN).

Note: To access data for a previously submitted query -- during the same session -- you may click the corresponding Resubmit Query hyperlink in the Claim Status: Previous Queries table. Date range may not exceed 12 months.

4. Click the Search button.

Note: Part B claim status information will be accessible for up to 12 months from the finalization date. Data associated with pending claims may change prior to finalization.

5. The Claim Status: Results - Part B results summary page will appear:
6. To customize your summary display results, you may select the number of records that you would like to view per page as well as sort records by date, patient’s last name, or by claim status.

Note: If you would like to store the summary of data displayed in the table, you may export the data to either Microsoft Excel or Acrobat Reader -- just click the corresponding icon at the bottom of the summary table.

7. Claim-level details pertaining to the selected non-assigned claim will display beneath the summary table. Data associated with pending claims may change prior to finalization.

6.2.5 Claims: MR ADR Status

The Medical Review (MR) Additional Development Request (ADR) Status lookup allows users to search for the review status of claims for which an additional documentation request was sent related to medical review.

To use the MR ADR Status lookup, the user should take the following steps:

1. Select MR ADR Status from the Claims menu

2. Enter information into the search form. The search form includes the following fields. At least one field must be completed.

   - MR Case Number
   - Control Number
   - Medicare ID
   - Search Date By
   - ADR Status: Pending or Received (optional field)
Once you have completed at least one field, click **Search**.

3. Results will appear, showing **Case Number, Claim Number, Medicare ID, and Date of Service From a and To**

2. Once you make a selection, three boxes will appear: **ADR, Review, and Education**, with the ADR details appearing automatically
In this tab, you will find more details about your ADR letter.

3. Next, click **Review** to view additional details about the medical review process.

4. Finally, click **Education** to see details about the education associated with the ADR. **Note:** Sometimes, education details may not be available.
5. To begin a new query, click the \textit{New Query} button located in the bottom right of the page.

6.3 Eligibility

Under the Eligibility menu, users can find options to look up an MBI or check eligibility.

6.3.1 Eligibility: MBI Lookup

To use the \textit{MBI Lookup}, the user should take the following steps:

1. Select \textit{MBI Lookup} from the \textit{Eligibility} menu

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{MBI_lookup.png}
\caption{Select MBI Lookup}
\end{figure}

2. The \textit{MBI Lookup} search page will appear. Enter the following information into these required fields:
   \begin{itemize}
   \item Beneficiary’s First Name
   \item Beneficiary’s Last Name
   \item Beneficiary’s Social Security Number
   \item Beneficiary’s Date of Birth
   \end{itemize}

3. Check the “I’m not a robot” box and follow the instructions (if any). When the green checkmark appears, click \textit{Search}
4. Results will appear, showing the beneficiary’s first name, last name, and MBI.

6.3.2 Eligibility: Check eligibility

The Check Eligibility feature allows users to verify a beneficiary’s eligibility status and view his or her benefits information. The user enters the beneficiary’s information (e.g., Medicare ID, first and last names, date of birth), and clicks the Search button to review the results of the query. Once the Eligibility/Benefits Inquiry results have been generated, the Benefits/Eligibility tab may display the following submenu options:

- Eligibility
- Deductibles/Caps
- Previous Inquiries
- Preventive
- MSP
- Plan Coverage
- Hospice/Home Health
- Inpatient
- QMB

**Note:** Benefits/Eligibility information is available **24/7** (excluding holidays and scheduled maintenance periods).

- The display and accessibility of specific **Benefits/Eligibility** tab **submenu** options (e.g., Hospice/Home Health, MSP) are contingent upon the availability of **active data** directly associated with the beneficiary and each **submenu** option.
- Once a specific beneficiary’s information has been entered and submitted, only the **submenu** options that contain **active data** will display.
- Eligibility queries are limited to 24 months in the past and four months in the future, based upon date of the query.

**Eligibility reports:** Click the **PDF** icon, located on every results page, and SPOT will automatically create a **printer-friendly** eligibility report in PDF format. Each section will focus on a different benefits category and include the patient’s information as well as the dates of service queried. You may the save the report and/or print a copy to place in the patient’s file for easy reference. To review an **example** of a complete **SPOT eligibility report**, please click here.

**To utilize the Benefits/Eligibility feature category, the user should take the following steps:**

1. Select the menu tab labeled **Eligibility** then the drop-down selection **Check Eligibility**
2. The **Benefits/Eligibility Query** page will appear:

![Eligibility & Benefits Inquiry](image)

**Figure 110:** **Eligibility/Benefits Inquiry Form – Part B**

3. You may submit a **new query** by entering a date of service range as well as the beneficiary’s **Medicare ID, last name, and either the first name or date of birth**

   **Note:** You may limit your query to the date(s) the service will be furnished to the patient, or you may specify any time period up to four months in the future and 24 months in the past.

4. Click **Search** button
You may resubmit a previously submitted eligibility query (within the same session) by clicking the corresponding Resubmit Query link in the Benefits/Eligibility: Previous Queries table. (Note: This table will only display previously submitted queries in the same session.)

5. The Eligibility/Benefits Inquiry results page will appear:

![Eligibility/Benefits Inquiry Results](image)

Figure III: Eligibility/Benefits Inquiry Results

6. The Eligibility/Benefits Inquiry results page will include the following information:

- **Beneficiary’s information:**
  - Name
  - Medicare ID
  - Date of Birth
  - Date of Death (when applicable)
  - Address
  - Medicare primary (yes or no)

- **Beneficiary’s eligibility/benefits information:**
NOTE: Information listed below only appears when applicable to the beneficiary.

- **Part A Eligibility: Effective Date** -- date indicating when the beneficiary first became eligible for Medicare Part A benefits
- **Part A Eligibility: Termination Date** -- date that indicates the termination of eligibility for Medicare Part A benefits. *No date in this field means Medicare Part A eligibility has not been terminated.*
- **Part B Eligibility: Effective Date** -- the date indicating when the beneficiary first became eligible for Medicare Part B benefits
- **Part B Eligibility: Termination Date** -- date that indicates the termination of eligibility for Medicare Part B benefits. *No date in this field means Medicare Part B eligibility has not been terminated.*
- **Inactive Periods** -- if data appears in the *Inactive Periods* section, it means that although the beneficiary is entitled to Medicare, he or she is ineligible for Medicare benefits over the specified period of time for one or more of the following reasons:
  - The Medicare beneficiary has been classified as an illegal alien in the United States.
  - The Medicare beneficiary has been deported from the United States.
  - The Medicare beneficiary has been incarcerated.

Note: Information specifying the reason for the period of ineligibility will not be released by HETS

- **QMB Enrollment** -- effective date, termination date, and plan
- **Medicare Diabetes Prevention Program (MDPP)** (effective date, termination date and period two end date)
- **Inactive Medicare Diabetes Prevention Program (MDPP) Periods** (effective date and termination date)
- **End State Renal Disease** (effective date, dialysis start date, dialysis end date, transplant discharge date)

7. **Since** the user entered the required beneficiary information on the Eligibility/Benefits Inquiry page, the Benefits/Eligibility submenu will now be visible, and more of the beneficiary’s information/history will be accessible:

The display and accessibility of specific Benefits/Eligibility tab submenu options (e.g., Hospice/Home Health, MSP) are contingent upon the availability of active data directly associated with the beneficiary and each submenu option. Once a specific beneficiary’s information has been entered and submitted, only the submenu options that contain active data will display. If no data exists for a specific beneficiary, the submenu tab will be grayed-out (see ‘Hospice/Home Health’ - Figure 117).

8. Select any of the Benefits/Eligibility submenu options displayed to view the corresponding information.

  **Note:** The display and accessibility of specific Benefits/Eligibility tab submenu options (e.g., Hospice/Home Health, MSP) are contingent upon the availability of active data directly associated with the beneficiary and each submenu option. Once a specific beneficiary’s information has been entered and submitted, only the submenu options that contain active data will display.

9. Click the PDF icon, located at the top and bottom of every eligibility results page, and SPOT will automatically create a printer-friendly eligibility report in PDF format. Each section of the SPOT Eligibility Report focuses on a different benefits category and includes the beneficiary’s information, the
dates of service queried, and all of the data returned by the query. You may save the report or print a copy to place in the patient’s file for easy reference.
6.3.3 Benefits/Eligibility: Data Category -- Deductibles/Caps

To access the beneficiary’s Deductible/Caps information, please complete the following steps:

1. Select the Deductible/Caps link from the Benefits/Eligibility submenu:
2. The beneficiary’s Deductible/Caps information will automatically display:

![Image of Deductible/Caps Results]

**Figure 112: Deductible/Caps Results**

**Note:** Click the PDF icon, located at the top and bottom of every eligibility results page, and SPOT will automatically create a printer-friendly eligibility report in PDF format.
6.3.4 Benefits/Eligibility: Data Category -- Preventive Services

Preventive services are described by the Healthcare Common Procedure Coding System (HCPCS) and in some cases, Current Procedural Technology® (CPT®) codes. Although there are many HCPCS and CPT® codes for which Medicare provides payment, the following is a listing of the preventive categories and their corresponding HCPCS code(s) currently returned by HETS:

- Smoking Cessation
- Alcohol Misuse Screening
- Annual Depression Screening
- Annual Wellness Visit (AWV)
- Behavioral Counseling For Alcohol Misuse
- Behavioral Counseling For Obesity
- Bone Density Measurements
- Cardiovascular Disease Screening (CARD)
- Colorectal Cancer Screening (COLO)
- Diabetes Screening Tests (DIAB)
- Fecal Occult Blood Test (FOBT)
- Hepatitis B Antibody Screening
- Hepatitis C Antibody Screening
- High Intensity Behavioral Counseling (HIBC)
- HIV Screening
- Initial Preventive Physical Examination (IPPE)
- Intensive Behavioral Therapy (IBT) for Cardiovascular Disease
- Intensive Behavioral Therapy for Obesity
- Lung Cancer Screening
- Pharmacogenomic Testing for Warfarin Response (PTWR)
- Pneumococcal Vaccines
- Prostate Cancer Screening (PROS)
- Screening Mammography (MAMM)
- Screening Pap Test (PAPT)
- Screening Pelvic Exam (PCBE)
- Ultrasound Screening for Abdominal Aortic Aneurysm (AAA)

For more information about this topic, please review:

- Preventive Service codes FAQ
- MLN Matters® Preventive Services Guide (coding and billing guidelines)

Note: If HETS does not return eligibility data for a particular code, SPOT will be unable to display it. In addition, data on certain codes will only be returned if the beneficiary meets the criteria required (e.g., age, gender, medical condition) for eligibility.
6.3.5 Preventive Services: Accessing the data

To access the beneficiary’s Preventive information/history, please complete the following steps:

1. Select the Preventive link from the Benefits/Eligibility submenu:

2. The beneficiary's Preventive information/history will automatically display:
## Eligibility/Benefits Data Results

### Dates of service searched: 04/01/2020 - 04/24/2020

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<th>Hospice/Home Health</th>
<th>Plan Coverage</th>
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#### Preventive

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<td>06/01/2012</td>
<td>04/24/2020</td>
<td>$0.00</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>8221</td>
<td>06/01/2012</td>
<td>04/24/2020</td>
<td>$0.00</td>
<td>0%</td>
<td></td>
</tr>
</tbody>
</table>

### Pneumococcal Vaccines

- **Date of Service:** 10/31/2019
- **Rendering NP:** [Redacted]

- **Date of Service:** 10/19/2019
- **Rendering NP:** [Redacted]
Note: Preventive Services information displays current information only -- no inference about historical eligibility may be made based on the returned next eligible dates. Preventive Services also displays gender specific information. In the example above, preventive services for women are displayed.

3. The Preventive information/history results page provides HCPCS codes, next professional date, next technical date, deductible, and coinsurance information associated with covered preventive services.
   Note: Click the PDF icon, located at the top and bottom of every eligibility results page, and SPOT will automatically create a printer-friendly eligibility report in PDF format.

6.3.6 Preventive Services: Professional and technical services

In the Preventive Services category:

- Professional preventive services refer to procedures performed by the physician (e.g., examination, interpretation of test results)
- Technical preventive services refer to procedures that involve screening or the performance of tests (e.g., radiology test, mammography screening).

For preventive services codes and billing guidelines, please review MLN Matters® Preventive Services Guide.

6.3.7 Preventive services: Next eligible dates

- The Next Professional Date or Next Technical Date associated with a particular procedure code refers to a date that meets one of the following criteria:
  - The date that the beneficiary was first eligible to receive the professional or technical preventive service
    Note: The date the beneficiary was first eligible to receive a preventive service may correspond to either the beneficiary’s initial Medicare Part A/B eligibility date or the effective date of Medicare’s coverage for the preventive service
  - The date that the beneficiary will be next eligible to receive the professional or technical preventive service
  - The Next Professional Date and Next Technical Date may be the same date. However, one date may list the date the service was first made available to the beneficiary, and the other may list the date the beneficiary will be next eligible to receive the service.

Note: Annual Wellness Visits (AWV) are covered by Medicare at 12 month intervals, which means that 11 full calendar months must pass after the month in which a beneficiary had received an AWV.
6.3.8 Benefits/Eligibility: Data Category -- MSP

To access the beneficiary’s MSP (i.e., Medicare secondary payer) information, please complete the following steps:

1. Select the MSP link from the Benefits/Eligibility submenu:

2. The beneficiary's MSP information will automatically display:

3. The beneficiary's MSP information results will include only active MSP data per the date(s) requested and will not be accessible if there is no MSP data or if notification of coverage primary to Medicare has not been received by CMS.

4. For each Medicare Secondary Payer (MSP) payer, the following information will be displayed:

   - **Effective Date** -- the date that indicates the start of the primary insurer's coverage.
   - **Termination Date** -- the date that indicates the termination of the primary insurer's coverage. *No date in this field means the primary insurance coverage has not been terminated.*
   - **Insurer Name** -- the name of the insurance company furnishing the coverage.
   - **Policy Number** -- the primary insuring organization’s policy number for the Medicare beneficiary.
   - **Type of Primary Insurance** -- the type of insurance provided for the beneficiary, which may fall into any of the following categories:
     - Medicare Secondary Working Aged Beneficiary or spouse with Employer Group Health Plan
     - Medicare Secondary End-Stage Renal Disease Beneficiary in the 12 month coordination period with an Employer Group Health Plan
     - Medicare Secondary No-Fault insurance including auto is primary
     - Medicare Secondary Workers’ Compensation
     - Medicare Secondary Public Health Service (PHS) or other Federal Agency
     - Medicare Secondary Black Lung
     - Medicare Secondary Veteran’s Administration
     - Medicare Secondary Disabled Beneficiary Under Age 65 with Large Group Health Plan
     - Medicare Secondary other liability insurance is primary
     - Workers’ Compensation Medicare Set-aside Arrangement
     - Address -- primary address of the insurer.
   - **Diagnosis Codes** -- only ICD codes are provided
6.3.9 Benefits/Eligibility: Data Category -- Plan Coverage

The Plan Coverage submenu option displays data regarding the beneficiary’s enrollment -- **as applicable** -- in one or more of the following plans:

- Medicare Advantage (MA)
- Part D contracts
- MA Managed Care Plans (i.e., Part C contracts) that provide Part A and B benefits for beneficiaries enrolled under a contract.

**Note:** If no active data is available, the Planned Coverage option will not be displayed.

To access the beneficiary’s Plan Coverage information, please complete the following steps:

1. Select the Plan Coverage link from the Benefits/Eligibility submenu:
2. The beneficiary's Plan Coverage information will automatically display:
Figure 115: Plan Coverage Information Results

Note: Click the PDF icon, located at the top and bottom of every eligibility results page, and SPOT will automatically create a printer-friendly eligibility report in PDF format.
3. **Plan Coverage** data provides information regarding the beneficiary’s enrollment — as applicable — in Medicare Advantage (MA) and Part D contracts and/or MA Managed Care Plans (i.e., Part C contracts) that provide Part A and B benefits for beneficiaries enrolled under a contract. The Plan Coverage results page will include the following information:

- **Beneficiary’s Information:**
  - Name
  - Medicare ID
  - Date of Birth
  - Date of Death (when applicable)

- **Plan Coverage information:**
  - **Plan Type** -- a full plan description followed by Plan Type code, which may be any of the following types:
    - Health Maintenance Organization Medicare Non Risk – HM
    - Health Maintenance Organization Medicare Risk – HN
    - Indemnity – IN
    - Preferred Provider Organization – PR
    - Point of Service – PS
    - Pharmacy – Part D
  - **Enrollment Date** -- the date that indicates the start of enrollment in the coverage plan.
  - **Disenrollment Date** -- the date that indicates the termination of enrollment to the coverage. *No date in this field means the plan enrollment has not been terminated.*
  - **Contract Number/Plan Benefit Package ID** -- the contract number followed by the plan number (if on file).
  - **MCO Bill Option Code** (when applicable) -- the bill option code of the Plan Type. This field only applies to plan types HM, HN, IN, PR, and PS (as defined above). *Note: This field will not be displayed for Part D plan type.*
  - **Contract website Address** (when applicable) -- the website address that will furnish information regarding the beneficiary’s insurance coverage.
  - **Plan Name** -- a descriptive name of the beneficiary’s insurance coverage organization.
  - **Address/Phone Number** -- the contact information for the beneficiary’s insurance coverage organization.

The display and accessibility of information in Plan Coverage are contingent upon the availability of active data. It is the responsibility of the insurer to notify the SSA of the plan and of any information associated with the plan (e.g., policy number, name of insurer). *Once the SSA has been notified,* the information will be shared with CMS’ systems, including its HETS.
6.3.10 Benefits/Eligibility: Data Category -- Hospice/Home Health

To access the beneficiary’s Hospice/Home Health information, please complete the following steps:

1. Select the Hospice/Home Health link from the Benefits/Eligibility submenu
2. The beneficiary's Hospice/Home Health information will automatically display:
### Eligibility/Benefits Data Results

**Dates of service searched:** 11/01/2017 - 08/01/2019

<table>
<thead>
<tr>
<th>Gender</th>
<th>Date of Birth: 11/03/1947</th>
<th>Date of Death:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Home Health Certification

<table>
<thead>
<tr>
<th>Certification (HCPCS Code G0180)</th>
<th>HHEH Certification Date: 07/24/2017</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>HHEH Certification Date: 03/09/2016</td>
</tr>
<tr>
<td></td>
<td>HHEH Certification Date: 01/07/2016</td>
</tr>
<tr>
<td></td>
<td>HHEH Certification Date: 04/13/2015</td>
</tr>
<tr>
<td></td>
<td>HHEH Certification Date: 12/05/2014</td>
</tr>
</tbody>
</table>

#### Home Health Care

<table>
<thead>
<tr>
<th>HHEH Start Date:</th>
<th>HHEH End Date:</th>
<th>Contractor Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>02/16/2019</td>
<td>04/16/2019</td>
<td></td>
</tr>
<tr>
<td>12/18/2018</td>
<td>02/15/2019</td>
<td></td>
</tr>
<tr>
<td>10/19/2018</td>
<td>12/17/2018</td>
<td></td>
</tr>
<tr>
<td>08/20/2018</td>
<td>10/18/2018</td>
<td></td>
</tr>
<tr>
<td>06/21/2018</td>
<td>08/19/2018</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NPI:</th>
<th>Contractor Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Hospice

<table>
<thead>
<tr>
<th>Effective Date</th>
<th>Revocation Code</th>
<th>Termination Date</th>
<th>NPI</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/15/2017</td>
<td>1</td>
<td>02/27/2017</td>
<td></td>
</tr>
<tr>
<td>11/16/2016</td>
<td>1</td>
<td>01/14/2017</td>
<td></td>
</tr>
<tr>
<td>09/17/2016</td>
<td>1</td>
<td>11/15/2016</td>
<td></td>
</tr>
</tbody>
</table>
3. The **Hospice/Home Health** results page will include the following information (when applicable):

- **Beneficiary’s Home Health Certification**
  - HHEH Certification Date(s)

- **Beneficiary’s Home Health Care information:**
  - HHEH Start Date -- the date the 60-day home health episode period began.
  - HHEH End Date -- the date the 60-day home health episode period terminated.
  - HHEH DOEBA Start Date -- the date of *earliest* billing activity for spell of illness.
  - HHEH DOLBA Start Date -- the date of *latest* billing activity for spell of illness.
  - NPI
  - Contractor Number
  - Contractor Name

- **Beneficiary’s Hospice information:**
  - Effective Date
  - Termination Date
  - Revocation Code (when applicable)
  - NPI
6.3.11 Benefits/Eligibility: Data Category -- Inpatient

To access the beneficiary’s Inpatient information, please complete the following steps:

1. Select the Inpatient link from the Benefits/Eligibility submenu
2. The beneficiary's Inpatient information will automatically display:

![Inpatient Information Results](image)

**Note:** Click the PDF icon, located at the top and bottom of every eligibility results page, and SPOT will automatically create a printer-friendly eligibility report in PDF format.

3. The Inpatient results page will include the following information:
   - Part A Deductible information
- Deductible Year
- Base Deductible

- Lifetime Reserve Days
  - Calendar Year
  - Lifetime Remaining Days
  - Lifetime Co-payment Amount per Day

- Lifetime Psychiatric Limitation Days
  - Lifetime Psychiatric Base Days
  - Lifetime Psychiatric Remaining Days

- Inpatient Spell information:
  - DOEBA Date -- the date of the *earliest* billing activity for the spell of illness.
  - DOLBA Date -- the date of the *latest* billing activity for the spell of illness.

- Hospital information:
  - Part A Remaining Deductible
  - Full Days Remaining ($0 per day)
  - Co-payment Days Remaining
  - Co-payment Amount per Day

- Skilled Nursing Facility (SNF) information:
  - SNF Days Remaining  ($0 per day)
  - SNF Co-payment Days Remaining
  - Co-payment Amount per Day

### 6.3.12 Benefits/Eligibility: Qualified Medicare Beneficiary (QMB)

To access the beneficiary’s QMB information, please complete the following steps:

1. Select the QMB link from the Benefits/Eligibility submenu
2. The beneficiary's QMB information will automatically display:
### Eligibility/Benefits Data Results

**Dates of service searched:** MM/DD/YYYY - MM/DD/YYYY

<table>
<thead>
<tr>
<th>Eligibility</th>
<th>Deductibles/Caps</th>
<th>Preventive</th>
<th>MSP</th>
<th>Plan Coverage</th>
<th>Hospice/Home Health</th>
<th>Inpatient</th>
<th>QMB</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Doe, Jane 987654321A</th>
<th>Gender: Male</th>
<th>Date of Birth: MM/DD/YYYY</th>
<th>Date of Death:</th>
</tr>
</thead>
</table>

#### Part A Deductible
- **Deductible Year:** 01/01/2017 - 12/31/2017
- **Base Deductible:** $0.00
- **Deductible Year:** 01/01/2016 - 12/31/2016
- **Base Deductible:** $0.00

#### Part B Deductible
- **Deductible Year:** 01/01/2017 - 12/31/2017
- **Base Deductible:** $0.00

#### Part B Plan Level Coinsurance
- **Calendar Year:** 01/01/2017 - 12/31/2017
- **Plan Level Coinsurance Percentage:** 0%

#### Lifetime Reserve Days
- **Calendar Year:** 01/01/2017 - 12/31/2017
- **Lifetime Co-payment Amount per Day:** $0.00
- **Calendar Year:** 01/01/2016 - 12/31/2016
- **Lifetime Co-payment Amount per Day:** $0.00
- **Lifetime Remaining Days:**
- **SNF Co-Payment Amount per day:** $0.00

#### Inpatient Spell
- **DOEBA Date:** 01/01/2017
- **DOLBA Date:** 12/31/2017

#### Hospital
- **Part A Remaining Deductible:** $0.00
- **Co-Payment Days Remaining:** 30
- **Full Days Remaining ($0 per day):** 60
- **Co-Payment Amount per day:** $0.00

#### Skilled Nursing Facility (SNF)
- **SNF Days Remaining ($0 per day):** 20
- **SNF Co-Payment Days Remaining:** 80
- **SNF Co-Payment Amount per day:** $0.00

---

*Figure 118: QMB information results*
• Part A Deductible information  
  ▪ Deductible Year  
  ▪ Base Deductible  
• Part B Deductible  
  ▪ Deductible Year  
  ▪ Base Deductible  
• Part B Plan Level Coinsurance  
  ▪ Calendar Year  
  ▪ Plan Level Coinsurance Percentage  
• Lifetime Reserve Days  
  ▪ Calendar Year  
  ▪ Lifetime Remaining Days  
  ▪ Lifetime Co-payment Amount per Day  
• Inpatient Spell  
  ▪ DOEBA Date  
  ▪ DOLBA Date  
• Hospital  
  ▪ Part A Remaining Deductible  
  ▪ Co-Payment Days Remaining  
  ▪ Full Days Remaining  
  ▪ Co-Payment Amount Per Day  
• Skilled Nursing Facility (SNF) information:  
  ▪ SNF Days Remaining  
  ▪ SNF Co-payment Days Remaining  
  ▪ Co-payment Amount per Day  

6.3.13 Benefits/Eligibility: ‘SPOT Eligibility Reports’

Once the eligibility query has been submitted, users may export the data to a printer-friendly eligibility report:

▪ The SPOT Eligibility Report represents a snapshot of the beneficiary’s eligibility profile based upon the dates of service queried and active data in HETS at the time the query was submitted.

▪ The SPOT Eligibility Report may include Medicare Part A/B eligibility status as well as all active data available at the time of your query, which may include Preventive Services, Deductibles/Caps, Inpatient, Hospice/Home Health, Medicare secondary payer (MSP), and Plan Coverage data categories.

▪ Each section of the SPOT Eligibility Report focuses on a different benefits category and includes the beneficiary’s information, the dates of service queried, and all of the data returned by the query.

▪ You may the save the SPOT Eligibility Report or print a copy to place in the patient’s file for easy reference. To review an example of a complete SPOT Eligibility Report, please click here.

To create a SPOT Eligibility Report, follow these steps:
1. Specify the **Dates of Service** parameters of your eligibility query and enter the beneficiary’s information. Click the **Submit** button.

2. Review the beneficiary’s eligibility profile; access to data will be based upon the dates of service specified in your query and active data in HETS at the time the query was submitted.

3. Click the ![PDF icon](PDF icon), located on every results page, and SPOT will automatically create a **printer-friendly** eligibility report in **PDF** format.
6.4 Payment Data

The Payment History feature allows users to search for payment information by Date Range or Check/EFT Number. Through the ‘Payment Data’ tab, SPOT also offers you access to remittance advice information through the ‘Request Remittance Advice’ form.

SPOT will only furnish information regarding payments processed by First Coast. Medicare payments for durable medical equipment (DME) or railroad claims will not be displayed.

Note: Data updates to SPOT application occur between 6:00-7:30 a.m. each weekday. Users may experience slower response times to claim and payment data queries or an interruption in access during these time periods.

6.4.1 Payment Data: Part A

To access payment information for a Part A provider, please take the following steps:

1. Select the menu tab labeled Payment Data, then Search payments
2. The Search Payments - Part A form will appear:

   **Search Payments**

   Please specify the parameters of your search by entering either a Date Range or a specific Check/EFT Number in the form below.

   **Note:** Payment Information will be accessible up to 12 months from the Payment Date.

   * Required
   * Select search type:
     - Payment Date
     - Check/EFT Number

   **Payment History: Previous Queries**

<table>
<thead>
<tr>
<th>History</th>
<th>From Date</th>
<th>To Date</th>
<th>Check/EFT Number</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Query 1</td>
<td>MM/DD/YYYY</td>
<td>MM/DD/YYYY</td>
<td>N/A</td>
<td>Resubmit Query</td>
</tr>
</tbody>
</table>

   **Figure 119: Payments: Query - Part A form**

   3. Specify the parameters of your query by selecting either a Date Range in which the payment dates may have occurred or by entering a specific Check/EFT Number.

   **Note:** To access data for a previously submitted query -- during the same session -- you may click the corresponding Resubmit Query hyperlink in the Payment History: Previous Queries table.

4. Click the Search button.

   **Note:** Part A payment information will be accessible for up to 12 months from the payment date.

5. If you enter a specific Check/EFT Number, the details for that particular payment will appear:

   **Payment Details:**

<table>
<thead>
<tr>
<th>Check/EFT Number:</th>
<th>987654321</th>
<th>Payment/Remittance Date:</th>
<th>MM/DD/YYYY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payment Status:</td>
<td>EFT outstanding</td>
<td>Payment Amount:</td>
<td>$1123.33</td>
</tr>
<tr>
<td>Remittance Number:</td>
<td>111222333</td>
<td>Remittance Reload Request:</td>
<td>Online Form</td>
</tr>
</tbody>
</table>

   **Figure 120: Payment History: Results - Part A: Payment Detail (Check/EFT Number)**
6. If you searched by **Date Range**, the **Payment History: Results - Part A** results summary page will appear:

![Payment History: Results - Part A: Summary Table]

7. To customize your display results, you may select the number of records that you would like to view per page as well as sort records by payment date or by payment status.

8. If you would like to view additional details regarding a particular payment, please click the corresponding hyperlink in the **Check/EFT Number** column. Details pertaining to the selected payment will display beneath the summary table.

9. If you would like to store the detailed results electronically, you may export them to either Microsoft Excel or Acrobat Reader -- just click the corresponding icon at the bottom of the summary table.

### 6.4.2 Payment Data: Part B

To access payment information for a Part B provider, please take the following steps:

1. Select the menu tab labeled **Payment Data** then **Search payments**

2. The **Search Payments - Part B** form will appear:

![Search Payments]

- **Payment History: Previous Queries**

**Figure 122: Payments: Query - Part B form**

---

3. Specify the parameters of your query by selecting either a **Date Range** in which the payment dates may have occurred or by entering a specific **Check/EFT Number**.

   **Note:** To access data for a previously submitted query -- during the same session -- you may click the corresponding **Resubmit Query** hyperlink in the Payment History: Previous Queries table.

4. Click the **Search** button.

   **Note:** Part B payment information will be accessible for up to 12 months from the payment date.

5. If you enter a specific **Check/EFT Number**, the details for that particular payment will appear:

    **Figure 123:** Payment History: Results - Part B: Payment Detail (Check/EFT Number)

6. If you searched by **Date Range**, the Payment History: Results - Part B results summary page will appear:

    **Figure 124:** Payment History: Results - Part B: Summary Table

7. To customize your display results, you may select the number of records that you would like to view per page as well as sort records by payment date or by payment status.

8. If you would like to view additional details regarding a particular payment, please click the corresponding hyperlink in the **Check/EFT Number** column. Details pertaining to the selected payment will display beneath the summary table:
9. If you would like to store the detailed results electronically, you may export them to either Microsoft Excel or Acrobat Reader -- just click the corresponding icon at the bottom of the summary table.

6.4.3 How to access remittance advice information

Part A and Part B SPOT users may access remittance advice (RA) information with a check or electronic funds transfer (EFT) number. This information is available through links within the ‘Payment Data’ tab at the top of the SPOT homepage or window at the center of the home page.

To view a remittance advice within SPOT, click on the ‘Payment Data’ tab at the top of the home page. Select ‘Request Remittance Advice’ under the drop-down menu. You may also select ‘Request Remittance Advice’ from the ‘Payment Data’ window at the bottom of the homepage.

Enter the respective check number or EFT number below ‘Check/EFT Number.’ Click on the ‘Request Remit’ button.

To check on the status of previously submitted remittance requests, select the ‘Click here’ link below the ‘Request Remit’ button.
Each request may take up to 30 minutes to process. Once you click ‘Request Remit’ you will be taken to a status page showing each of the RA requests you have submitted.

### Remittance Advice Request Status - Part B

Below are the Remittance Advice requests you’ve submitted and their respective status. Click on the ones with a status of Complete to view the Remittance Advice in a PDF format.

Your request will be processed within 30 minutes.

<table>
<thead>
<tr>
<th>Check/EFT Number</th>
<th>Date Requested</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>111111111</td>
<td>MM/DD/YYYY</td>
<td>Processing</td>
</tr>
<tr>
<td>222222222</td>
<td>MM/DD/YYYY</td>
<td>Processing</td>
</tr>
<tr>
<td>333333333</td>
<td>MM/DD/YYYY</td>
<td>Processing</td>
</tr>
</tbody>
</table>

![Figure 127: Remittance Advice Request Status](image)

Once your request has been completed, come back to the remittance advice request status window. Under the ‘Status’ row, click on the link ‘Completed.’

### Remittance Advice Request Status - Part A

Below are the Remittance Advice requests you’ve submitted and their respective status. Click on the ones with a status of Complete to view the Remittance Advice in a PDF format.

<table>
<thead>
<tr>
<th>Check/EFT Number</th>
<th>Date Requested</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>EFT 22222222</td>
<td>MM/DD/YYYY</td>
<td>Completed</td>
</tr>
</tbody>
</table>

![Figure 128: Remittance Advice Request Status Complete](image)

You will be shown the respective remittance advice.

![Figure 129: Sample remittance advice](image)

You can save the remittance as a downloadable Adobe Acrobat® document (.pdf) or print the document. Use the ‘print’ or ‘save as’ buttons within your browser to save or print the remittance advice.
Other ways to access the ‘Request Remittance Advice’ form
You will also find a link to the ‘Request Remittance Advice’ in the ‘Claim Details’ window. If you query the status on a claim, ‘Claim Details’ appear once you click on your link to the DCN (Part A) or the ICN (Part B) tied to your claim.

Figure 130: Access remittances through claim details

By clicking on the link next to ‘Remittance Number’ within ‘Claim Details’ you will be brought to the ‘Request Remittance’ form.

Also, in reviewing the status of a payment, you will find links to the ‘Request Remittance Advice’ form within the ‘Payment Details’ window. There is also a link to the form next to the ‘Remittance Reload Request’ under payment details.

Figure 131: Access remittances through Payment Details window
6.5 Secure Documentation

In Secure Documentation, users have the option to submit documentation, request documentation, retrieve documentation, or check status.

6.5.1 Secure Documentation: Submit Documentation

The Secure Documentation feature allows users to submit documentation to First Coast’s e-documentation system. Forms submitted after 6 p.m. ET during weekdays, at any time during a weekend, or on First Coast Service Options’ corporate holidays will receive a receipt date that reflects First Coast’s next business day. The following forms are available for electronic submission.

Part A:
- Additional Claim Development Response - Respond to ADR for pre-pay claim
- Additional Development Response for TPE-related Inquiries
- Provider Audit & Reimbursement
- Credit Balance Report
- Electronic Data Interchange (EDI) Enrollment Form
- Feedback on the SPOT - Questions and suggestions about SPOT
- General Inquiry Request - Questions about Medicare program/policies

Part B:
- Additional Claim Development Response - Respond to ADR for pre-pay claim
- Additional Development Response for TPE-related Inquiries
- Electronic Data Interchange (EDI) Enrollment Form
- Feedback on the SPOT - Questions and suggestions about SPOT
- General Inquiry Request - Questions about Medicare program/policies
- MSP Overpayment Form - Voluntary refund of an overpayment for an MSP claim
- Non-MSP Overpayment Form - Voluntary refund of an overpayment for a Non-MSP claim
- Overpayment Redetermination Request - Appeal of an overpayment decision

6.5.2 Secure Documentation: Submitting a document

1. Select Submit Documentation from the Secure Documentation submenu
2. The Submit Form: Selection form will appear. Selections will differ based upon the line of business of the profile selected.
6.5.3 Secure Documentation: Additional Development Response (ADR) form (Part A/B)

**ADR form: Submission Requirements:**

- The additional development response (ADR) form is to be used to respond to claim ADR requests for prepay (i.e., non-finalized) claims.
- You must include a copy of the ADR request letter you received from the First Coast Service Options as well as any requested documentation in your submission. All documents must be submitted in PDF format (6MB maximum).
- Only one submission per ADR request letter will be accepted, and the processing of your claim will be based upon the information in your submission.
Note: If the receipt date of your response is not within the timeliness guidelines of the date listed in the ADR letter, or if you did not include a copy of the ADR letter and/or any of the requested documentation in your submission, your service or claim may be denied.

- Submissions on weekends, holidays or after 6 p.m. ET weekdays will receive a receipt date that reflects the next business day.
- The Part A and Part B versions of the ADR form are identical with the exception of the ICN/DCN fields
- SPOT’s ADR form should not be used to respond to any of the following:
  - Development requests from other operational areas (e.g., EDI, provider enrollment)
  - Post-payment medical review development requests
  - Pre-payment/post-payment ADR requests for non-First Coast claims
  - PWK submissions
  - Appeal ADR requests
  - ADR requests from the ZPIC
  - ADR requests from the RAC
  - ADR requests from the SMRC

---

**Figure 134: Additional Development Response (ADR) form – Part A**
6.5.4 ADR form: Completing the form

1. Select **Submit Documentation** from the **Secure Documentation** submenu

2. Select Additional Claim Development Response; the form will appear

   **Note:** When selected, the ADR form will be presented in its non-expanded state. Since Part A and Part B ADR forms are almost identical, the completion process will be illustrated by the Part A version:

3. Enter the DCN number (ICN for Part B)
4. Enter your telephone number

5. Upload a copy of the claim ADR letter received from First Coast (prepay claims only) in **PDF** format

Figure 137: ADR Letter Example – Part A
6. Click the ‘Choose File’ button
7. Navigate to the file on your computer

8. Once you have uploaded a copy of your ADR letter (in PDF format), the form will automatically expand to display the Support Documentation section of the form:

9. Upload additional support documentation in PDF format:
   a. Select Document Type
   b. Click the Browse button
   c. Navigate to the file on your computer
   d. Click Add More button and repeat the process to add any additional documentation (8MB total/PDF format)
10. After you have finished adding the requested documentation, sign the form electronically:

![Part A – ADR Form – Sign form electronically](image1)

11. Check to make sure that you have completed all required fields and that you have uploaded your support documentation.

   a. If you click the Submit button, and any error is identified by the application (e.g., formatting error, required field data missing), you will need to reload any support documentation as well as correct the error before clicking the Submit button again.

12. Click the Submit button

12. If your submission was successful, you will receive a confirmation screen.
13. You will also receive a confirmation email indicating which form was filed and your e-documentation confirmation number

From: <thespotportal@ncso.com>
Date: March 30, 2015 at 9:55:09 AM EDT
To: RellerStreetClinic@ncso.com
Subject: Confirmation: Confirmation Number - 21976CE2-03CA-431E-AE36-80AD3B5E8FA5

Dear SPOT user,

Thank you for using SPOT to submit your secure message to First Coast Service Options Inc.

The confirmation number of the Additional Claim Development Response submission is Confirmation Number - 21976CE2-03CA-431E-AE36-80AD3B5E8FA5.

Only one submission per ADR letter will be accepted, and the processing of your claim will be based upon the information provided in your submission. Submissions on weekends, holidays, or after 6 p.m. ET weekdays will receive a receipt date that reflects the next business day.

If the receipt date of your response is not within the timeliness guidelines of the date listed in the ADR letter, or if you did not include a copy of the ADR letter and/or any of the requested documentation in your submission, your service or claim may be denied.

Please allow 48-72 hours before checking the status of your request.

With Regards,
The SPOT project team

Figure 142: Secure Documentation: ADR Confirmation Email

6.5.5 Secure Documentation: Additional Development Response for TPE-related Inquiries

Part A and B providers can respond to ADRs related to the TPE program using this form. Enter the required information and upload a copy of the original ADR request letter sent to you by First Coast’s medical review department as well as any requested documentation. **All documentation must be submitted in PDF format.**

1. Select Submit Documentation under Secure Documentation

2. Select Additional Development Response for TPE-related Inquiries; the form will appear:
3. Enter information in the required fields. (Note: Part B will require an ICN instead of DCN)

4. Click Browse to locate a file on your computer and upload the original ADR letter in PDF format.

5. Once you have uploaded a copy of your ADR letter, the form will automatically expand to display the support documentation section of the form:

Figure 144: Support Documentation

5. Upload additional support documentation in PDF format:
   a) Select Document Type
   b) Click the Browse button
   c) Navigate to the file on your computer
   d) Click Add More Documentation button and repeat the process to add any additional documentation (8MB total/PDF format)

6. After you have finished adding the requested documentation, sign the form electronically and check the box.

7. Click Submit
8. A confirmation form will appear:

<table>
<thead>
<tr>
<th>Additional Claim Development Response: Confirmation Number -</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your Additional Claim Development Response was submitted successfully, and a confirmation message has been sent to the email associated with your EIDM account. Please allow <strong>48-72 hours</strong> before checking the status of your request. Submissions on weekends, holidays or after 8 p.m. ET weekdays will receive a receipt date that reflects the next business day.</td>
</tr>
</tbody>
</table>

*Figure 145: MR ADR Confirmation*

6.5.6 Secure Documentation: Provider Audit & Reimbursement (Part A)

Part A provider groups including hospitals, nursing homes, skilled nursing homes, end-stage renal disease treatment facilities, federally-qualified health centers and rural health centers may file annual cost report information through First Coast’s Secure Online Provider Tool (SPOT).

1. Once you have logged into SPOT, to submit Provider Audit & Reimbursement (PARD) documents, click on the ‘Secure Documentation’ tab located at the top right menu bar.
2. From that drop-down menu, select ‘Submit Documentation.’
3. From the drop-down menu, choose ‘Provider Audit & Reimbursement’ then Next
4. Once the next screen has loaded, select the “Document Type” drop-down menu. This menu will present several form options:

<table>
<thead>
<tr>
<th>Provider Audit &amp; Reimbursement Request</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Required</em></td>
</tr>
<tr>
<td>Document Type:</td>
</tr>
<tr>
<td>Please select one</td>
</tr>
<tr>
<td>Reopening</td>
</tr>
<tr>
<td>Appeals</td>
</tr>
<tr>
<td>SSI Realignment Request (DSH)</td>
</tr>
<tr>
<td>Provider-Based Determination</td>
</tr>
<tr>
<td>Wage Index/Occupational Mix Submissions</td>
</tr>
<tr>
<td>Desk Review/Audit Additional Documentation</td>
</tr>
<tr>
<td>Submit FOIA Request</td>
</tr>
<tr>
<td>Submit PS&amp;R Request</td>
</tr>
<tr>
<td>General Correspondence</td>
</tr>
<tr>
<td>Certified Registered Nurse Anesthetist</td>
</tr>
</tbody>
</table>

*Figure 146: PARD Document Types*

- Reopening (Select this option if you are updating or changing a cost report previously settled.)
- Appeals (Select this option if submitting additional documentation in support of an appealed cost report.)
• SSI Realignment Request (DSH) (Select this option if you wish to request to have your SSI Ratio recomputed or realigned based on your cost reporting period for IPPS payment.)
• Provider-based determination – Select this option to request initial setup or change in a unit’s provider-based status.
• Wage Index/Occupational Mix Submissions – Select this option to upload documentation for the yearly wage index and occupational mix audits
• Desk Review/Audit Additional Documentation (Select this option if you wish to provide additional documentation related to a request for information or cost report audit.)
• Submit FOIA Request (Select this option to submit a Freedom of Information Act request for Medicare cost reports.)
• Submit PS&R Request (Select this option for Provider Statistics & Reimbursement reports (summary of paid claims for cost report)).
• General Correspondence – Used more typically for correspondence related to a request for an interim rate change, a tentative settlement change, TEFRA exception request, SCH low volume request, a request for change in statistical basis, CMS tie-in notice, bankruptcy, or a 50-percent reduction request.
• Certified Registered Nurse Anesthetist (Select this option if you are a Part A hospital and need to complete the form to request for exemption.)

**PARD confirmation messages status**

To review an update on your submissions via SPOT, select the 'Secure Documentation' dropdown.

In order to access confirmation messages via SPOT or to retrieve correspondence generated by Provider Audit & Reimbursement department (PARD), open the Messages screen by either selecting the ‘New Messages’ hyperlink at the top of screen or selecting ‘View Messages’ in dropdown box. A short description of the columns is noted below. The columns can be sorted if you click on the column headers of the table on screen.

### 6.5.7 Secure Documentation: Credit Balance Report (Part A)

Part A providers can easily submit their CMS-838 form (credit balance report) via secure messaging in SPOT. To submit a credit balance report via SPOT, select **Secure Documentation** from the top navigation menu.

- Select *Submit Documentation*
- In the next drop-down, for request type, select Credit Balance Report
The NPI, PTAN and Location will be pre-populated

Choose the submission quarter and then browse to find your form. Note: You must first click the link provided to access the CMS-838 form and complete it before uploading.

Add any comments and an electronic signature

Click the certification box and then Submit

6.5.8 Secure Documentation: MSP Overpayment Refund form (Part B)

MSP Overpayment Refund form (Part B): Submission Requirements:

- This form is for a voluntary refund of an overpayment for a Medicare secondary payer (MSP) claim
- If specific patient and claim data are not available for all related claims due to statistical sampling, please indicate methodology and formula used to determine amount and the reason for overpayment in support documentation.
- All documents must be submitted in PDF format (6MB maximum)
- The processing of your request will be based solely on the information included in your submission
Submissions on weekends, holidays or after 6 p.m. ET weekdays will receive a receipt date that reflects the next business day.

**MSP Overpayment Refund form (Part B): Completing the form**

1. Select **Submit Documentation** from the **Secure Documentation** submenu

2. Select the form you need; the selected form will appear:

![Part B – MSP Overpayment Form](image)

3. Enter data in all required sections and fields

4. Upload Support Documentation in PDF format (6MB maximum)

5. Click the **Add file** button, and an additional line will appear. Repeat the process listed above to navigate to the file. **Note:** To remove the first file, click the Clear button

6. **Note:** To remove any additional files, click the ‘Delete’ button located next to the file you wish to remove

7. Enter your electronic signature:

8. Check to make sure that you have completed all required fields and that you have uploaded your support documentation. If you click the ‘Submit’ button, and any error is identified by the application (e.g., formatting error, required field data missing), you will need to reload any support documentation as well as correct the error before clicking the Submit button again.

9. Click the **Submit** button. If your submission was successful, a confirmation page will appear, and you will receive a notification email specifying the form filed and your confirmation number.
6.5.9 Secure Documentation: Non-MSP Overpayment Refund form (Part B)

Non-MSP Overpayment Refund form (Part B): Submission Requirements:

- This form is for a voluntary refund of an overpayment for a Non-MSP claim
- If specific patient and claim data are not available for all related claims due to statistical sampling, please indicate methodology and formula used to determine amount and the reason for overpayment in support documentation.
- All documents must be submitted in PDF format (6MB maximum)
- The processing of your request will be based solely on the information included in your submission
- Submissions on weekends, holidays or after 6 p.m. ET weekdays will receive a receipt date that reflects the next business day.

Non-MSP Overpayment Refund form (Part B): Completing the form
1. Select Submit Documentation from the Secure Documentation submenu
2. Select the form you need; the selected form will appear:

![Non-MSP Overpayment Refund Form](image)

Figure 149: Part B – Non-MSP Overpayment Form

3. Enter data in all required sections and fields
4. Upload Support Documentation in PDF format (6MB maximum)
5. Click the Add file button, and an additional line will appear. Repeat the process listed above to navigate to the file. Note: To remove the first file, click the Clear button.
6. Enter your electronic signature:

7. Check to make sure that you have completed all required fields and that you have uploaded your support documentation. If you click the Submit button, and any error is identified by the application (e.g., formatting error, required field data missing), you will need to reload any support documentation as well as correct the error before clicking the Submit button again.

8. Click the Submit button. If your submission was successful, a confirmation page will appear, and you will receive a notification email specifying the form filed and your confirmation number.

6.5.10 Secure Documentation: Overpayment Redetermination Request (Part B)

**Overpayment Redetermination Request (Part B): Submission Requirements:**

- This form is to appeal an overpayment decision
- You must upload a copy of your demand letter as part of your submission.
- If multiple ICNs are affected by this request, please upload a complete list and associated claim information. All documents must be submitted in PDF format (6MB maximum)
- The processing of your request will be based solely on the information included in your submission
- Submissions on weekends, holidays or after 6 p.m. ET weekdays will receive a receipt date that reflects the next business day.

**Overpayment Redetermination Request (Part B): Completing the form**

1. Select **Submit Documentation** from the **Secure Documentation** submenu

2. Select the form you need; the selected form will appear:

![Overpayment Redetermination Request Form](image-url)
3. Enter data in all required sections and fields:

   **Note:** The **Accounts Receivable number** is the 13-digit number that may be found on the header of the overpayment request letter or at the top of the **Health Data Insight Request** form. You may enter a maximum of **1000 characters** (including punctuation and spaces) in the **Additional Information to Consider** field.

4. Upload **Support Documentation** in PDF format (6MB maximum)

5. Click the **Add file** button, and an additional line will appear. Repeat the process listed above to navigate to the file. Note: To remove the first file, click the Clear button.

6. Enter your electronic signature.

7. Check to make sure that you have completed all required fields and that you have uploaded your support documentation. If you click the **Submit** button, and any error is identified by the application (e.g., formatting error, required field data missing), you will need to reload any support documentation as well as correct the error before clicking the Submit button again.

8. Click the **Submit** button. If your submission was successful, a confirmation page will appear, and you will receive a notification email specifying the form filed and your confirmation number.

### 6.5.11 Secure Documentation: Electronic Data Interchange (EDI) Enrollment Form (Part A/B)

- The purpose of this form is to add new practitioners to your electronic billing profile, change electronic remittance advice information, and change billing agents or clearing houses information electronically. You may also use it to request First Coast’s free Part B Medicare billing software, ABILITY | PC-ACE.

**EDI Enrollment Form (Part A/B): Completing the form**

1. Select **Submit Documentation** from the **Secure Documentation** submenu.

2. Select the form you need; the selected form will appear:
**Figure 151: Part A/B EDI Enrollment Form**

Enter data into all required fields

3. Click **Next** to proceed to next page

4. Upload Support Documentation in PDF format

5. Upload **Support Documentation** in PDF format (6MB maximum)

3. **Add More Documentation** if needed

3. Enter your electronic signature

4. Check to make sure that you have completed all required fields and that you have uploaded your support documentation. If you click the **Submit** button, and any error is identified by the application (e.g., formatting error, required field data missing), you will need to reload any support documentation as well as correct the error before clicking the Submit button again.

5. Click the **Submit** button. If your submission was successful, a confirmation page will appear, and you will receive a notification email specifying the form filed and your confirmation number

**6.5.12 Secure Documentation: General Inquiry Request Form (Part A/B)**

**General Inquiry Request Form (Part A/Part B): Submission Requirements:**

- The purpose of this form is to submit questions regarding the Medicare program
- Support documentation is optional. All documents must be submitted in PDF format (6MB maximum)
- The processing of your request will be based solely on the information included in your submission
- Submissions on weekends, holidays or after 6 p.m. ET weekdays will receive a receipt date that reflects the next business day.

**General Inquiry Request Form (Part A/Part B): Completing the form**

1. Select **Submit Documentation** from the **Secure Documentation** submenu

2. Select the form you need; the selected form will appear:

3. Enter data in all required fields

4. Upload **Support Documentation** in PDF format

5. Click the **Add file** button, and an additional line will appear. Repeat the process listed above to navigate to the file.

6. Check to make sure that you have completed all required fields and that you have uploaded your support documentation. If you click the **Submit** button, and any error is identified by the application (e.g., formatting error, required field data missing), you will need to reload any support documentation as well as correct the error before clicking the Submit button again.

7. Click the **Submit** button

8. If your submission was successful, a confirmation page will appear, and you will receive a notification email specifying the form filed and your confirmation number
6.5.13 Secure Documentation: SPOT Feedback Form (Part A/Part B)

SPOT Feedback Form (Part A and Part B): Submission Requirements:

- The purpose of this form is to submit questions or comments regarding the SPOT
- The processing of your request will be based solely on the information included in your submission
- Submissions on weekends, holidays or after 6 p.m. ET weekdays will receive a receipt date that reflects the next business day.

SPOT Feedback Form (Part A and Part B): Completing the form

1. Select Submit Documentation from the Secure Documentation submenu
2. Select the form you need; the selected form will appear:
3. Enter email address
4. Select question type
5. Enter your question or comment
6. Click Submit button

6.5.14 Secure Documentation: Requesting a document

1. Select Request Documentation from the Secure Documentation submenu

![Request Secure Documentation]

Figure 152: Request Secure Documentation

2. Select your document type and click Next

6.5.15 Secure Documentation: Overpayment Demand Letter

If you select “Demand Letter,” the Overpayment Demand Letter request form will appear. Your NPI, PTAN and Location will be pre-populated. Enter your date of letter from and to, then click Search.
6.5.16 Secure Documentation: 1099 Form

If you select “1099 form,” the 1099 Request form will appear. Your NPI, PTAN, and TIN/SSN will be pre-populated. Choose from the drop-down menu whether you want a copy, correction, or dispute of your 1099 form. Then, select the year, as far back as nine years. Fill in the provider’s full name, telephone number, address, city, and ZIP code. Then a reason for your request or description of changes is required. If requesting a correction or dispute, support documentation must be uploaded. Add your electronic signature and click the box for certification. Then, click Submit.

NOTE: You will receive a confirmation email with a confirmation number, which you must use when retrieving your document.
6.5.17 Secure Documentation: Provider Data Summary (PDS)

The Secure Documentation feature offers users the opportunity to request a customized Provider Data Summary (PDS). Note: Data reports are available 24/7 (excluding holidays and scheduled maintenance periods).

6.5.18 PDS Request: Part A

The Provider Data Summary (PDS) report for Part A helps facilities identify recurring billing issues through a detailed analysis of its billing patterns in comparison with those of similar facility types during a specified time period.

Overview of PDS report -- Part A

The PDS report for Part A providers is comprised of two main sections:

- **Comparative data table** -- contains the comparative data compiled from claims that were finalized over the designated report period for the provider as well as those for the provider’s peer group. Peers are all individuals located in the provider’s geographic area that belong to the same facility type.

- **Message code table** -- contains a list of adjustment codes, reject codes, line denial codes, and returned to provider (RTP) codes -- organized by place of service (e.g., inpatient Part A, inpatient Part B) and claim type (i.e., automated, hard copy) -- that impacted the provider’s claims during the specified reporting period. The table also includes data regarding the number of claims affected.

To utilize the Data Reports -- PDS Request feature, the user should take the following steps:

1. Select the menu tab labeled Secure Documentation then Request Documentation
2. Select the PDS option from the request type submenu
3. The PDS Request page will appear:

![Provider Data Summary (PDS) Request](image)

*Figure 155: PDS Request Page – Part A*
4. Select the following information:
   - **Month 1 (required) and Month 2 (optional)**

   **NOTE:** Users may view one month or compare two months within the 12 previous months from the current date.

5. Click the **Data Summary** button to initiate report request.

6. The **PDS Request** results page will appear:

   **Figure 156: PDS Request Results Page -- Part A**

   **Comparative Data Table (PDS -- Part A)**

   **Message Code Table (PDS -- Part A)**

7. Review PDS report.
Figure 157: PDS Request Comparative Data Table – Part A

<table>
<thead>
<tr>
<th>Data Category</th>
<th>Data Type</th>
<th>FEB12</th>
<th>% of Total (A)</th>
<th>MAR12</th>
<th>% of Total (B)</th>
<th>% of Total (C)</th>
<th>Change FEB12/MAR12</th>
<th>% Change (B - A)</th>
<th>FEB12 Peer AVG</th>
<th>% of Total (C)</th>
<th>Diff (B - C)</th>
<th>%Diff (A - C)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Processed by Origin</td>
<td>Automated</td>
<td>5,922</td>
<td>98.4%</td>
<td>6,679</td>
<td>99.6%</td>
<td>-757</td>
<td>1.20%</td>
<td>8,082</td>
<td>96.5%</td>
<td>-2.16%</td>
<td>(0.10%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hardcopy</td>
<td>97</td>
<td>1.60%</td>
<td>26</td>
<td>0.40%</td>
<td>71</td>
<td>(1.20%)</td>
<td>120</td>
<td>1.50%</td>
<td>-23</td>
<td>0.10%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>6,019</td>
<td>100%</td>
<td>6,706</td>
<td>100%</td>
<td>-886</td>
<td>0.00%</td>
<td>8,202</td>
<td>100%</td>
<td>-2.183</td>
<td>0.00%</td>
<td></td>
</tr>
<tr>
<td>Processed by Place of Service</td>
<td>Inpatient Part A</td>
<td>725</td>
<td>12.1%</td>
<td>950</td>
<td>14.3%</td>
<td>-234</td>
<td>2.20%</td>
<td>943</td>
<td>11.5%</td>
<td>-217</td>
<td>0.60%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hospital Based or Inpatient (Part B)</td>
<td>7</td>
<td>0.13%</td>
<td>8</td>
<td>0.13%</td>
<td>-1</td>
<td>0.00%</td>
<td>21</td>
<td>0.30%</td>
<td>-14</td>
<td>(0.20%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Outpatient</td>
<td>5,283</td>
<td>87.3%</td>
<td>5,726</td>
<td>85.4%</td>
<td>-443</td>
<td>(2.40%)</td>
<td>6,417</td>
<td>76.2%</td>
<td>-1.134</td>
<td>9.60%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other (Part B)</td>
<td>3</td>
<td>0.00%</td>
<td>11</td>
<td>0.20%</td>
<td>-8</td>
<td>0.20%</td>
<td>820</td>
<td>10.0%</td>
<td>-617</td>
<td>(10.0%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Reserved for Natl Assignment</td>
<td>0</td>
<td>0.00%</td>
<td>0</td>
<td>0.00%</td>
<td>0</td>
<td>0.00%</td>
<td>0</td>
<td>0.00%</td>
<td>0</td>
<td>0.00%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>6,019</td>
<td>100%</td>
<td>6,706</td>
<td>100%</td>
<td>-886</td>
<td>0.00%</td>
<td>8,202</td>
<td>100%</td>
<td>-2.182</td>
<td>0.00%</td>
<td></td>
</tr>
<tr>
<td>Processed by Category</td>
<td>Clean Claims</td>
<td>4,947</td>
<td>82.2%</td>
<td>6,360</td>
<td>79.9%</td>
<td>-413</td>
<td>(2.30%)</td>
<td>6,662</td>
<td>91.2%</td>
<td>-1.715</td>
<td>1.00%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rejected</td>
<td>173</td>
<td>2.99%</td>
<td>260</td>
<td>3.90%</td>
<td>-87</td>
<td>1.00%</td>
<td>308</td>
<td>3.80%</td>
<td>-135</td>
<td>(0.90%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Duplicate Claim Rejects</td>
<td>19</td>
<td>0.33%</td>
<td>46</td>
<td>0.70%</td>
<td>-27</td>
<td>0.40%</td>
<td>63</td>
<td>0.80%</td>
<td>-44</td>
<td>(0.50%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sub Total</td>
<td>5,139</td>
<td>85.4%</td>
<td>5,666</td>
<td>84.5%</td>
<td>-527</td>
<td>(0.90%)</td>
<td>7,033</td>
<td>95.6%</td>
<td>-1.894</td>
<td>(0.40%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Adjustments</td>
<td>260</td>
<td>4.39%</td>
<td>238</td>
<td>4.20%</td>
<td>-23</td>
<td>(0.10%)</td>
<td>272</td>
<td>3.30%</td>
<td>-12</td>
<td>(1.00%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Line Denial</td>
<td>620</td>
<td>10.3%</td>
<td>756</td>
<td>11.3%</td>
<td>-136</td>
<td>1.00%</td>
<td>896</td>
<td>10.6%</td>
<td>-276</td>
<td>(2.60%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sub Total</td>
<td>880</td>
<td>14.5%</td>
<td>1,039</td>
<td>15.5%</td>
<td>-159</td>
<td>0.90%</td>
<td>1,168</td>
<td>14.2%</td>
<td>-288</td>
<td>0.49%</td>
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<td></td>
<td>Total</td>
<td>6,019</td>
<td>100%</td>
<td>6,706</td>
<td>100%</td>
<td>-886</td>
<td>0.00%</td>
<td>8,202</td>
<td>100%</td>
<td>-2.182</td>
<td>0.00%</td>
<td></td>
</tr>
<tr>
<td>Processed by DTR</td>
<td>0-15 days</td>
<td>4,576</td>
<td>76.3%</td>
<td>5,086</td>
<td>75.6%</td>
<td>-492</td>
<td>(0.40%)</td>
<td>5,492</td>
<td>76.0%</td>
<td>-916</td>
<td>9.00%</td>
<td></td>
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<tr>
<td></td>
<td>16 - 30 days</td>
<td>611</td>
<td>10.2%</td>
<td>690</td>
<td>10.3%</td>
<td>-79</td>
<td>0.10%</td>
<td>1,225</td>
<td>14.9%</td>
<td>-165</td>
<td>(4.70%)</td>
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<tr>
<td></td>
<td>31 - 60 days</td>
<td>371</td>
<td>6.23%</td>
<td>503</td>
<td>7.50%</td>
<td>-132</td>
<td>1.30%</td>
<td>600</td>
<td>7.30%</td>
<td>-239</td>
<td>(3.10%)</td>
<td></td>
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<tr>
<td></td>
<td>51 - 90 days</td>
<td>128</td>
<td>2.19%</td>
<td>112</td>
<td>1.73%</td>
<td>16</td>
<td>(0.40%)</td>
<td>202</td>
<td>2.50%</td>
<td>-74</td>
<td>(0.40%)</td>
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<tr>
<td></td>
<td>91 - 120 days</td>
<td>77</td>
<td>1.33%</td>
<td>44</td>
<td>0.70%</td>
<td>33</td>
<td>(0.60%)</td>
<td>124</td>
<td>1.50%</td>
<td>-47</td>
<td>(0.20%)</td>
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<tr>
<td></td>
<td>121 - 180 days</td>
<td>90</td>
<td>1.55%</td>
<td>65</td>
<td>1.00%</td>
<td>25</td>
<td>(0.50%)</td>
<td>165</td>
<td>2.00%</td>
<td>-76</td>
<td>(0.50%)</td>
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<tr>
<td></td>
<td>over 180 days</td>
<td>166</td>
<td>2.80%</td>
<td>223</td>
<td>3.30%</td>
<td>-57</td>
<td>0.50%</td>
<td>392</td>
<td>4.80%</td>
<td>-226</td>
<td>(2.60%)</td>
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<td></td>
<td>Total</td>
<td>6,019</td>
<td>100%</td>
<td>6,706</td>
<td>100%</td>
<td>-886</td>
<td>0.00%</td>
<td>8,202</td>
<td>100%</td>
<td>-2.182</td>
<td>0.00%</td>
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<tr>
<td>Processed by Claim Status</td>
<td>Paid</td>
<td>5,763</td>
<td>95.7%</td>
<td>6,382</td>
<td>94.9%</td>
<td>-599</td>
<td>(0.80%)</td>
<td>7,844</td>
<td>95.6%</td>
<td>-2.081</td>
<td>0.10%</td>
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<td></td>
<td>Denied</td>
<td>10</td>
<td>0.20%</td>
<td>16</td>
<td>0.20%</td>
<td>-6</td>
<td>0.00%</td>
<td>19</td>
<td>0.20%</td>
<td>-9</td>
<td>0.00%</td>
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<td></td>
<td>Rejected</td>
<td>173</td>
<td>2.09%</td>
<td>268</td>
<td>3.84%</td>
<td>-95</td>
<td>0.90%</td>
<td>306</td>
<td>3.70%</td>
<td>-132</td>
<td>(0.80%)</td>
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<td></td>
<td>Cancelled</td>
<td>73</td>
<td>1.29%</td>
<td>69</td>
<td>1.00%</td>
<td>4</td>
<td>(0.20%)</td>
<td>34</td>
<td>0.40%</td>
<td>39</td>
<td>0.89%</td>
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<td>Total</td>
<td>6,019</td>
<td>100%</td>
<td>6,706</td>
<td>100%</td>
<td>-886</td>
<td>0.00%</td>
<td>8,202</td>
<td>100%</td>
<td>-2.182</td>
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<tr>
<td>RTP</td>
<td>Automated</td>
<td>112</td>
<td>100%</td>
<td>100</td>
<td>100%</td>
<td>12</td>
<td>0.00%</td>
<td>298</td>
<td>99.3%</td>
<td>-186</td>
<td>0.79%</td>
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<td></td>
<td>Hardcopy</td>
<td>0</td>
<td>0.00%</td>
<td>0</td>
<td>0.00%</td>
<td>0</td>
<td>0.00%</td>
<td>2</td>
<td>0.70%</td>
<td>-2</td>
<td>(0.70%)</td>
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<td></td>
<td>Total</td>
<td>112</td>
<td>100%</td>
<td>100</td>
<td>100%</td>
<td>12</td>
<td>0.00%</td>
<td>300</td>
<td>100%</td>
<td>-188</td>
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<td>Report identifier</td>
<td>Description</td>
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<td>Data category: Processed by origin <em>(Location: Column one)</em></td>
<td>Data includes comparisons of volumes and percentages of claims that were submitted by the facility or by peer facilities electronically (i.e., “Automated”) or as paper claims (i.e., “Hard copy”) during the specified time period.</td>
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<td>Data category: Processed by place of service <em>(Location: Column one)</em></td>
<td>Data includes comparisons of volumes and percentages of claims processed -- organized by place of service (e.g., “Inpatient Part A,” “Hospital Based or Inpatient (Part B),” “Outpatient”) -- for services billed by the facility or by peer facilities during the specified time period.</td>
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<td>Data category: Processed by category <em>(Location: Column one)</em></td>
<td>Data includes comparisons of volumes and percentages of claims -- organized by processing category -- (i.e., “Clean Claims,” “Rejected,” “Duplicate Claim Rejects,” “Adjustments,” “Line Denials”) for services billed by the facility or by peer facilities during the specified time period.</td>
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<td>Data category: Processed by DTR <em>(Location: Column one)</em></td>
<td>Data includes comparisons of volumes and percentages of the timeframe (e.g., “0-15 days,” “61-90 days,” “over 180 days”) -- between the date of service and the date processed -- for claims submitted by the facility or by peer facilities during the specified time period.</td>
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<tr>
<td>Data category: Processed by claim status <em>(Location: Column one)</em></td>
<td>Data includes comparisons of volumes and percentages of claims -- organized by claim status -- (i.e., “Paid,” “Denied,” “Rejected,” “Canceled”) for services billed by the facility or by peer facilities during the specified time period.</td>
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<td>Data category: RTP <em>(Location: Column one)</em></td>
<td>Data includes comparisons of volumes and percentages of automated and hard copy claims -- submitted by the facility or by the peer facilities during the specified time period -- that were returned to provider (RTP).</td>
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<tr>
<td>Data category: Processed by origin Data type: Automated <em>(Location: Column two)</em></td>
<td>The number/percentage of claims that were submitted by the facility or by peer facilities electronically (i.e., “Automated”) during the specified time period.</td>
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<tr>
<td>Data category: Processed by origin Data type: Hard copy <em>(Location: Column two)</em></td>
<td>The number/percentage of claims that were submitted by the facility or by peer facilities as paper claims (i.e., “Hard copy”) during the specified time period.</td>
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<td>Report identifier</td>
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<td><strong>Data category: Processed by origin</strong></td>
<td>The total number/percentage of claims that were submitted by the facility or by peer facilities during the specified time period.</td>
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<tr>
<td>Data type: Total</td>
<td>The total number/percentage of claims that were submitted by the facility or by peer facilities during the specified time period.</td>
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<td>(Location: Column two)</td>
<td>The total number/percentage of claims that were submitted by the facility or by peer facilities during the specified time period.</td>
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<tr>
<td><strong>Data category: Processed by place of service</strong></td>
<td>Specific data types (e.g., “Inpatient Part A,” “Outpatient”, “Other Part B”) -- based on place of service -- may vary from month to month and from facility to facility. In this section, comparative data (volumes and percentages) will be presented based upon the classification of claims (based on place of service) that were submitted by the facility or by peer facilities during the specified time period.</td>
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<td>Data type: Varies</td>
<td>Specific data types (e.g., “Inpatient Part A,” “Outpatient”, “Other Part B”) -- based on place of service -- may vary from month to month and from facility to facility. In this section, comparative data (volumes and percentages) will be presented based upon the classification of claims (based on place of service) that were submitted by the facility or by peer facilities during the specified time period.</td>
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<td>(Location: Column two)</td>
<td>Specific data types (e.g., “Inpatient Part A,” “Outpatient”, “Other Part B”) -- based on place of service -- may vary from month to month and from facility to facility. In this section, comparative data (volumes and percentages) will be presented based upon the classification of claims (based on place of service) that were submitted by the facility or by peer facilities during the specified time period.</td>
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<td><strong>Data category: Processed by category</strong></td>
<td>The volume/percentage of claims -- submitted by the facility or by peer facilities during the specified time period -- that processed successfully.</td>
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<td>Data type: Clean claims</td>
<td>The volume/percentage of claims -- submitted by the facility or by peer facilities during the specified time period -- that processed successfully.</td>
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<td>(Location: Column two)</td>
<td>The volume/percentage of claims -- submitted by the facility or by peer facilities during the specified time period -- that processed successfully.</td>
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<td><strong>Data category: Processed by category</strong></td>
<td>The volume/percentage of claims -- submitted by the facility or by peer facilities during the specified time period -- that were rejected.</td>
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<td>Data type: Rejected claims</td>
<td>The volume/percentage of claims -- submitted by the facility or by peer facilities during the specified time period -- that were rejected.</td>
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<td>(Location: Column two)</td>
<td>The volume/percentage of claims -- submitted by the facility or by peer facilities during the specified time period -- that were rejected.</td>
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<td><strong>Data category: Processed by category</strong></td>
<td>The volume/percentage of claims -- submitted by the facility or by peer facilities during the specified time period -- that were duplicates (i.e., submitted more than once).</td>
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<tr>
<td>Data type: Duplicate claims</td>
<td>The volume/percentage of claims -- submitted by the facility or by peer facilities during the specified time period -- that were duplicates (i.e., submitted more than once).</td>
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<tr>
<td>(Location: Column two)</td>
<td>The volume/percentage of claims -- submitted by the facility or by peer facilities during the specified time period -- that were duplicates (i.e., submitted more than once).</td>
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<td><strong>Data category: Processed by category</strong></td>
<td>The volume/percentage of claims -- submitted by the facility or by peer facilities during the specified time period -- that processed after the claims were adjusted.</td>
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<td>Data type: Adjustments</td>
<td>The volume/percentage of claims -- submitted by the facility or by peer facilities during the specified time period -- that processed after the claims were adjusted.</td>
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<td>(Location: Column two)</td>
<td>The volume/percentage of claims -- submitted by the facility or by peer facilities during the specified time period -- that processed after the claims were adjusted.</td>
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<td><strong>Data category: Processed by category</strong></td>
<td>The volume/percentage of services -- billed by the facility or by peer facilities during the specified time period -- that were denied in the claims submitted.</td>
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<td>Data type: Line denials</td>
<td>The volume/percentage of services -- billed by the facility or by peer facilities during the specified time period -- that were denied in the claims submitted.</td>
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<td>(Location: Column two)</td>
<td>The volume/percentage of services -- billed by the facility or by peer facilities during the specified time period -- that were denied in the claims submitted.</td>
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<td><strong>Data category: Processed by category</strong></td>
<td>The total number/percentage of claims that were submitted by the facility or by peer facilities during the specified time period.</td>
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<td>Data type: Total</td>
<td>The total number/percentage of claims that were submitted by the facility or by peer facilities during the specified time period.</td>
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<td>The total number/percentage of claims that were submitted by the facility or by peer facilities during the specified time period.</td>
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<td><strong>Data category: Processed by DTR</strong></td>
<td>Data includes comparisons of volumes and percentages of the timeframe (e.g., “0-15 days,” “61-90 days,” “over 180 days”) -- between the date of service and the date processed -- for claims submitted by the facility or by peer facilities during the specified time period.</td>
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<td>Data type: Date ranges</td>
<td>Data includes comparisons of volumes and percentages of the timeframe (e.g., “0-15 days,” “61-90 days,” “over 180 days”) -- between the date of service and the date processed -- for claims submitted by the facility or by peer facilities during the specified time period.</td>
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<td>(Location: Column two)</td>
<td>Data includes comparisons of volumes and percentages of the timeframe (e.g., “0-15 days,” “61-90 days,” “over 180 days”) -- between the date of service and the date processed -- for claims submitted by the facility or by peer facilities during the specified time period.</td>
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<td><strong>Data category: Processed by claim status</strong>&lt;br&gt;Data type: Paid claims&lt;br&gt;(Location: Column two)</td>
<td>The volume/percentage of claims -- submitted by the facility or by peer facilities during the specified time period -- that were paid.</td>
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<td><strong>Data category: Processed by claim status</strong>&lt;br&gt;Data type: Denied claims&lt;br&gt;(Location: Column two)</td>
<td>The volume/percentage of claims -- submitted by the facility or by peer facilities during the specified time period -- that were denied.</td>
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<td><strong>Data category: Processed by claim status</strong>&lt;br&gt;Data type: Rejected claims&lt;br&gt;(Location: Column two)</td>
<td>The volume/percentage of claims -- submitted by the facility or by peer facilities during the specified time period -- that were rejected.</td>
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<td><strong>Data category: Processed by claim status</strong>&lt;br&gt;Data type: Canceled claims&lt;br&gt;(Location: Column two)</td>
<td>The volume/percentage of claims -- submitted by the facility or by peer facilities during the specified time period -- that were canceled by the submitter.</td>
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<tr>
<td><strong>Data category: Processed by claim status</strong>&lt;br&gt;Data type: Total&lt;br&gt;(Location: Column two)</td>
<td>The total number/percentage of claims that were submitted by the facility or by peer facilities during the specified time period.</td>
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<tr>
<td><strong>Data category: RTP</strong>&lt;br&gt;Data type: Automated&lt;br&gt;(Location: Column two)</td>
<td>The number/percentage of claims -- submitted by the facility or by peer facilities electronically (i.e., “Automated”) during the specified time period that were returned to provider (RTP).</td>
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<td><strong>Data category: RTP</strong>&lt;br&gt;Data type: Hard copy&lt;br&gt;(Location: Column two)</td>
<td>The number/percentage of claims -- submitted by the facility or by peer facilities as paper claims (i.e., “Hard copy”) -- during the specified time period that were returned to provider (RTP).</td>
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<tr>
<td><strong>Data category: RTP</strong>&lt;br&gt;Data type: Total&lt;br&gt;(Location: Column two)</td>
<td>The total number/percentage of claims -- submitted by the facility or by peer facilities during the specified time period -- that were returned to provider (RTP).</td>
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<td>FEB12 (i.e., Month 1)&lt;br&gt;(Location: Column three)</td>
<td>Facility’s data -- from all six data categories -- that pertain to the first month listed.</td>
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<tr>
<td>% of total (A)&lt;br&gt;(Location: Column four)</td>
<td>Facility’s data -- percentages of claim volumes (from all six data categories) -- for the first month listed.</td>
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<tr>
<td>MAR12 (i.e., Month 1)</td>
<td>Facility’s data -- from all six data categories -- that pertain to the second month listed.</td>
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<td><strong>Location:</strong> Column five</td>
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<td>% of total (B)</td>
<td>Facility’s data -- percentages of claim volumes (from all six data categories) -- for the second month listed.</td>
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<td><strong>Location:</strong> Column six</td>
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<tr>
<td>Change FEB12-MAR12 (i.e., Month 1-Month 2)</td>
<td>Comparison of facility’s data -- from all six data categories -- volume changes between the first and second months listed.</td>
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<td><strong>Location:</strong> Column seven</td>
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<tr>
<td>% Change (B-A)</td>
<td>Comparison of facility’s data -- percentage changes in claim volumes (all six categories) -- between the first and second months listed.</td>
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<td>FEB12 PEER AVERAGE</td>
<td>Averages of peer group’s data -- from all six data categories -- that pertain to the first month listed.</td>
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<tr>
<td>% of total (C)</td>
<td>Peer group’s data (averages) -- percentages of claim volumes (from all six data categories) -- for the first month listed.</td>
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<td><strong>Location:</strong> Column 10</td>
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<tr>
<td>Diff (+/-)</td>
<td>Comparison of facility and peer group’s data -- differences between the facility and the peer group’s claim volumes (from all six data categories) during the specified time period.</td>
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<td><strong>Location:</strong> Column 11</td>
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<tr>
<td>% Diff (A-C)</td>
<td>Comparison of facility and peer group’s data -- percentage changes in claim volumes (all six categories) -- between the facility and the peer group’s data.</td>
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</table>
PDS report -- Part A: Message code table

The second section of the PDS report is the “Message code table.” The table contains a list of adjustment codes, reject codes, line denial codes, and RTP codes -- organized by place of service (e.g., inpatient Part A, inpatient Part B) and claim type (i.e., automated, hard copy) -- that impacted the provider’s claims during the specified reporting period. The table also includes data regarding the number of claims affected.

Figure 158: PDS Request Message Code Table -- Part A

![Table image]

Note: Specific categories of codes (e.g., “Adjustments,” “Rejects”, “Line denials,” “RTP”) -- organized by place of service and claim type -- may vary from month to month. To review the most common inquiries received by the provider contact center and learn how to increase the number of claims that process successfully, please refer to First Coast’s Claims resources page.

6.5.19 PDS Request: Part B

The Provider Data Summary (PDS) report for Part B providers helps identify recurring billing issues through a detailed analysis of its billing patterns in comparison with those of similar provider types during a specified time period.
Overview of PDS report -- Part B

The PDS report for Part B providers is comprised of two main sections:

- **Comparative data table** -- contains the comparative data compiled from claims that were finalized over the designated report period for the provider as well as those for the provider’s peer group. Peers are all individuals located in the provider’s geographic area that belong to the same specialty or facility type.

- **Message code table** -- contains a list of top reason codes (and their associated descriptors) that caused the provider’s claims to be denied or returned as unprocessable (RUC) during the designated reporting period. The table also includes data on the frequency of their occurrence during the reporting period.

To utilize the **Data Reports -- PDS Request** feature, the user should take the following steps:

1. Select the menu tab labeled **Secure Documentation**, then **Request Documentation**
2. Select the **PDS** option from the drop-down menu
3. The **PDS Request** page will appear:

![Provider Data Summary (PDS) Request](image)

*Figure 159: PDS Request Page – Part B*

4. Select the following information:
   - **Month 1 (required) and Month 2 (optional)**
   
     *NOTE*: Users may view one month or compare two months within the 12 previous months from the current date.

5. Click the **Data Summary** button to initiate report request

6. The **PDS Request** results page will appear:
Figure 160: PDS Request Results Page – Part B

Figure 161: PDS Request Comparative Data Table – Part B
<table>
<thead>
<tr>
<th>Report identifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Data category: Claim Totals</strong>&lt;br&gt;<em>(Location: Column one)</em></td>
<td>Data includes comparisons of total amounts (in dollars) of allowed and approved claims as well as the total number of claims approved for services billed by the provider or the provider’s peers during the specified time period.</td>
</tr>
<tr>
<td><strong>Data category: Claim Volumes</strong>&lt;br&gt;<em>Services</em>&lt;br&gt;<em>(Location: Column one)</em></td>
<td>Data includes comparisons of volumes and percentages of services in claims designated as paid, denied, duplicate, processed (subtotal), and returned as unprocessable (RUC) that were submitted by the provider or the provider’s peers during the specified time period.</td>
</tr>
<tr>
<td><strong>Data category: Claim Billed Dollars</strong>&lt;br&gt;<em>(Location: Column one)</em></td>
<td>Data includes comparisons of dollar amounts and percentages of services billed in claims submitted by the provider or the provider’s peers during the specified time period.</td>
</tr>
<tr>
<td><strong>Data category: % of Services Received</strong>&lt;br&gt;<em>Services</em>&lt;br&gt;<em>(Location: Column one)</em></td>
<td>Data includes comparisons of percentages of services billed in claims that were processed or returned as unprocessable (RUC) and were submitted by the provider or the provider’s peers during the specified time period.</td>
</tr>
<tr>
<td><strong>Data category: % of Services Processed</strong>&lt;br&gt;<em>Services</em>&lt;br&gt;<em>(Location: Column one)</em></td>
<td>Data includes comparisons of percentages of denied or duplicate services billed in claims that were submitted by the provider or the provider’s peers during the specified time period.</td>
</tr>
<tr>
<td><strong>Data category: Claim Totals</strong>&lt;br&gt;<em>Data type: Total Allowed $</em>&lt;br&gt;<em>(Location: Column two)</em></td>
<td>The total amount (in dollars) that Medicare allowed for the specific services billed by the provider or the provider’s peers during the specified time period.</td>
</tr>
<tr>
<td><strong>Data category: Claim Totals</strong>&lt;br&gt;<em>Data type: Total Approved $</em>&lt;br&gt;<em>(Location: Column two)</em></td>
<td>The total amount (in dollars) of approved claims for services billed by the provider or the provider’s peers during the specified time period.</td>
</tr>
<tr>
<td><strong>Data category: Claim Totals</strong>&lt;br&gt;<em>Data type: Total Claims Approved</em>&lt;br&gt;<em>(Location: Column two)</em></td>
<td>The total number of approved claims for services billed by the provider or the provider’s peers during the specified time period.</td>
</tr>
<tr>
<td><strong>Data category: Claim Volumes</strong>&lt;br&gt;<em>Services</em>&lt;br&gt;<em>Data type: Approved</em>&lt;br&gt;<em>(Location: Column two)</em></td>
<td>The total number/percentage of approved services billed in claims submitted by the provider or the provider’s peers during the specified time period.</td>
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<tr>
<td>Report identifier</td>
<td>Description</td>
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<tr>
<td><strong>Data category: Claim Volumes (Services)</strong>&lt;br&gt;<strong>Data type: Denied</strong>&lt;br&gt;(<strong>Location:</strong> Column two)</td>
<td>The total number/percentage of denied services billed in claims submitted by the provider or the provider’s peers during the specified time period.</td>
</tr>
<tr>
<td><strong>Data category: Claim Volumes (Services)</strong>&lt;br&gt;<strong>Data type: Duplicate</strong>&lt;br&gt;(<strong>Location:</strong> Column two)</td>
<td>The total number/percentage of duplicate services billed in claims submitted by the provider or the provider’s peers during the specified time period.</td>
</tr>
<tr>
<td><strong>Data category: Claim Volumes (Services)</strong>&lt;br&gt;<strong>Data type: Subtotal (Processed)</strong>&lt;br&gt;(<strong>Location:</strong> Column two)</td>
<td>The total number/percentage of processed services billed in claims submitted by the provider or the provider’s peers during the specified time period.</td>
</tr>
<tr>
<td><strong>Data category: Claim Volumes (Services)</strong>&lt;br&gt;<strong>Data type: Unprocessable</strong>&lt;br&gt;(<strong>Location:</strong> Column two)</td>
<td>The total number/percentage of services billed in claims designated as returned as unprocessable (RUC) that were submitted by the provider or the provider’s peers during the specified time.</td>
</tr>
<tr>
<td><strong>Data category: Claim Volumes (Services)</strong>&lt;br&gt;<strong>Data type: Total</strong>&lt;br&gt;(<strong>Location:</strong> Column two)</td>
<td>The total number/percentage of services billed by the provider or the provider’s peers during the specified time period.</td>
</tr>
<tr>
<td><strong>Data category: Claim Billed Dollars (Services)</strong>&lt;br&gt;<strong>Data type: Approved</strong>&lt;br&gt;(<strong>Location:</strong> Column two)</td>
<td>The total amount (in dollars)/percentage of approved services billed in claims submitted by the provider or the provider’s peers during the specified time period.</td>
</tr>
<tr>
<td><strong>Data category: Claim Billed Dollars (Services)</strong>&lt;br&gt;<strong>Data type: Denied</strong>&lt;br&gt;(<strong>Location:</strong> Column two)</td>
<td>The total amount (in dollars)/percentage of denied services billed in claims submitted by the provider or the provider’s peers during the specified time period.</td>
</tr>
<tr>
<td><strong>Data category: Claim Billed Dollars (Services)</strong>&lt;br&gt;<strong>Data type: Duplicate</strong>&lt;br&gt;(<strong>Location:</strong> Column two)</td>
<td>The total amount (in dollars)/percentage of duplicate services billed in claims submitted by the provider or the provider’s peers during the specified time period.</td>
</tr>
<tr>
<td><strong>Data category: Claim Billed Dollars (Services)</strong>&lt;br&gt;<strong>Data type: Subtotal (Processed)</strong>&lt;br&gt;(<strong>Location:</strong> Column two)</td>
<td>The total amount (in dollars)/percentage of processed services billed in claims submitted by the provider or the provider’s peers during the specified time period.</td>
</tr>
<tr>
<td>Report identifier</td>
<td>Description</td>
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</tr>
</tbody>
</table>
| **Data category: Claim Billed Dollars (Services)**  
*Data type: Unprocessable*  
*(Location: Column two)* | The total amount (in dollars)/percentage of services billed in claims that were submitted by the provider or the provider’s peers during the specified time period and were returned as unprocessable (RUC). |
| **Data category: Claim Billed Dollars (Services)**  
*Data type: Total*  
*(Location: Column two)* | The total amount (in dollars)/percentage of services billed in claims submitted by the provider or the provider’s peers during the specified time period. |
| **Data category: % of Services Received**  
*Data type: Processed*  
*(Location: Column one)* | The percentage of processed services billed in claims that were submitted by the provider or the provider’s peers during the specified time period. |
| **Data category: % of Services Received**  
*Data type: Unprocessable*  
*(Location: Column one)* | The percentage of services billed in claims submitted by the provider or the provider’s peers during the specified time period, but the claims were returned as unprocessable (RUC). |
| **Data category: % of Services Processed**  
*Data type: Denied*  
*(Location: Column one)* | The percentage of processed services billed in claims that were submitted by the provider or the provider’s peers during the specified time period. |
| **Data category: % of Services Received**  
*Data type: Duplicate*  
*(Location: Column one)* | The percentage of services billed in claims submitted by the provider or the provider’s peers during the specified time period, but the claims were returned as unprocessable (RUC). |
| **Number of patients** | Number of beneficiaries for whom services were furnished by the provider or the provider’s peer group during the specified time period. |
| **FEB12 (i.e., Month 1)**  
*(Location: Column three)* | Provider’s data -- from all five data categories -- that pertain to the first month listed. |
| **% of total (A)**  
*(Location: Column four)* | Provider’s data -- percentages of claim volumes (services), and claim billed dollars (services) -- for the first month listed. |
| **MAR12 (i.e., Month 2)**  
*(Location: Column five)* | Provider’s data -- from all five data categories -- that pertain to the second month listed. |
| **% of total (B)**  
*(Location: Column six)* | Provider’s data -- percentages of claim volumes (services), and claim billed dollars (services) -- for the second month listed. |
<table>
<thead>
<tr>
<th>Report identifier</th>
<th>Description</th>
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<tbody>
<tr>
<td>Change FEB12-MAR12 (i.e., Month 1-Month 2)</td>
<td>Comparison of provider’s data -- from all five data categories -- volume changes between the first and second months listed.</td>
</tr>
<tr>
<td>% Change (B-A)</td>
<td>Comparison of provider’s data -- percentage changes in claim volumes (services) and claim billed dollars (services) -- between the first and second months listed.</td>
</tr>
<tr>
<td>FEB12 PEER AVERAGE</td>
<td>Averages of peer group’s data -- from all five data categories -- that pertain to the first month listed.</td>
</tr>
<tr>
<td>% of total (C)</td>
<td>Peer group’s data (averages) -- percentages of claim volumes (services) and claim billed dollars (services) -- for the first month listed.</td>
</tr>
<tr>
<td>Diff (+/-)</td>
<td>Comparison of provider and peer group’s data -- differences in claim volumes (services) and claim billed dollars (services) -- between the provider and peer group’s data during the specified time period.</td>
</tr>
<tr>
<td>% Diff (A-C)</td>
<td>Comparison of provider and peer group’s data -- percentage changes in claim volumes (services) and claim billed dollars (services) -- between the provider and the peer group’s data.</td>
</tr>
</tbody>
</table>
The second section of the PDS report is the “Message code table.” The table contains a list of top reason codes (and their associated descriptors) that caused the provider’s claims to be denied or returned as unprocessable (RUC) during the designated reporting period. The table also includes data on the frequency of their occurrence during the reporting period.

Figure 162: PDS Request Message Code Table – Part B

To review the most common inquiries received by the provider contact center and learn how to increase the number of claims that process successfully, please refer to First Coast’s Claims resources page.
6.5.20 Secure Documentation: Provider-specific Comparative Billing Report (CBR) -- Part B

At this time, SPOT offers access to Comparative Billing Reports (CBR) solely for Part B providers. Due to the volume of data included within a Part A CBR, requests for Part A CBRs must be submitted by fax or Messaging. For more information Part A CBRs, please refer to Requesting a comparative billing report -- Part A providers and the CBR: Guide -- Part A.

The CBR for Part B shows how an individual physician or non-physician practitioner compares to his or her peer group by using their specialty as the basis for forming the peer group. Although there are three types of CBRs available to Part B providers, the only type of CBR available through SPOT is the Provider-specific CBR.

- Provider-specific CBRs are most useful for individual physicians and non-physician practitioners
- Provider-specific CBRs are not considered useful for multi-specialty clinics and group practices (i.e., Specialty Code: 70). To learn more about Medicare provider and supplier specialty codes, please click here.
- Provider-specific CBRs furnish a comparison of the provider’s claims activity against peers
- Provider-specific CBRs report data in descending order based upon allowed dollars per procedure code

Requests for Provider-specific CBRs generally take between 30-60-minutes to process, but requestors may log off SPOT while waiting for the report to be generated.

Note: Since Medicare bases a Part B Provider-specific CBR on dates of service and not processed dates, Medicare must allow two to three months to permit claims to be finalized before a report can be generated. For example, January data is not available until April or May.

For more information, please refer to the CBR: Guide Part B. To learn more about other types of CBRs not available through SPOT and how to request them, please click here.

Overview of ‘Provider-specific CBR Request -- Part B’ Results:
- Results encompass only the claims information related to the provider number identified in the header (top) section of the report.
- Information featured in the header section outlines the parameters of the report, including the dates specified in the request, total number of beneficiaries for whom claims were submitted, and the county in which the provider furnishes services.
- Data is reported in descending order based upon allowed dollars per procedure code.
- Report furnishes a comparison of the provider’s claims activity against his or her peers in the same specialty. Note: Validity of report is based upon the assumption that all providers included within the comparison have reported accurate specialty and claims information to the contractor.
- Report only includes information pertaining to the requesting provider’s Medicare patients.
To see the **Data Reports -- CBR Request -- Part B** feature, take the following steps:

1. Select the menu tab labeled **Secure Documentation** then **Request Documentation**
2. Select the **CBR** option from the request type submenu
3. The **CBR Request** page will appear:

![Figure 163: Provider-specific CBR Request Form -- Part B Page](image)

4. Enter the following data report parameters:
   - **Date range** -- users may specify a date range of up to 18 months based upon dates of service; however, only data from finalized claims may be accessed.
     - From Date and To Date: (data entry fields)
       - Dates specified must have occurred after April 1, 2011
       - Dates specified must be in the “mm/dd/yyyy” format (i.e., two-digit day, two-digit month, and four-digit year separated by front slashes)
       - Date range (i.e., From Date-To Date) **may not exceed 18 months**
5. Click the *Generate Report* button to initiate report request.

**Figure 164:** Provider-specific CBR Request: Request Status – Part B

<table>
<thead>
<tr>
<th>Report Dates</th>
<th>Date Requested</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>01-01-2014 to 02-01-2014</td>
<td>03-27-2014</td>
<td>Processing</td>
</tr>
</tbody>
</table>

6. Once generated, the CBR Request results will be accessible through *Retrieve Documentation* in the Secure Documentation menu.

7. The first page of the CBR will contain a listing of the column headings and corresponding descriptions of the data contained within the first section of the report. For more information, please refer to the CBR Guide – Part B.

**Figure 165:** Part B – Provider-specific CBR: Report descriptors

### Points to Remember when Reviewing This Report:

- This report provides data for one provider number only (PIN). If you have multiple provider numbers or suffixes, this report encompasses only the claims information related to the provider number identified in the header (top) section of the report.
- The information in the header section provides you with the parameters of your report such as: county, area, total number of beneficiaries for whom claims were submitted, dates the data was drawn against. The data is reported in descending allowed dollars per procedure code.
- This report provides you with a comparison of your claims activity against your peers (all other providers listed in the specialty to which you are being compared).
- The validity of the report is based on the assumption that you and other providers have reported accurate specialty and claims information.
- Your request will be processed in 24 - 48 hours.

<table>
<thead>
<tr>
<th>Descriptor</th>
<th>What it Actually Means:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Unique Medicare ID (A)</td>
<td>Total number of beneficiaries to whom you rendered a service (regardless of the procedure code(s) billed).</td>
</tr>
<tr>
<td>Procedure Code (A)</td>
<td>The CPT code and short descriptor defining the service(s) billed.</td>
</tr>
<tr>
<td>Unique Medicare ID (B)</td>
<td>The total number of your beneficiaries to whom you provided the individual service (by CPT/procedure code).</td>
</tr>
<tr>
<td>Services (C)</td>
<td>The total number of services per procedure code that you billed regardless of the number of beneficiaries in your practice.</td>
</tr>
<tr>
<td>Allowed Services (D)</td>
<td>The total number of allowed services per procedure code regardless of the number of beneficiaries in your practice.</td>
</tr>
<tr>
<td>Percent of Services (E)</td>
<td>The percent of the specific service to all services rendered. Calculated by: Total services billed by your “Peer Group” or Specialty divided by the total number of services rendered by your “Peer Group” or Specialty.</td>
</tr>
<tr>
<td>Percent of Services (F)</td>
<td>The percent of the specific service rendered by you to all services rendered by your “Peer Group” or Specialty. Calculated by: Total services billed for a specific service divided by the total number of services rendered by all providers in your “Peer Group” or Specialty.</td>
</tr>
<tr>
<td>Ratio I PEER (G)</td>
<td>A statistical comparison of a specific service rendered within your “Peer Group” or Specialty to all services rendered by that “Peer Group” or Specialty. Calculated by: Total services billed for a specific service for all providers in your “Peer Group” or Specialty divided by the total number of services rendered by the “Peer Group” or Specialty.</td>
</tr>
<tr>
<td>Ratio I PIN (H)</td>
<td>A statistical comparison of a specific service rendered by you to all services rendered by you. Calculated by: Total services billed for a specific service column (C) divided by the total number of beneficiaries who received the service.</td>
</tr>
<tr>
<td>Ratio II PEER (I)</td>
<td>A statistical comparison of the number of times your “Peer Group” or Specialty rendered a specific service to each beneficiary who received that service. Calculated by: Total number of services billed for a specific service column (C) divided by the number of beneficiaries who received the service.</td>
</tr>
<tr>
<td>Ratio II PIN (J)</td>
<td>A statistical comparison of the number of times you rendered a specific service to each beneficiary who received the service. Calculated by: Total number of services billed for a specific service column (C) divided by the number of beneficiaries who received the service.</td>
</tr>
<tr>
<td>Allowed Dollars (K)</td>
<td>The total allowed dollars for the claims submitted by you for each individual procedure code detailed on the table.</td>
</tr>
<tr>
<td>Percent Allowed PEER (L)</td>
<td>A comparison by percent of the total allowed dollars for a specific service for all providers in your “Peer Group” or Specialty to all allowed dollars for all services in your “Peer Group” or Specialty. Calculated by: Total allowed dollars for a specific service divided by the total allowed dollars for all services.</td>
</tr>
<tr>
<td>Percent Allowed PIN (M)</td>
<td>A comparison by percent of the total allowed dollars for a specific service you rendered to all allowed dollars for all services you rendered. Calculated by: The total allowed dollars for a specific service (K) divided by the total allowed dollars for all services, total of column (K).</td>
</tr>
</tbody>
</table>
Part B – Provider-specific CBR: Data Results

- The provider-specific CBR encompasses only the claims information related to the provider number identified in the header (top) section of the report.

- Information featured in the header section outlines the parameters of the report, including the dates specified in the request, total number of beneficiaries for whom claims were submitted, and the county in which the provider furnishes services.

- Data is reported in descending order based upon allowed dollars per procedure code

- The provider-specific CBR furnishes a comparison of the provider’s claims activity against his or her peers in the same specialty

**Note:** Validity of report is based upon the assumption that all providers included within the comparison have reported accurate specialty and claims information to the contractor.

- The provider-specific CBR only includes information pertaining to the requesting provider’s Medicare patients

**Table 16: CBR Request -- Part B Results**

<table>
<thead>
<tr>
<th>Report Identifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>(A) Total Unique Medicare ID Count</td>
<td>Total number of beneficiaries for whom the provider rendered a service -- regardless of the procedure code(s) billed</td>
</tr>
<tr>
<td>Procedure Code</td>
<td>The CPT® code and short descriptor defining the services billed</td>
</tr>
<tr>
<td>(B) Unique Medicare IDs</td>
<td>The total number of beneficiaries for whom the provider furnished the individual service -- organized by CPT®/procedure code</td>
</tr>
<tr>
<td>(C) Svc.</td>
<td>The total number of services per procedure code that was billed by the provider -- regardless of the number of beneficiaries served by the provider’s practice</td>
</tr>
<tr>
<td>(D) Allw. Svc.</td>
<td>The total number of allowed services per procedure code, -- regardless of the number of beneficiaries served by the provider’s practice</td>
</tr>
<tr>
<td>(E) Peer (Percentage of Services)</td>
<td>The percentage of the specific service to all services rendered. <strong>Calculated by:</strong> Total services billed by provider’s <strong>Peer Group or Specialty</strong> for a specific service divided by the total services billed for all services rendered by provider’s <strong>Peer Group or Specialty multiplied by 100</strong></td>
</tr>
<tr>
<td>(F) PIN (Percentage of Services)</td>
<td>The percentage of the specific service rendered by the provider to all services rendered by the provider <strong>Calculated by:</strong> Total services for a specific service -- Column (C) divided by the total of Column (C) multiplied by 100</td>
</tr>
<tr>
<td>(G) Peer (Ratio I)</td>
<td>A statistical comparison of a specific service rendered within a provider’s <strong>Peer Group or Specialty</strong> for all beneficiaries serviced by that <strong>Peer Group or Specialty</strong> <strong>Calculated by:</strong> Total services billed for a specific service for all providers in the <strong>Peer Group or Specialty divided by</strong> the total number of beneficiaries serviced by the <strong>Peer Group or Specialty</strong></td>
</tr>
<tr>
<td>Report Identifier</td>
<td>Description</td>
</tr>
<tr>
<td>-------------------</td>
<td>-------------</td>
</tr>
</tbody>
</table>
| (H) PIN (Ratio I) | A statistical comparison of a specific service rendered by the provider to all beneficiaries serviced by that provider  
**Calculated by:**  
Total services billed for a specific service -- Column (C) -- divided by the provider’s total beneficiary population -- Column (A) |
| (I) Peer PIN (Ratio II) | A statistical comparison of the number of times the provider’s Peer Group or Specialty rendered a specific service to each beneficiary who received that service  
**Calculated by:**  
Total number of services billed for a specific service divided by the number of beneficiaries who received the service |
| (J) PIN (Ratio II) | A statistical comparison of the number of times the provider rendered a specific service to each beneficiary who received that service  
**Calculated by:**  
Total number of services billed for a specific service -- Column (C) -- divided by the number of beneficiaries who received the service -- Column (B) |
| (K) Allowed Dollars | The total allowed dollars for the claims submitted by the provider for each individual procedure code detailed within the table |
| (L) Peer PIN (Percentage Allowed) | A comparison (by percentage) of the total allowed dollars for a specific service for all providers within the provider’s Peer Group or Specialty to all allowed dollars for all services in the provider’s Peer Group or Specialty  
**Calculated by:**  
The total allowed dollars for a specific service divided by the total allowed dollars for all services |
| (M) PIN (Percentage Allowed) | A comparison (by percentage) of the total allowed dollars for a specific service the provider rendered to all allowed dollars for all services the provider rendered  
**Calculated by:**  
The total allowed dollars for a specific service -- Column (K) -- divided by the total allowed dollars for all services -- total of Column (K) |
Figure 166: Part B – Provider-specific CBR: Section one, page one

Figure 167: Part B – Provider-specific CBR: Section one, page two

Figure 168: Part B – Provider-specific CBR: Section two
Part B – Provider-specific CBR: No data available

CBR data may not be available for a provider if:

- The date of service parameters of the CBR request do not encompass finalized claims

  **Note:** Since Medicare bases a Part B Provider-specific CBR on dates of service and not processed dates, Medicare must allow two to three months to permit claims to be finalized before a report can be generated. For example, January data is not available until April or May.

- The provider belongs to Medicare specialty code 70 (i.e., multi-specialty clinics and group practices)

  **Note:** Provider-specific CBRs are not designed for multi-specialty clinics or group practices (i.e., Specialty Code: 70). If a Provider-specific CBR is generated for a multi-specialty clinic or group practice, only the last page of the report will contain data.

6.5.21 Secure Documentation: Retrieve documentation

To retrieve a document that you have requested:

1. Click on *Retrieve Documentation* from the Secure Documentation menu.
2. From the documentation type drop-down request, select the documentation type you have requested (1099 form or CBR)
NOTE: If selecting 1099 form, you will be asked to enter the confirmation number you received after you submitted your request:

![Retrieve secure documentation](image)

**Figure 170:** Enter 1099 form confirmation number

3. Click *Submit*

4. Depending on which form you are retrieving, you may receive a status of “Pending” or “Completed”

![1099 Form](image)

**Figure 171:** 1099 form pending

5. If the status is “Completed” you may click the link and retrieve your document

6.5.22 Secure Documentation: Check Status

You may check the status of any form submitted electronically through SPOT’s Secure Documentation feature; however, it must have been *submitted by your* SPOT account.

If the form was submitted for the *same provider* by a *different SPOT account*, the status of that request will *not* be available through your SPOT account. To check the status of any Secure Documentation forms submitted by your SPOT account, please take the following steps:

1. Select *Check Status* from the Secure Documentation menu:
2. The Check Status: Query form will appear:
3. Enter search parameters.  
   **Note:** The Status Query forms are identical for Part A and Part B:  
   a. If you wish to search for the status of all the forms submitted through SPOT during a specific time period, enter the submission date range. E-documentation status will be accessible for 12 months from the submission date.  
   b. If you wish to search for one specific submission, you may enter the confirmation number that was sent to the account holder’s email address.  

4. Click the **Search** button  
   **Note:** Only requests submitted through the same SPOT account will be available.  
   The results of your query will appear. You may customize your view based upon submission date, and you may also control how many status records will appear on the page.

---

**TROUBLESHOOTING & SUPPORT**

### 6.6 Error Messages

#### 6.6.1 401 Permission Error

1. To use the SPOT, you must complete both parts of the new user registration process through the EIDM website. The first step of the process is to create your EIDM account, which will contain your personal information (e.g., name, home address, email address, date of birth). However, having an EIDM account by itself does not automatically grant access to the SPOT application.  

2. The second step of the process is to request access to the SPOT application, which will establish your billing provider profile (e.g., business name and address, NPI, PTAN, TIN, line of business). However, your access request must be approved before you may log on to SPOT for the first time.
3. If you have your EIDM account and attempt to log on to SPOT before your SPOT application access request has been approved (i.e., no request submitted, request in pending status, or request in denied status), a 401 permission error message will be returned:

![SPOT Error Message]

**Figure 173: 401 Permission Error**

4. If you have an EIDM account and have submitted your SPOT access request, you will receive an email once your request has been approved or denied. However, if you are unsure of the status of your SPOT access request, you may contact the SPOT Help Desk (855-416-4199 (press 1 for general assistance; 2 for enrollment) or email: FCSOSpotHelp@fcso.com). Please make sure to include your EIDM account User ID and request confirmation number.

5. Clear your internet browser’s cache between logins. If you have acquired an EIDM account and have approved access to the SPOT, you may encounter the 401 permission error message if you have not cleared your internet browser’s cache between logins to either the EIDM or SPOT websites.

6. To avoid this error in the future, please make sure to clear your internet browser’s cache at the end of every visit to the EIDM website or the SPOT website. When you wish to access the website again, make sure to open a new internet browser window to log in.

### 6.6.2 System Not Available

This type of error message will display if any features are temporarily unavailable due to technical issues or the unavailability of required CMS systems (e.g., EIDM, HETS, FISS) due to scheduled/unscheduled maintenance.

### 6.6.3 Data Matching Error

This type of error message will automatically display when beneficiary data entered does not match corresponding data maintained by Medicare.
Data matching errors occur when the beneficiary data entered by the portal user does not correspond to data entered in related fields and/or does not match the information contained within CMS’ systems (e.g., HETS). If the beneficiary’s information does not match, the provider internet portal will display an error message, and no information will be returned until the data entered has been corrected.

### 6.6.4 Data Format Error

This type of error message will automatically display when the data entered is not entered in the format required by the system (e.g., dates must be entered in the mm/dd/yyyy format). To protect the privacy of beneficiary information, any personally identifiable information (PII) entered (e.g., Medicare ID, first and last names, date of birth) must match the corresponding beneficiary’s information as maintained by Medicare.

Data format errors occur when the data entered by the portal user does not match the required format:

- **Medicare ID**
  - 10 digits if using a HICN or 11 if using a Medicare Beneficiary Identifier (MBI)
  - No dashes or non-alphanumeric characters

- **Date of Birth**
  - MM/DD/YYYY
  - Numbers and front slashes only

- **Date of Service**
  - MM/DD/YYYY
  - Numbers and front slashes only
  - Current date/Past date (i.e., future dates may not be used)

If the data entered does not comply with the format required by the system, the provider internet portal will display an error message, and no information will be returned until the data entered has been corrected.

### 6.6.5 Data Incomplete Error

This type of error message will automatically display when the data entered is incomplete or no data is entered/selected in a required field.

If the data entered is incomplete or no data is entered/selected in a required field, the provider internet portal will display an error message, and no information will be returned until data has been entered/selected in all required fields.

### 6.6.6 Online Help

The Help tab offers three submenu options:

- **FAQs** -- this subsection of Help provides a direct link to the On-the-SPOT FAQs

- **User Guide** -- this subsection of Help provides a direct link to the Secure Provider Online Tool ‘The SPOT’ User Guide

- **Feedback** -- this subsection of Help offers users the opportunity to submit their comments, suggestions, and inquiries about SPOT.

### 6.6.7 Technical Support

<table>
<thead>
<tr>
<th>Table 17: SPOT Technical Support</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Organization</strong></td>
</tr>
</tbody>
</table>

The SPOT: User Guide, Version 17.2
First Coast SPOT Help Desk | 855-416-4199 (press 1 general assistance; 2 for enrollment) | FCSOSPOTHelp@FCSO.com | SPOT first-level user support and problem reporting

### 6.6.8 Live Chat on SPOT

Through Live Chat, First Coast representatives are available 10 a.m. to 2 p.m., Monday through Friday, to help users locate resources on SPOT as well as the First Coast provider website.

To access Live Chat, click on the ‘Chat’ button on the lower right corner of your screen. You may also click on the dialogue icon located at the top right of your screen next to the ‘Help’ link.

- SPOT representatives may assist with questions such as:
  - Updating passwords in your Enterprise Identity Management (EIDM) account
  - Completing the remote identity proofing process (RIDP) and multifactor authentication (MFA)
  - Creating additional SPOT profiles
  - Locating information on the First Coast provider site

Due to Medicare data security restrictions, First Coast representatives will not have access to claims or provider records in SPOT and will not be able to answer specific claim or Medicare beneficiary questions. Any issues requiring specific account details will be referred to the SPOT Help Desk.

Please do not enter personal or protected health information (PHI) in the Live Chat dialogue box. PHI includes beneficiaries’ name, their Medicare ID or Social Security number, secondary insurance information. If you have any questions related to PHI, please review the Centers for Medicare & Medicaid Services HIPAA Basics for Providers guide.

### 7 GLOSSARY

The following definitions are provided for terms used in this manual as well as relevant cross-reference to additional terms that associated with those definitions:

**Table 18: Glossary**

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beneficiary</td>
<td>A person who has health care insurance through the Medicare or Medicaid programs.</td>
</tr>
<tr>
<td>CMS</td>
<td>The Centers for Medicare &amp; Medicaid Services (CMS) is the federal agency responsible for administering the Medicare program as well as parts of Medicaid.</td>
</tr>
<tr>
<td>Date of Service</td>
<td>Date service was provided to beneficiary</td>
</tr>
<tr>
<td>DOEBA</td>
<td>Date of the earliest billing activity on record</td>
</tr>
<tr>
<td>DOLBA</td>
<td>Date of the latest billing activity on record</td>
</tr>
<tr>
<td>FCSO</td>
<td>First Coast Service Options Inc. (First Coast) is the MAC responsible for processing Part A and Part B Medicare claims for providers and suppliers in Florida, Puerto Rico, and the U.S. Virgin Islands.</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>HETS-UI</td>
<td>HIPAA Eligibility Transaction System User Interface (HETS-UI) is a HIPAA-compliant, web-based application that furnishes beneficiary eligibility/benefit data (obtained from CMS’ beneficiary eligibility databases) for providers.</td>
</tr>
<tr>
<td>HHS</td>
<td>The Department of Health and Human Services (HHS) is the federal agency responsible for overseeing the administration of Medicare, Medicaid, and Children's Health Insurance Programs.</td>
</tr>
<tr>
<td>Lifetime Reserve Days</td>
<td>The additional days that Medicare covers when a beneficiary is in a hospital for more than 90 days. Beneficiaries have a total of 60 reserve days that may be used during his or her lifetime.</td>
</tr>
<tr>
<td>MAC</td>
<td>Medicare administrative contractor (MAC) is a privately owned company that contracts with Medicare to manage the processing of Medicare claims in its assigned jurisdiction.</td>
</tr>
<tr>
<td>Medicare ID</td>
<td>Medicare ID numbers are used to identify specific individuals within the Medicare system to ensure that all information and claims for that person are recorded and billed to the correct account.</td>
</tr>
<tr>
<td>MM/DD/YYYY</td>
<td>Month, Day, Year format (e.g., 01-02-2012)</td>
</tr>
<tr>
<td>PDS</td>
<td>The Provider Data Summary (PDS) is a report that allows providers to identify recurring billing issues through a detailed analysis of personal billing patterns in comparison with those of similar provider types (during a specified time period).</td>
</tr>
<tr>
<td>Peer Group</td>
<td>A group of providers that either use the same type of bill (e.g., 76x) or belong to the same specialty</td>
</tr>
<tr>
<td>PHI</td>
<td>Protected Health Information (PHI) refers to information about health status, provision of health care, or payment for health care that may be linked to a specific individual</td>
</tr>
<tr>
<td>PII</td>
<td>Personally Identifiable Information (PII) refers to information that may be used to distinguish or trace an individual’s identity (e.g., name, Social Security number) when used alone or in combination with other personal information (e.g., date of birth).</td>
</tr>
<tr>
<td>Plan Coverage</td>
<td>Information regarding the beneficiary’s enrollment under MA and Part D contracts and/or MA Managed Care Plans (Part C contracts) that provide Part A and B benefits for beneficiaries enrolled under a contract.</td>
</tr>
<tr>
<td>SPOT</td>
<td>Secure Provider Online Tool (SPOT) is First Coast’s provider internet portal/web-based application, which offers access to essential Medicare information, including claim status, beneficiary eligibility and benefits information, payment history, and data reports.</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
</tr>
<tr>
<td>------</td>
<td>------------</td>
</tr>
<tr>
<td>User</td>
<td>In the context of this manual, a user is an individual who requires and/or has acquired access to First Coast’s Secure Provider Online Tool (SPOT).</td>
</tr>
</tbody>
</table>
8 ACRONYMS

Table 19: Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADR</td>
<td>Additional Development Response</td>
</tr>
<tr>
<td>APC</td>
<td>Ambulatory Payment Classification</td>
</tr>
<tr>
<td>API</td>
<td>Application Program Interface</td>
</tr>
<tr>
<td>ARS</td>
<td>Acceptable Risk Safeguards</td>
</tr>
<tr>
<td>CAS</td>
<td>Client Automated System</td>
</tr>
<tr>
<td>CMS</td>
<td>Centers for Medicare &amp; Medicaid Services</td>
</tr>
<tr>
<td>CWF</td>
<td>Common Working File</td>
</tr>
<tr>
<td>E&amp;M</td>
<td>Evaluation and Management</td>
</tr>
<tr>
<td>EDI</td>
<td>Electronic Data Interchange</td>
</tr>
<tr>
<td>EIDM</td>
<td>Enterprise Identity Management</td>
</tr>
<tr>
<td>ESRD</td>
<td>End-stage renal disease</td>
</tr>
<tr>
<td>FCSO</td>
<td>First Coast Service Options Inc.</td>
</tr>
<tr>
<td>FFS</td>
<td>Fee-for service</td>
</tr>
<tr>
<td>FISS</td>
<td>Fiscal Intermediary Standard (or Shared) System</td>
</tr>
<tr>
<td>FR</td>
<td>Functional Requirement</td>
</tr>
<tr>
<td>HETS</td>
<td>HIPAA Eligibility Transaction System</td>
</tr>
<tr>
<td>HHA</td>
<td>Home health agency</td>
</tr>
<tr>
<td>HHEH</td>
<td>Home Health Episode History (HHEH)</td>
</tr>
<tr>
<td>HHS</td>
<td>The Department of Health and Human Services</td>
</tr>
<tr>
<td>JSM/TDL</td>
<td>Joint Signature Memorandum/Technical Design Letter</td>
</tr>
<tr>
<td>MA</td>
<td>Medicare Advantage</td>
</tr>
<tr>
<td>MAC</td>
<td>Medicare administrative contractor (MAC)</td>
</tr>
<tr>
<td>MCARE</td>
<td>Medicare Customer Assistance Regarding Eligibility</td>
</tr>
<tr>
<td>MCS</td>
<td>Multi-Carrier System</td>
</tr>
<tr>
<td>NPI</td>
<td>National Provider Identifier</td>
</tr>
<tr>
<td>NR</td>
<td>Nonfunctional Requirement</td>
</tr>
<tr>
<td>PECOS</td>
<td>Provider Enrollment Chain and Ownership System</td>
</tr>
<tr>
<td>PHI</td>
<td>Protected Health Information (PHI)</td>
</tr>
<tr>
<td>PII</td>
<td>Personally Identifiable Information (PII)</td>
</tr>
<tr>
<td>PMP</td>
<td>Project Management Plan</td>
</tr>
<tr>
<td>Acronym</td>
<td>Definition</td>
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<td>------------------------------------------------</td>
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<tr>
<td>POS</td>
<td>Point of Service</td>
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<tr>
<td>PPA</td>
<td>Project Process Agreement</td>
</tr>
<tr>
<td>PTAN</td>
<td>Provider Transaction Access Number</td>
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<tr>
<td>RUG</td>
<td>Resource Utilization Group</td>
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<tr>
<td>SAS</td>
<td>Statistical Analysis Software</td>
</tr>
<tr>
<td>SDMP</td>
<td>System Development Management Plan</td>
</tr>
<tr>
<td>SNF</td>
<td>Skilled Nursing Facility</td>
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<tr>
<td>SOW</td>
<td>Statement of Work</td>
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<tr>
<td>SSN</td>
<td>Social Security Number</td>
</tr>
<tr>
<td>SPOT</td>
<td>Secure Provider Online Tool</td>
</tr>
<tr>
<td>TIN</td>
<td>Tax Identification Number</td>
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9 Referenced Documents

The documents listed below have been used as references for the development of this guide:

Table 20: Referenced Documents

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<thead>
<tr>
<th>Document Name</th>
<th>Document Number</th>
<th>Issuance Date</th>
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<tr>
<td>Secure Provider Online Tool ‘SPOT’: Communication Management Plan</td>
<td>D8208 – Communications Plan</td>
<td>02/10/2015</td>
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<tr>
<td>Secure Provider Online Tool: Business Requirements</td>
<td>D8208 – internet Portal Project</td>
<td>01/20/2012</td>
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<td>Internet Portal - Project Charter</td>
<td>D8208 – Project Charter</td>
<td>07/16/2011</td>
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<tr>
<td>Internet Portal - Business Case</td>
<td>D8208 – Business Case</td>
<td>07/08/2011</td>
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<tr>
<td>JSM/TDL 10264</td>
<td>D8208 – Monthly PIES reporting</td>
<td>05/14/2010</td>
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