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1. INTRODUCTION

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’ Identity Management (IDM) system, 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.

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.

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

SPOT: Access and Limitations

Portal access

- SPOT offers members of its provider community in Florida, Puerto Rico, and the U.S. Virgin Islands secure, online access Medicare Data.
- Registered users may access Medicare data through the portal free-of-charge.
- Part A Military Treatment Facilities (MTFs) will only have access to eligibility, MBI lookup, claim status, and remittance advice.
- To protect proprietary and beneficiary data, users are prompted with a session timeout warning message after 20 minutes of inactivity. If there are no responses to the session timeout warning, users will automatically be logged out after the session limit expires at 30 minutes. There are no limitations to periods of active use.

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 IDM
- Access to Medicare data through the SPOT website is dependent upon the availability of CMS’ systems (i.e., IDM, 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.

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:
  ▪ Microsoft Edge
  ▪ Firefox v31 (or later)
  ▪ Chrome v35 (or later)
  ▪ Safari v6.1 (or later)
▪ Plug-ins: Verify that you have the latest versions of JAVA and ActiveX
▪ Pop-up blockers: Disable pop-up blockers prior to access

**SPOT: Integration with CMS’ IDM system**
To mitigate risk to all stakeholders, access to SPOT requires the existence of an IDM account and a registration process to request access to the portal application. Although users do not need a separate IDM account for each application, they must request access to each application separately.

**Acceptance of IDM 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

**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.
3. GETTING STARTED

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

Registration instructions

**Step 1: Organization registration**

Organizations must submit a new organization form that designates an approver and is signed by their authorized or delegated official:

- Provider office or organization form [PDF]
- Billing service or clearinghouse form [PDF]

**Step 2. Action for approvers**

Once the organization is created and approved, the organization must be established in IDM by the approver.

- View Approver registration instructions

**Step 3. Additional user registration**

Additional users should first determine their role.

- View How to register for SPOT: Determine your role and complete instructions

Already know your desired role?

- View backup approver registration instructions
- View end user registration instructions

**Step 4: Login to SPOT**


Note: If you 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).
IDM ACCOUNT/ACCESS MANAGEMENT

IDM Account: ‘My Profile’

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

IDM Account: ‘My Profile’ -- Change Password

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

1. Navigate to and log in to CMS’ IDM portal: https://home.idm.cms.gov/
2. Select **My Profile**

3. Select **Personal Contact Information** on the left menu. Then, click the pen icon to edit the information. When through, click **Submit Changes**.
IDM Account: ‘My Profile’ -- Forgot Password or User ID

If you can’t remember your IDM account Password or User ID and your account has not been locked, follow these steps:


![Image of IDM login page](image1.jpg)

**Figure 3:** IDM Account Profile: Forgot Password

2. Click the underlined “Password” or “User ID” in the link below the red New User Registration button. Follow the steps to reset your password or User ID.

**LOCKED ACCOUNT:** If you enter the incorrect password too many times, your account may become locked. You may either wait 30 minutes, and use the Forgot Password link, or you may follow these steps to request that your account be unlocked and your password reset:

- Call the SPOT Help Desk (855-416-4199, option 1)
- Answer identity authentication questions
- Ask the SPOT Help Desk representative to unlock your account and reset your password
- An email will be sent to the email associated with the IDM account.
- Click on the link to the Reset Password page included in the email
IDM Account: ‘My Profile’ – View/Modify Profile and Roles

2. Enter your User ID and Password, click to agree to the Terms and Conditions, and click Sign In.
3. Once you choose your MFA device, retrieve the code, and enter it, you will enter the IDM portal.

![Figure 4: IDM Account: My Profile](image)

**Modify Personal Contact Information**

- After selecting the My Profile Box, select Personal Contact Information on the left menu. Then, click the pen icon to edit the information. When through, click the Submit Changes button.

**Modify Business Contact Information**

- After selecting the My Profile box, select Business Contact Information on the left menu. Then, click the pen icon to edit the information. When through, click the Submit Changes button.

**Change Password or Security Question**

- After selecting the My Profile Box, select Change Password or Change Security Question from the left menu. Make your changes and click the green button.

**Manage MFA and Recovery Devices**

- After selecting the My Profile Box, select Manage MFA and Recovery Devices from the left menu. Remove an MFA by clicking the red icon or use the ‘Add another device’ drop-down and follow the prompts to add a new device. [View this MFA help page](#) for a visual guide.
View/Modify Existing Role Details
  ▪ Once logged into IDM, click the Manage My Roles button.
  ▪ Next to the role you wish to view, click the blue icon to “View details.”
  ▪ If you wish to make changes, click the green Modify Role button.
  ▪ Once you are done making changes, click the Submit Changes button.

Remove Role
  ▪ Once logged into IDM, click the Manage My Roles button.
  ▪ Next to the role you wish to remove, click the red icon. You will be asked, “Are you sure you want to remove this role?” If so, click the red Remove Role button.

Add Role
  ▪ Once logged into IDM, click the Manage My Roles button.
  ▪ Next to the application/role you wish to add to, click the green icon.
  ▪ From the drop-down menu, select your desired role.
  ▪ On the same screen, type in the Legal Business Name of your organization and select the State/Territory.
  ▪ **Note:** You must click Search to find your organization in the drop-down menu.
  ▪ Click Review Request, review your information, enter your reason for request, and click Submit Role Request.

5. ACCESSING SPOT

Accessing the SPOT Application: IDM Registered/Approved Users

1. Navigate to [https://thespot.fcsoc.com/portal](https://thespot.fcsoc.com/portal)
2. The **IDM Login** page will appear.
**Figure 5: IDM Portal Login**

**Note:** If you have your IDM 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), an error message will be returned:

![IDM Portal Login](image)

**Figure 6: Permission Error**

**Note:** If you have acquired an IDM account and have approved access to the SPOT, you may also encounter the permission error message if you have not cleared your internet browser’s cache between logins to either the IDM or SPOT websites.

3. Enter your **User ID**, **Password**, agree to the Terms and Conditions, and click **Sign In**. Retrieve your MFA information to proceed.

4. Select your organization, PTAN, and NPI from the drop-down menus. Click **Submit**.
Figure 7: Select your organization

5. Arrive at the SPOT homepage
‘SPOT’: Organization and Navigation

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.
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 10: SPOT: Top navigation

6. USING 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.

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.

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.”
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.

Overpayment Correction Request: Confirmation

Your overpayment correction request was submitted successfully, and a confirmation message has been sent to the email listed in your official EIDM profile for the SPOT. Please allow 7-10 business days before retrieving your Overpayment Demand Letter in secure documentation.

Figure 15: Overpayment correction request: Confirmation

 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 reopenings 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.
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
- 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.
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)
- For a complete list of restricted codes and modifiers, please see https://medicare.fcso.com/SPOT_Instructions/0371054.asp
- 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 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 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 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

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.

<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 DOS From</td>
<td>DOS From</td>
<td>N/A</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>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>Both fields must be changed</td>
</tr>
<tr>
<td>Edit Diagnosis Code</td>
<td>Diagnosis Code</td>
<td>N/A</td>
<td>The primary diagnosis code may be changed.</td>
</tr>
<tr>
<td>Edit Procedure Code</td>
<td>Procedure Code</td>
<td>Billed Amount</td>
<td>The replacement code must be one that may be used in a claim reopening request.</td>
</tr>
<tr>
<td>Add Modifier</td>
<td>Modifier (first available field)</td>
<td>N/A</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>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>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.
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>![Image of tooltip for Date of Service]</td>
</tr>
<tr>
<td>Diagnosis Code</td>
<td>![Image of tooltip for Diagnosis Code]</td>
</tr>
<tr>
<td>Procedure Code</td>
<td>![Image of tooltip for Procedure Code]</td>
</tr>
<tr>
<td>Modifier</td>
<td>![Image of tooltip for Modifier]</td>
</tr>
<tr>
<td>Units Billed</td>
<td>![Image of tooltip for Units Billed]</td>
</tr>
<tr>
<td>Billed Amount</td>
<td>![Image of tooltip for Billed Amount]</td>
</tr>
</tbody>
</table>

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

Figure 16: Request Types: Hospice

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>
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>

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>

### 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 7: Claim Reopening Request Types: DOS Category

<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 20: 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**.
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 Reopen 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)**

<table>
<thead>
<tr>
<th>ICD-10 Format Guidelines (Outpatient Claims with a DOS on or after October 1, 2015)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Three to seven digits</td>
</tr>
<tr>
<td><strong>Character 1:</strong> Alpha</td>
</tr>
<tr>
<td><strong>Note:</strong> All letters used except U</td>
</tr>
<tr>
<td><strong>Character 2:</strong> Numeric</td>
</tr>
<tr>
<td><strong>Characters 3-7:</strong> Alphanumeric</td>
</tr>
<tr>
<td><strong>Decimal Placement:</strong> After first 3 characters</td>
</tr>
<tr>
<td><strong>Placeholder Character:</strong> “X” is used as a placeholder character to allow for future expansion.</td>
</tr>
</tbody>
</table>

**Figure 21: Request Type: Edit Diagnosis Code – Editable Field**
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>
<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 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>

Table 10: Claim Reopening Request Types: Edit Procedure Code

Figure 22: Request Type: Edit Procedure Code – Editable Fields
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>
<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 23: Modifier Category -- Editable Fields
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 12: Claim Reopening Request Types: 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</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>

### Figure 24: Request Type: Edit Units Billed – 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.*
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>

### Claim Reopening Request

For each line item you wish to edit, please select the type of request; add, change, or remove values in the applicable field(s); and click the **Review** button to proceed to the next page.

**Note:** Editable fields will have a white background and may vary depending upon the type of request selected. Tooltips furnish additional guidance regarding the required formatting for each field type.

![Figure 25: Request Type: Billed Amount](image)

**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

**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 your 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 26: 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
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 27:** 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:

![Image of Claim Reopening Inquiry page]

**Figure 28:** 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:

![Image of Claim Reopening Query error]

**Figure 29:** 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 30:** **Claim Reopening Path: Claim Reopening: Request Form**

**Claim Reopening Requests: Completing the Request Form**

**Tips:**

- 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:

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 33: Claim Reopening Request: Tooltip](image)

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 34: Claim Reopening Request: Review Changes](image)

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 35: 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**.

**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.

**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.

**Figure 36:** Claim redetermination form – Part B
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:

   ![Claimant Name: Electronic Signature](image)

   **Figure 37:** 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.

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.

Figure 38: Appeals Outcome Search

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
To begin a new query, click **New Query**.

**Figure 39: Appeals Search Results**
6.2 Claims

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.

Claim Status/First and Second Appeal Submissions: 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 Form](image)

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:
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 claim, click on the DCN number in the last column.

9. 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 41: Claim Status: Results - Part A**

**Figure 42: View claim details**
Submitting Part A first and second level appeals through claim status

1. Complete the claim status search form and click the Search button.
2. Choose the claim from the resulting list and click on the DCN to view the available appeals options.

![Claim Status Results Table]

**Figure 43:** Part A claim status results

**Figure 60:** Part A claim status results

Part A redetermination request (level 1)

1. To submit a level one appeal (redetermination), click on the *Submit an Appeal* button. NOTE: Level one appeals are also available through the appeals menu.
2. Complete the form, upload supporting documentation, and click *Submit*
3. A confirmation page will be displayed when the redetermination request has been accepted.

Part A reconsideration request (level 2)

1. To submit a level two appeal (reconsideration), click on the L2 request link from the claim status page.
2. Complete the fields on the Claim Reconsideration Form, load supporting documentation, and click *Submit*
3. A confirmation page will be displayed when the reconsideration request has been accepted.

**Additional appeal documentation (level 2 reconsideration request)**

Additional supporting documentation can be submitted on an open or requested level 2 reconsideration request and will automatically be added to the appeal.
1. Click on the **Submit Additional Documents** link

2. Upload the file and click **Submit**

3. A confirmation page will be displayed once the additional documentation has been accepted.

**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:

![Check Claims Status](image)

*Figure 50: 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]

**Figure 52:** 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.

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:
4. 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.**

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. **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.**

---

**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)
Figure 56: MR ADR Status Search

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* and *To*.

Figure 57: Search Results

2. Once you make a selection, three boxes will appear: *ADR*, *Review*, and *Education*, with the *ADR* details appearing automatically.
Figure 58: ADR Information Tab

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.

Figure 59: ADR Review Tab

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 **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.

**Eligibility: MBI Lookup**

To use the **MBI Lookup**, the user should take the following steps:

1. Select **MBI Lookup** from the **Eligibility** menu

![Select MBI Lookup](image)

2. The **MBI Lookup** search page will appear. Enter the following information into these required fields:
   - Beneficiary’s First Name
   - Beneficiary’s Last Name
   - Beneficiary’s Social Security Number
   - Beneficiary’s Date of Birth

3. Check the “I’m not a robot” box and follow the instructions (if any). When the green checkmark appears, click **Search**
4. Results will appear, showing the beneficiary’s first name, last name, and MBI. NOTE: You can retrieve an MBI for a beneficiary up to four years from the beneficiary’s date of death.

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
- PBID
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 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 Form](image)

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 beneficiary’s 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: (NOTE: The image below is only an example. More or less information may appear depending on the beneficiary.)
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 A Eligibility: Message** – displays the reason a beneficiary is insured with Medicare

- **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.*

- **Part B Eligibility: Message** – displays the reason a beneficiary is insured with Medicare

- **Part B Acupuncture Benefit** information

- **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)

- **PBID** - Part B Immunosuppressant Drug Benefit – effective date and termination 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.

**Benefits/Eligibility: Data Category -- Deductibles/Caps**

To access the beneficiary’s Deductibles/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:

![Eligibility/Benefits Data Results](image)

**Figure 66: 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.
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
- MDPP
- Cognitive Services
- COVID-19 immunization data
- Influenza immunization data
- Pneumococcal immunization data
- 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)
- Fecal Occult Blood Test (FOBT)
- Hepatitis B Antibody Screening
- Hepatitis C Antibody Screening
- High Intensity Behavioral Counseling (HIBC)
- HIV Screening
- Human papillomavirus (HPV) 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 the 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.
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. The beneficiary's Preventive information/history will automatically display:

![Preventive Information/History Results (Female)](image)

Figure 67: Preventive Information/History Results (Female)
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.

2. 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.

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.

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.

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

- **Group Number** -- group number of the insurance plan

- **Patient Relationship** -- person subscribing to or carrying the insurance plan

- **ORM Indicator** - Ongoing responsibility of medicals (ORM) indicator:
  - Y = the liability, no fault, workers compensation, auto insurance is responsible for all medical claims that are related.
  - N or blank = ORM is not applicable.
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 69: **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.
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. The beneficiary’s Hospice/Home Health information will automatically display:

![Hospice/Home Health Information Results](image)

**Figure 70: Hospice/Home Health 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.

2. 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 Date -- the date of *earliest* billing activity for spell of illness.
     - HHEH DOLBA Date -- the date of *latest* billing activity for spell of illness.
     - NPI
     - Contractor Number
     - Contractor Name
     - Patient Status Code
     - Description
Notice of Admission Indicator
Indicator Description

Beneficiary’s Hospice information:
- Effective Date
- Termination Date
- DOEBA Date
- DOLBA Date
- Revocation Code (when applicable)
- NPI
- Billed Days

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)

Figure 71: Inpatient 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. The Inpatient results page will include the following information:
   - **Part A Deductible information**
     - Deductible Year
     - Base Deductible
   - **Part A Free Services deductible**
     - Deductible Year
     - Deductible
   - **Lifetime Reserve Days**
     - Calendar Year
     - Lifetime Base Days
     - Lifetime Co-payment Amount per Day
     - Lifetime Remaining Days
   - **Lifetime Psychiatric Limitation Days**
     - Lifetime Psychiatric Base Days
     - Lifetime Psychiatric Remaining Days
   - **Inpatient Hospital 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.
     - Part A Remaining Deductible
     - Full Days Remaining ($0 per day)
     - Co-payment Days Remaining
     - Co-payment Amount per Day
   - **Hospital Stay**
     - Start Date
     - End Date
     - Billing NPI
   - **Skilled Nursing Facility (SNF) information:**
     - DOEBA date
     - DOLBA date
     - SNF Days Remaining ($0 per day)
     - SNF Co-payment Days Remaining
     - Co-payment Amount per Day
   - **SNF Stay**
     - Start Date
- End Date
- Billing NPI

**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:

![Figure 72: QMB information results](image)

---

Page 75
• 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

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 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)**, 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.

**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:

   ![Figure 73: Payments: Query - Part A form](image)

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:

<table>
<thead>
<tr>
<th>Payment Details:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Check/EFT Number: 987654321</td>
</tr>
<tr>
<td>Payment Status: EFT outstanding</td>
</tr>
<tr>
<td>Remittance Number: 111222333</td>
</tr>
</tbody>
</table>

![Figure 74: Payment History: Results - Part A: Payment Detail (Check/EFT Number)](image)

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

![Figure 75: Payment History: Results - Part A: Summary Table](image)

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.

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:

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 77:** 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:

![Payment History: Results - Part B: Summary Table](image)

**Figure 78:**  **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:

![Payment History: Results - Part B: Payment Details](image)

**Figure 79:**  **Payment History: Results - Part B: Payment Details**

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.

**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.

**Figure 80: Remittance advice request form**

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. Size limitation for remittance retrieval is 8MB.

**Figure 81: Remittance Advice Request Status**

Once your request has been completed, come back to the remittance advice request status window. Under the ‘Status’ row, click on the link ‘Completed.’
Figure 82: Remittance Advice Request Status Complete

You will be shown the respective remittance advice.

![Remittance Advice Request Status - Part A](image)

<table>
<thead>
<tr>
<th>Check/EFT Number</th>
<th>Date Requested</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>EFT 222222</td>
<td>MM/DD/YYYY</td>
<td>Completed</td>
</tr>
</tbody>
</table>

Figure 83: Sample remittance advice

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.

![Claim Details](image)

Figure 84: 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 85: Access remittances through Payment Details window](image)

### Demand Letter / Overpayment Details

The Demand Letter / Overpayment Details feature may be used to obtain Overpayment/Demand Letters and corresponding financial details.

To view Demand Letter / Overpayment Details within SPOT, click on the ‘Payment Data’ tab at the top of the homepage. Select ‘Demand Letter / Overpayment Details’ under the drop-down menu.

- The NPI, PTAN and Location will be pre-populated.
- Enter the ‘Date of Letter From’ and ‘To’, then click ‘Search’.

![Figure 86: Demand Letter / Overpayment Details](image)

Results will display below the query form.
- To view / download the letter, click the ‘Letter Number’. Note: Letters are in PDF format.
- Click ‘View Details’ to access additional letter information

![Demand Letter / Overpayment Info](image)

**Figure 87: Demand Letter / Overpayment Info**

Overpayment letter details include the balance on the debt when the letter was issued, the total balance, and other financial information related to the debt, including the accounts receivable (AR) transaction number(s). To view transactions related to the specific debt, click the ‘Transaction Number’ for details. View the next section, AR transaction for more information.

**AR Transaction Details**

In addition to obtaining AR transaction details via the Demand Letter / Overpayment results query, you may also access AR transaction details directly from the ‘Payment Data’ tab at the top of the homepage. Select ‘AR Transaction Details’ from the drop-down menu.

- The NPI, PTAN and Location will be pre-populated.
- Enter the ‘Claim Number’ OR ‘AR Transaction Number’ and click ‘Search’.

![Accounts Receivable Transaction Details](image)

**Figure 88: Accounts Receivable Transaction Details**
AR transaction details include the beneficiary’s name, the claim number involved in the transaction, the date of service, the amount collected, interest accrued and remaining balance, and other information as applicable.

- To obtain specific AR transaction Activity details, select an overpayment activity type as shown in Figure 106 – AR Transaction Info
  - Recoupment
  - Adjustment
  - Collection
- Once selected, click the Additional Activity Details button to access activity details, when applicable.

![Figure 89: AR Transaction Info](image)

### 6.5 Secure Documentation

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

**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
- ADR response for medical review
- Provider Audit & Reimbursement
- Credit Balance Report
- Prior Authorization Request Form
- 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
- ADR response for medical review
- 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
- Prior Authorization Request form

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.
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 First Coast as well as any requested documentation in your submission. All documents must be submitted in PDF format (15 MB 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

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:
Additional Development Response Form

Please enter the required information in the fields below, and upload a copy of the original ADR request letter as well as any requested documentation. All documentation must be submitted in PDF format.

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

* Required

DCN: 1234567890111FLA

Telephone:

State:

ADR Letter (PDF file only) File uploaded: [Browse...] [Clear]

* Claimant Name:

Electronic signature

☐ I certify that I am an authorized representative of this provider and attest that the information submitted to support this request is accurate and complete. I further certify that the electronic signature above to be the legally-binding equivalent of my handwritten signature.

Figure 93: **Part A – Additional Development Response (ADR) – initial view**

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 94: **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:
   - Select Document Type
   - Click the Browse button
   - Navigate to the file on your computer
   - Click Add More button and repeat the process to add any additional documentation (15 MB total/PDF format)

10. After you have finished adding the requested documentation, sign the form electronically:
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

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

From: <thespotportal@fcso.com>
Date: March 30, 2015 at 9:55:09 AM EDT
To: BakerStreetClinic@fcso.com
Subject: Confirmation: Confirmation Number - 21976CE2-03CA-431E-AE36-80AD285E8FA5

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-AE36-80AD285E8FA5.

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 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 99: Secure Documentation: ADR Confirmation Email

Secure Documentation: ADR response for Medical Review (MR) (Part A/Part B)

Part A and B providers can respond to ADR from the Medical Review department. 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 (15 MB maximum)

1. Select Submit Documentation under Secure Documentation

2. Select ADR response for Medical Review; the form will appear:
Figure 100: Medical Review ADR Response Form – Part A

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.

6. 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 (15 MB total/PDF format)

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

8. Click Submit

9. A confirmation form will appear:
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:

   - 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.)
8. Provider-based determination – Select this option to request initial setup or change in a unit’s provider-based status.

9. Wage Index/Occupational Mix Submissions – Select this option to upload documentation for the yearly wage index and occupational mix audits

10. 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.)

11. Submit FOIA Request (Select this option to submit a Freedom of Information Act request for Medicare cost reports.)

12. Submit PS&R Request (Select this option for Provider Statistics & Reimbursement reports (summary of paid claims for cost report)).

13. 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.

14. 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.

**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

**Secure Documentation: Prior Authorization Request Form (Part A)**

Part A providers can easily submit their Prior Authorization Request (PAR) forms in SPOT for certain hospital outpatient department services. To submit your request, click Secure Documentation from the top navigation menu.

- Select Submit Secure Documentation
- In the next drop-down menu, select Prior Authorization Request Form to be directed to the request form

The NPI, PTAN, and state will be pre-populated.

If you need assistance, click the additional links for information on procedure codes, coverage, and documentation requirements.

Next, access the Standard OPD PAR coversheet by clicking the link to download and complete the PDF form.

To upload your completed PAR coversheet, click Choose File to browse.

Click Add More Documentation to upload other documents.

Confirm you have included the PAR coversheet by selecting ‘Yes’ from the drop-down. The coversheet is required to process your request.

Click Submit.

A confirmation page will appear:

---

**Figure 104: Prior Authorization Request Form - Part A**

- The NPI, PTAN, and state will be pre-populated.
- If you need assistance, click the additional links for information on procedure codes, coverage, and documentation requirements.
- Next, access the Standard OPD PAR coversheet by clicking the link to download and complete the PDF form.
- To upload your completed PAR coversheet, click Choose File to browse.
- Click Add More Documentation to upload other documents.
- Confirm you have included the PAR coversheet by selecting ‘Yes’ from the drop-down. The coversheet is required to process your request.
- Click Submit.
- A confirmation page will appear:
Figure 105:  Prior authorization request form confirmation page

- You will receive an email confirmation as well. Please allow up to 10 business days for your form to be processed.
- Once a decision has been made on your request, you will receive an email from SPOT notifying you that you have a message in your SPOT inbox:

Figure 106:  Correspondence notification email

- Once you are back in SPOT, you will see a new message indicator at the top of the page:

Figure 107:  SPOT new message indicator

- Click on New Messages to open your PDF file/letter
- The letter will indicate whether your request has been approved or not approved, as well as additional instructions and information
- If you have any questions about your letter, you may call 855-340-5975, Monday-Friday, 8 a.m.-4 p.m. ET
Secure Documentation: Prior Authorization Request Form (Part B)
Part B providers can easily submit their Prior Authorization Request Forms in SPOT for certain hospital outpatient department services or repetitive non-emergent ambulance transport requests. To submit your request, click Secure Documentation from the top navigation menu.

- Select *Secure Documentation*
- In the next drop-down menu, select *Prior Authorization Request Form* to be directed to the request form

![Prior Authorization Request Form](image)

**Figure 108: Prior Authorization Request Type Selection – Part B**

- The NPI, PTAN, and state will be pre-populated
- Select the service type to be directed to the appropriate PAR request form
Figure 109: Prior Authorization Request Form – Part B

- Complete the PAR coversheet
- Upload your completed prior authorization coversheet and click Choose File to browse
- Click Add More Documentation to upload other documents
- Click Submit
- A confirmation page will appear
- You will receive an email confirmation as well. Please allow up to 10 business days for your form to be processed
- Once a decision has been made on your request, you will receive an email from SPOT notifying you that you have a message in your SPOT inbox:
  - Once you are back in SPOT, you will see a new message indicator at the top of the page
  - Click on New Messages to open your PDF file/letter
  - The letter will indicate whether your request has been approved or not approved, as well as additional instructions and information
  - If you have any questions about your letter, you may call 855-340-5975, Monday-Friday, 8 a.m.-4 p.m.
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 (8 MB 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:

![Figure 110: 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

**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 (8 MB 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:
3. Enter data in all required sections and fields

4. Upload Support Documentation in PDF format (8 MB 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.

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 (8 MB 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)

**Figure 112: Part B – Overpayment Redetermination Request**

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 (8 MB 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.

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 113: Part A/B EDI Enrollment Form]

3. Enter data into all required fields
4. Click Next to proceed to next page
5. Upload Support Documentation in PDF format
6. Upload Support Documentation in PDF format (6 MB maximum)
7. Add More Documentation if needed
8. Enter your electronic signature
9. 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.
10. 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.
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 (8 MB 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

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
Secure Documentation: Requesting a document

1. Select Request Documentation from the Secure Documentation submenu

![Request Secure Documentation](image)

**Figure 114: Request Secure Documentation**

2. Select your document type and click Next

**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 you 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.
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).

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:
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 117:**  PDS Request Results Page – Part A

7. Review PDS report.
### Figure 118: 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>Change FEB12-MAR12</th>
<th>% Change (B - A)</th>
<th>FEB12 PRR AVG</th>
<th>% of total (C)</th>
<th>Diff (+/-)</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>98.5%</td>
<td>-2,160</td>
<td>(0.10%)</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>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>6,019</td>
<td>100%</td>
<td>6,705</td>
<td>100%</td>
<td>-685</td>
<td>0.00%</td>
<td>8,202</td>
<td>100%</td>
<td>-2,183</td>
<td>0.00%</td>
</tr>
<tr>
<td>Processed by Place of Service</td>
<td>Inpatient Part A</td>
<td>726</td>
<td>12.1%</td>
<td>960</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>
</tr>
<tr>
<td></td>
<td>Hospital Based or Inpatient (Part B)</td>
<td>7</td>
<td>0.10%</td>
<td>8</td>
<td>0.10%</td>
<td>-1</td>
<td>0.00%</td>
<td>21</td>
<td>0.30%</td>
<td>-14</td>
<td>(0.20%)</td>
</tr>
<tr>
<td></td>
<td>Outpatient</td>
<td>5,283</td>
<td>87.8%</td>
<td>5,726</td>
<td>85.4%</td>
<td>-443</td>
<td>(2.40%)</td>
<td>6,417</td>
<td>78.2%</td>
<td>-1,134</td>
<td>9.60%</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>-817</td>
<td>(10.0%)</td>
</tr>
<tr>
<td></td>
<td>Reserved for Nat 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>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>6,019</td>
<td>100%</td>
<td>6,705</td>
<td>100%</td>
<td>-685</td>
<td>0.00%</td>
<td>8,201</td>
<td>100%</td>
<td>-2,182</td>
<td>0.00%</td>
</tr>
<tr>
<td>Processed by Category</td>
<td>Clean Claims</td>
<td>4,947</td>
<td>82.2%</td>
<td>5,360</td>
<td>79.9%</td>
<td>-413</td>
<td>(2.30%)</td>
<td>6,662</td>
<td>81.2%</td>
<td>-1,715</td>
<td>1.00%</td>
</tr>
<tr>
<td></td>
<td>Rejected</td>
<td>173</td>
<td>2.00%</td>
<td>260</td>
<td>3.00%</td>
<td>-87</td>
<td>1.00%</td>
<td>308</td>
<td>3.00%</td>
<td>-135</td>
<td>(0.00%)</td>
</tr>
<tr>
<td></td>
<td>Duplicate Claim Rejects</td>
<td>19</td>
<td>0.30%</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>
</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>85.8%</td>
<td>-1,894</td>
<td>(0.40%)</td>
</tr>
<tr>
<td></td>
<td>Adjustments</td>
<td>200</td>
<td>4.00%</td>
<td>203</td>
<td>4.20%</td>
<td>-3</td>
<td>(0.10%)</td>
<td>272</td>
<td>3.30%</td>
<td>-12</td>
<td>1.00%</td>
</tr>
<tr>
<td></td>
<td>Line Denial</td>
<td>820</td>
<td>10.3%</td>
<td>756</td>
<td>11.3%</td>
<td>-135</td>
<td>1.00%</td>
<td>895</td>
<td>10.9%</td>
<td>-276</td>
<td>(0.60%)</td>
</tr>
<tr>
<td></td>
<td>Sub Total</td>
<td>880</td>
<td>14.6%</td>
<td>1,039</td>
<td>15.6%</td>
<td>-159</td>
<td>0.00%</td>
<td>1,168</td>
<td>14.2%</td>
<td>-288</td>
<td>0.40%</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>6,019</td>
<td>100%</td>
<td>6,705</td>
<td>100%</td>
<td>-685</td>
<td>0.00%</td>
<td>8,201</td>
<td>100%</td>
<td>-2,182</td>
<td>0.00%</td>
</tr>
<tr>
<td>Processed by DTR</td>
<td>0-15 days</td>
<td>4,576</td>
<td>76.0%</td>
<td>5,068</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>
</tr>
<tr>
<td></td>
<td>16-30 days</td>
<td>611</td>
<td>10.2%</td>
<td>690</td>
<td>10.3%</td>
<td>-70</td>
<td>0.10%</td>
<td>1,226</td>
<td>14.0%</td>
<td>-615</td>
<td>(4.70%)</td>
</tr>
<tr>
<td></td>
<td>31-60 days</td>
<td>371</td>
<td>6.20%</td>
<td>503</td>
<td>7.50%</td>
<td>-132</td>
<td>1.30%</td>
<td>600</td>
<td>7.30%</td>
<td>-299</td>
<td>(1.10%)</td>
</tr>
<tr>
<td></td>
<td>61-90 days</td>
<td>128</td>
<td>2.10%</td>
<td>112</td>
<td>1.70%</td>
<td>16</td>
<td>(0.40%)</td>
<td>202</td>
<td>2.50%</td>
<td>-74</td>
<td>(0.40%)</td>
</tr>
<tr>
<td></td>
<td>91-120 days</td>
<td>77</td>
<td>1.30%</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>
</tr>
<tr>
<td></td>
<td>121-180 days</td>
<td>90</td>
<td>1.50%</td>
<td>66</td>
<td>1.00%</td>
<td>25</td>
<td>(0.50%)</td>
<td>166</td>
<td>2.00%</td>
<td>-76</td>
<td>(0.50%)</td>
</tr>
<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>(2.00%)</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>6,019</td>
<td>100%</td>
<td>6,705</td>
<td>100%</td>
<td>-685</td>
<td>0.00%</td>
<td>8,201</td>
<td>100%</td>
<td>-2,182</td>
<td>0.00%</td>
</tr>
<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>
</tr>
<tr>
<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>
</tr>
<tr>
<td></td>
<td>Rejected</td>
<td>173</td>
<td>2.90%</td>
<td>258</td>
<td>3.80%</td>
<td>-85</td>
<td>0.90%</td>
<td>305</td>
<td>3.70%</td>
<td>-132</td>
<td>(0.80%)</td>
</tr>
<tr>
<td></td>
<td>Canceled</td>
<td>73</td>
<td>1.20%</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>0.80%</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>6,019</td>
<td>100%</td>
<td>6,705</td>
<td>100%</td>
<td>-685</td>
<td>0.00%</td>
<td>8,201</td>
<td>100%</td>
<td>-2,182</td>
<td>0.00%</td>
</tr>
<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>0.70%</td>
</tr>
<tr>
<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>
</tr>
<tr>
<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>
<td>0.00%</td>
</tr>
<tr>
<td>Report identifier</td>
<td>Description</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------</td>
<td>-------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Data category: Processed by origin (Location: Column one)</strong></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>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Data category: Processed by place of service (Location: Column one)</strong></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>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Data category: Processed by category (Location: Column one)</strong></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>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Data category: Processed by DTR (Location: Column one)</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>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Data category: Processed by claim status (Location: Column one)</strong></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>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Data category: RTP (Location: Column one)</strong></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>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| **Data category: Processed by origin**  
*Data type: Automated (Location: Column two)* | The number/percentage of claims that were submitted by the facility or by peer facilities electronically (i.e., “Automated”) during the specified time period. |
| **Data category: Processed by origin**  
*Data type: Hard copy (Location: Column two)* | 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. |
<table>
<thead>
<tr>
<th>Report identifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Data category: Processed by origin</strong>&lt;br/&gt;<em>Data type: Total</em>&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>
</tr>
<tr>
<td><strong>Data category: Processed by place of service</strong>&lt;br/&gt;<em>Data type: Varies</em>&lt;br/&gt;(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>
</tr>
<tr>
<td><strong>Data category: Processed by category</strong>&lt;br/&gt;<em>Data type: Clean claims</em>&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 processed successfully.</td>
</tr>
<tr>
<td><strong>Data category: Processed by category</strong>&lt;br/&gt;<em>Data type: Rejected claims</em>&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>
</tr>
<tr>
<td><strong>Data category: Processed by category</strong>&lt;br/&gt;<em>Data type: Duplicate claims</em>&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 duplicates (i.e., submitted more than once).</td>
</tr>
<tr>
<td><strong>Data category: Processed by category</strong>&lt;br/&gt;<em>Data type: Adjustments</em>&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 processed after the claims were adjusted.</td>
</tr>
<tr>
<td><strong>Data category: Processed by category</strong>&lt;br/&gt;<em>Data type: Line denials</em>&lt;br/&gt;(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>
</tr>
<tr>
<td><strong>Data category: Processed by category</strong>&lt;br/&gt;<em>Data type: Total</em>&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>
</tr>
<tr>
<td><strong>Data category: Processed by DTR</strong>&lt;br/&gt;<em>Data type: Date ranges</em>&lt;br/&gt;(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>
</tr>
<tr>
<td>Report identifier</td>
<td>Description</td>
</tr>
<tr>
<td>------------------</td>
<td>-------------</td>
</tr>
</tbody>
</table>
| **Data category: Processed by claim status**  
*Data type: Paid claims*  
*(Location: Column two)* | The volume/percentage of claims -- submitted by the facility or by peer facilities during the specified time period -- that were paid. |
| **Data category: Processed by claim status**  
*Data type: Denied claims*  
*(Location: Column two)* | The volume/percentage of claims -- submitted by the facility or by peer facilities during the specified time period -- that were denied. |
| **Data category: Processed by claim status**  
*Data type: Rejected claims*  
*(Location: Column two)* | The volume/percentage of claims -- submitted by the facility or by peer facilities during the specified time period -- that were rejected. |
| **Data category: Processed by claim status**  
*Data type: Canceled claims*  
*(Location: Column two)* | The volume/percentage of claims -- submitted by the facility or by peer facilities during the specified time period -- that were canceled by the submitter. |
| **Data category: Processed by claim status**  
*Data type: Total*  
*(Location: Column two)* | The total number/percentage of claims that were submitted by the facility or by peer facilities during the specified time period. |
| **Data category: RTP**  
*Data type: Automated*  
*(Location: Column two)* | 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). |
| **Data category: RTP**  
*Data type: Hard copy*  
*(Location: Column two)* | 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). |
| **Data category: RTP**  
*Data type: Total*  
*(Location: Column two)* | 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). |
| **FEB12 (i.e., Month 1)**  
*(Location: Column three)* | Facility’s data -- from all six data categories -- that pertain to the first month listed. |
| **% of total (A)**  
*(Location: Column four)* | Facility’s data -- percentages of claim volumes (from all six data categories) -- for the first month listed. |
<table>
<thead>
<tr>
<th>Report identifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<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>
</tr>
<tr>
<td>(Location: Column five)</td>
<td></td>
</tr>
<tr>
<td>% of total (B)</td>
<td>Facility’s data -- percentages of claim volumes (from all six data categories) -- for the second month listed.</td>
</tr>
<tr>
<td>(Location: Column six)</td>
<td></td>
</tr>
<tr>
<td>Change FEB12-MAR12</td>
<td>Comparison of facility’s data -- from all six data categories -- volume changes between the first and second months listed.</td>
</tr>
<tr>
<td>(i.e., Month 1-Month 2)</td>
<td></td>
</tr>
<tr>
<td>(Location: Column seven)</td>
<td></td>
</tr>
<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>
</tr>
<tr>
<td>(Location: Column eight)</td>
<td></td>
</tr>
<tr>
<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>
</tr>
<tr>
<td>(Location: Column nine)</td>
<td></td>
</tr>
<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>
</tr>
<tr>
<td>(Location: Column 10)</td>
<td></td>
</tr>
<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>
</tr>
<tr>
<td>(Location: Column 11)</td>
<td></td>
</tr>
<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>
</tr>
<tr>
<td>(Location: Column 12)</td>
<td></td>
</tr>
</tbody>
</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 119: PDS Request Message Code Table -- Part A

![PDS Request Message Code Table -- Part A](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](#).

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 120: 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:
### Comparative Data Table (PDS -- Part B)

<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>Change FEB12-MAR12</th>
<th>% Change (B-A)</th>
<th>FEB12 Peers AVG</th>
<th>% of total (C)</th>
<th>Diff(+-)</th>
<th>%Diff(A-C)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claim Totals</td>
<td>Total Allowed $</td>
<td>95,468</td>
<td>91,942</td>
<td>3,526</td>
<td>134,919</td>
<td>39,451</td>
<td>29.46%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total Approved $</td>
<td>75,057</td>
<td>72,884</td>
<td>2,173</td>
<td>102,228</td>
<td>27,171</td>
<td>27.17%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Message Code Table (PDS -- Part B)

<table>
<thead>
<tr>
<th>Message Code</th>
<th>Message</th>
<th>Volume</th>
</tr>
</thead>
<tbody>
<tr>
<td>CO 170</td>
<td>Payment is denied when performed/billed by this type of provider.</td>
<td>2</td>
</tr>
<tr>
<td>CO 21</td>
<td>This injury/illness is the liability of the no-fault carrier.</td>
<td>1</td>
</tr>
<tr>
<td>CO 22</td>
<td>This care may be covered by another payer per coordination of benefits.</td>
<td>1</td>
</tr>
<tr>
<td>CO 11</td>
<td>The diagnosis is inconsistent with the procedure.</td>
<td>1</td>
</tr>
<tr>
<td>CO 17</td>
<td>Information requested from the Billing/Rendering Provider was not provided or was insufficient to complete.</td>
<td>1</td>
</tr>
<tr>
<td>CO 31</td>
<td>Patient cannot be identified as our insured.</td>
<td>7</td>
</tr>
<tr>
<td>CO 24</td>
<td>Charges are covered under a capitation agreement/managed care plan.</td>
<td>6</td>
</tr>
</tbody>
</table>

**Figure 121:** PDS Request Results Page – Part B

**Figure 122:** 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> (Location: Column one)</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> (Services)</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> (Location: Column one)</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> (Location: Column one)</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> (Location: Column one)</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>
</tbody>
</table>
| **Data category: Claim Totals** 
*Data type: Total Allowed $* 
(Location: Column two) | 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.                                                      |
| **Data category: Claim Totals** 
*Data type: Total Approved $* 
(Location: Column two) | The total amount (in dollars) of approved claims for services billed by the provider or the provider’s peers during the specified time period.                                                                   |
| **Data category: Claim Totals** 
*Data type: Total Claims Approved* 
(Location: Column two) | The total number of approved claims for services billed by the provider or the provider’s peers during the specified time period.                                                                                  |
| **Data category: Claim Volumes** (Services) 
*Data type: Approved* 
(Location: Column two) | The total number/percentage of approved services billed in claims submitted by the provider or the provider’s peers during the specified time period.                                                            |
<table>
<thead>
<tr>
<th>Report identifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Data category: Claim Volumes (Services)</strong></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><em>Data type: Denied</em></td>
<td></td>
</tr>
<tr>
<td><em>(Location: Column two)</em></td>
<td></td>
</tr>
<tr>
<td><strong>Data category: Claim Volumes (Services)</strong></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><em>Data type: Duplicate</em></td>
<td></td>
</tr>
<tr>
<td><em>(Location: Column two)</em></td>
<td></td>
</tr>
<tr>
<td><strong>Data category: Claim Volumes (Services)</strong></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><em>Data type: Subtotal (Processed)</em></td>
<td></td>
</tr>
<tr>
<td><em>(Location: Column two)</em></td>
<td></td>
</tr>
<tr>
<td><strong>Data category: Claim Volumes (Services)</strong></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><em>Data type: Unprocessable</em></td>
<td></td>
</tr>
<tr>
<td><em>(Location: Column two)</em></td>
<td></td>
</tr>
<tr>
<td><strong>Data category: Claim Volumes (Services)</strong></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><em>Data type: Total</em></td>
<td></td>
</tr>
<tr>
<td><em>(Location: Column two)</em></td>
<td></td>
</tr>
<tr>
<td><strong>Data category: Claim Billed Dollars (Services)</strong></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><em>Data type: Approved</em></td>
<td></td>
</tr>
<tr>
<td><em>(Location: Column two)</em></td>
<td></td>
</tr>
<tr>
<td><strong>Data category: Claim Billed Dollars (Services)</strong></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><em>Data type: Denied</em></td>
<td></td>
</tr>
<tr>
<td><em>(Location: Column two)</em></td>
<td></td>
</tr>
<tr>
<td><strong>Data category: Claim Billed Dollars (Services)</strong></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><em>Data type: Duplicate</em></td>
<td></td>
</tr>
<tr>
<td><em>(Location: Column two)</em></td>
<td></td>
</tr>
<tr>
<td><strong>Data category: Claim Billed Dollars (Services)</strong></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><em>Data type: Subtotal (Processed)</em></td>
<td></td>
</tr>
<tr>
<td><em>(Location: Column two)</em></td>
<td></td>
</tr>
<tr>
<td>Report identifier</td>
<td>Description</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Data category: Claim Billed Dollars</strong> (Services)</td>
<td>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).</td>
</tr>
<tr>
<td><strong>Data type: Unprocessable</strong> (Location: Column two)</td>
<td></td>
</tr>
<tr>
<td><strong>Data category: Claim Billed Dollars</strong> (Services)</td>
<td>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.</td>
</tr>
<tr>
<td><strong>Data type: Total</strong> (Location: Column two)</td>
<td></td>
</tr>
<tr>
<td><strong>Data category: % of Services Received</strong></td>
<td>The percentage of processed 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 type: Processed</strong> (Location: Column one)</td>
<td></td>
</tr>
<tr>
<td><strong>Data category: % of Services Received</strong></td>
<td>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).</td>
</tr>
<tr>
<td><strong>Data type: Unprocessable</strong> (Location: Column one)</td>
<td></td>
</tr>
<tr>
<td><strong>Data category: % of Services Processed</strong></td>
<td>The percentage of processed 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 type: Denied</strong> (Location: Column one)</td>
<td></td>
</tr>
<tr>
<td><strong>Data category: % of Services Received</strong></td>
<td>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).</td>
</tr>
<tr>
<td><strong>Data type: Duplicate</strong> (Location: Column one)</td>
<td></td>
</tr>
<tr>
<td><strong>Number of patients</strong></td>
<td>Number of beneficiaries for whom services were furnished by the provider or the provider’s peer group during the specified time period.</td>
</tr>
<tr>
<td><strong>FEB12 (i.e., Month 1)</strong> (Location: Column three)</td>
<td>Provider’s data -- from all five data categories -- that pertain to the first month listed.</td>
</tr>
<tr>
<td><strong>% of total (A)</strong> (Location: Column four)</td>
<td>Provider’s data -- percentages of claim volumes (services), and claim billed dollars (services) -- for the first month listed.</td>
</tr>
<tr>
<td><strong>MAR12 (i.e., Month 2)</strong> (Location: Column five))</td>
<td>Provider’s data -- from all five data categories -- that pertain to the second month listed.</td>
</tr>
<tr>
<td><strong>% of total (B)</strong> (Location: Column six)</td>
<td>Provider’s data -- percentages of claim volumes (services), and claim billed dollars (services) -- for the second month listed.</td>
</tr>
<tr>
<td>Report identifier</td>
<td>Description</td>
</tr>
<tr>
<td>------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>Change FEB12-MAR12 (i.e., Month 1-Month 2) (Location: Column seven)</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) (Location: Column eight)</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 (Location: Column nine)</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) (Location: Column 10)</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 (+/-) (Location: Column 11)</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) (Location: Column 12)</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>
PDS report -- Part B: Message code 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.

![PDS Request Message Code Table -- Part B](image)

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.

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 124: 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 125: Provider-specific CBR Request: Request Status – Part B](image)
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 126: Part B – Provider-specific CBR: Report descriptors
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) Svcs.</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. Svcs.</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. Calculated by: Total services billed by provider’s Peer Group or Specialty for a specific service divided by the total services billed for all services rendered by provider’s Peer Group or Specialty multiplied by 100</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. Calculated by: 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 Peer Group or Specialty for all beneficiaries serviced by that Peer Group or Specialty. Calculated by: Total services billed for a specific service for all providers in the Peer Group or Specialty divided by the total number of beneficiaries serviced by the Peer Group or Specialty</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 (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 (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) |
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.

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)

![Retrieve secure documentation](image_url)
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 131:** 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 132:** 1099 form pending

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

**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:
Figure 133: Secure Documentation: Check Status: Query Form

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.

### 6.6 TROUBLESHOOTING & SUPPORT

**Error Messages**

**Permission Error**

1. To use the SPOT, you must complete both parts of the new user registration process through the IDM website. The first step of the process is to create your IDM account, which will contain your personal information (e.g., name, home address, email address, date of birth). However, having an IDM 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 IDM 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 permission error message will be returned:
Figure 134: Permission Error

4. If you have an IDM 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 IDM account User ID and request confirmation number.

5. Clear your internet browser’s cache between logins. If you have acquired an IDM 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 IDM 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 IDM 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.

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., IDM, HETS, FISS) due to scheduled/unscheduled maintenance.

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.
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.

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.

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.

Technical Support

<table>
<thead>
<tr>
<th>Organization</th>
<th>Telephone</th>
<th>Email</th>
<th>Role/Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Coast SPOT</td>
<td>855-416-4199</td>
<td><a href="mailto:FCSOSPOTHelp@FCSO.com">FCSOSPOTHelp@FCSO.com</a></td>
<td>SPOT first-level user support and problem reporting</td>
</tr>
<tr>
<td>Help Desk</td>
<td>(press 1 general assistance; 2 for enrollment)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


## 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>
<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>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>Term</td>
<td>Definition</td>
</tr>
<tr>
<td>------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Peer Group</td>
<td>A group of providers that either use the same type of bill (e.g., I76x) 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>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>
## 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>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>MCA</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>POS</td>
<td>Point of Service</td>
</tr>
<tr>
<td>PPA</td>
<td>Project Process Agreement</td>
</tr>
</tbody>
</table>
### 9. Referenced Documents

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

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

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<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTAN</td>
<td>Provider Transaction Access Number</td>
</tr>
<tr>
<td>RUG</td>
<td>Resource Utilization Group</td>
</tr>
<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>
</tr>
<tr>
<td>SOW</td>
<td>Statement of Work</td>
</tr>
<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>
</tr>
</tbody>
</table>