

Novitasphere Part A User Manual



Updated 04.07.2024

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1. General Information

1.1. Portal Feature Access

All Novitasphere users receive the same level of access to all the features in Novitasphere. Features available are based on the provider enrollment details. This user manual pertains to Part A organizations. All Part A facilities, except Military Treatment Facilities (MTFs), will receive access to all features listed. MTFs have access to only the following features:

- Eligibility
- MBI Lookup
- Claim Info > Claim Status
- Retrieve Documents > View/Retrieve Remittance Advice

1.2. Accessibility Information

Novitasphere has been carefully designed with various accessibility options to allow use by all individuals. These options include the ability to:

- Change the font size without sacrificing usability
- Navigate the application using just a keyboard (with the use of assistive software such as JAWS)
- Listen to most of the website and the user guide using a screen reader (with the use of assistive software such as JAWS)

If you encounter issues with your assistive technology and its compatibility with Novitasphere, please use our Accessibility Request Form to request assistance:

- JL: <https://www.novitas-solutions.com/webcenter/portal/MedicareJL/pagebyid?contentId=00180501>

- JH: <http://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00180501>

1.3. Glossary of Terms

- **Novitasphere** - Novitas Solutions free, web-based application which offers access to claims, eligibility, and more for Novitas Solutions providers, billing services, and clearinghouses.
- **837 Claim File** - Inbound Electronic Claim File.
- **999 Acknowledgement** - Indicates whether the file successfully passed the initial file structure edits.
- **277CA Claims Acknowledgement** - The 277CA indicates whether claims have been accepted or rejected for processing consideration.
- **835 Electronic Remittance Advice (ERA)** - The ERA is the Health Insurance Portability and Accountability Act (HIPAA)-compliant remittance file containing finalized payment or rejection information from the Medicare processing system.

1.4. Acronym Listing

- **ADR** - Additional Documentation Request
- **EDI** - Electronic Data Interchange
- **DCN** - Document Control Number
- **GIF** - Graphics Interchange Format
- **HHEH** - Home Health Eligibility History
- **IDM** - Identity Management
- **MAP** - Medicare Advantage Plan
- **MDPP** - Medicare Diabetes Prevention Program
- **MBI** - Medicare Beneficiary Identifier
- **MSP** - Medicare Secondary Payer
- **NPI** - National Provider Identifier
- **PDF** - Portable Document Format in Adobe Acrobat Reader software
- **PTAN** - Provider Transaction Access Number
- **PPV** - Pneumococcal Pneumonia Vaccination
- **QMB** - Qualified Medicare Beneficiary program
- **SSN** - Social Security Number
- **TIFF** - Tagged Image File Format

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2. Getting Started

2.1. Access Novitasphere

To access the Novitasphere website, you must be running Microsoft Edge, Google Chrome, Apple Safari, or Mozilla Firefox.

Once you have registered in Identity Management (IDM), and been approved under a specific role, navigate to the Novitasphere URL below and log in.

Accept the disclaimer displayed on the screen to proceed to the Novitasphere home page, see **Figure 1 – Novitasphere Disclaimer**.

If you have received new mail, a message will appear on the home screen indicating “New Messages! Please check your Retrieve Documents Mailbox for new correspondence.” Important Medicare Communications messages may also appear in the home screen.

Note - After 30 minutes of inactivity, Novitasphere will automatically log you off, and you will need to sign back on to Novitasphere to continue.

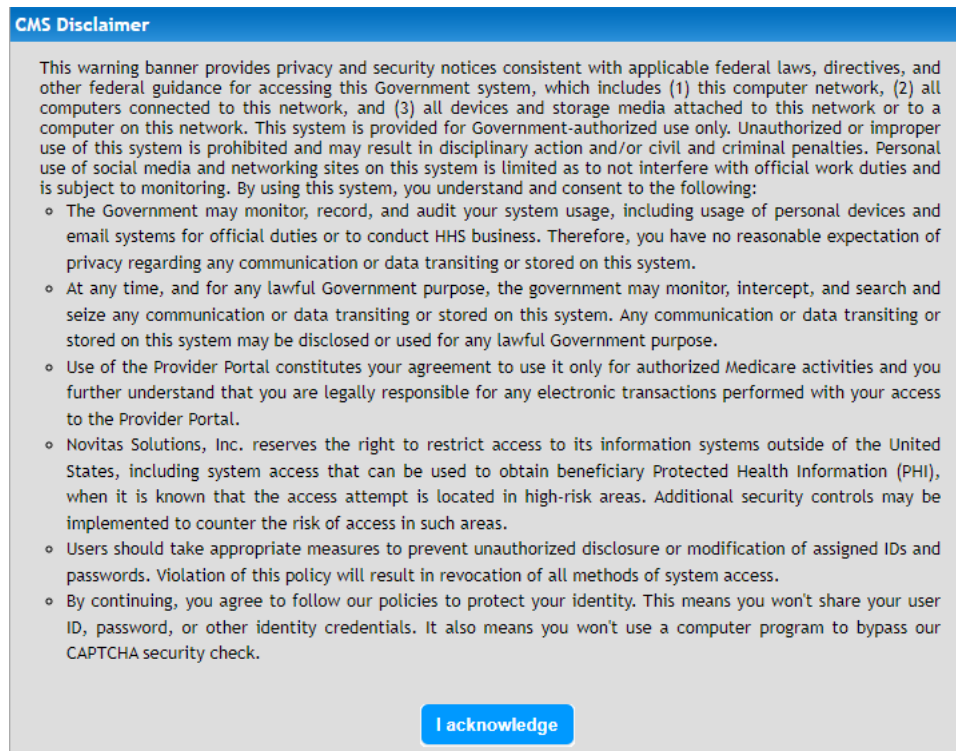


Figure 1 – Novitasphere Disclaimer

2.1.2. Multiple Organizations and/or Providers:

Upon successful login, if you have roles for more than one organization, you will be asked to select an organization and/or provider. You also can “Switch Organizations” and “Switch Providers” at any time once logged in by using the links in the upper right corner of the screen.

The “Switch Organizations” capability is used to select between organizations that you have been approved to access.

The “Switch Providers” capability is used to select a provider that is linked to the organization you have selected.

Note - If you have access to only one organization, you will not have the “Switch Organizations” option. If your organization only has one provider linked, you will not have the “Switch Provider option.

To switch organization: Select the dropdown arrow as displayed in **Figure 2 – Switch Organization** to select the appropriate Organization.

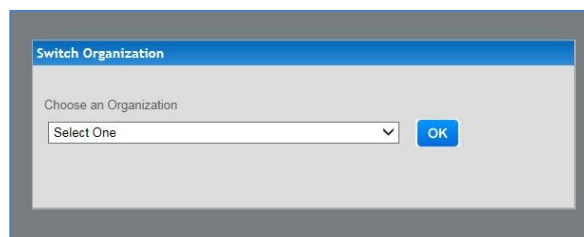


Figure 2 - Switch Organization

To switch providers: Select the dropdown arrow as displayed in **Figure 3 – Switch Provider** to choose the Provider you wish to view.



Figure 3 – Switch Provider

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3. Printing in Novitasphere

Select the **“PDF”** icon on the screen you would like to print. This opens a PDF of all information. You will need Adobe Acrobat Reader software. Once the PDF document is open, you may print to your local printer.

If the “PDF” icon is not available on your screen you will need to perform a browser print by clicking “File, Print” on your browser toolbar.



Figure 4 – PDF Icon

4. Eligibility

Novitasphere interfaces with the CMS HIPAA Eligibility Transaction System (HETS) to obtain eligibility information. HETS is considered the authoritative source for beneficiary information. Per CMS, “The HIPAA Eligibility Transaction System (HETS) is intended to allow the release of eligibility data to Medicare providers or their authorized billing agents for the purpose of preparing an accurate Medicare claim, determining beneficiary liability, or determining eligibility for specific services.” More information about HETS can be found at <https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp/index.html>.

Medicare Diabetes Prevention Program (MDPP) providers enrolled with specialty D1: Effective with the April 16, 2018 release, the modified MDPP supplier Eligibility response will return only the following information (as applicable for the Medicare Beneficiary):

- Medicare Beneficiary Demographics
- Date of Death
- Unlawful Occurrences
- Medicare Part B Entitlement
- MDPP Coverage
- ESRD - Medicare Beneficiaries in an active ESRD occurrence are not MDPP eligible.
- Medicare Advantage (MA) Enrollment(s) - Contact the MA plan for MDPP Coverage Information.
- Medicare as a Secondary Payer (MSP) Enrollment(s)

4.1. Check Eligibility

To obtain Benefit Eligibility Details: Select the **Eligibility** option on the Novitasphere toolbar and then select Check Eligibility from the sub-menu options, as shown in **Figure 5 – Benefit & Eligibility Input**.

The screenshot displays the 'Benefit Eligibility Details' page in the Novitasphere portal. The page has a blue header with navigation links: Home, Reference, Self Service Tools, Contact Us, Live Chat, Switch Organization, and Switch Provider. On the left, a sidebar lists various services: Eligibility (with a sub-menu for Check Eligibility and ACO Reach), MBI Lookup, Claims Submission/ERA, Claims Info, Medical Review Claims, Retrieve Documents, Submit Documents, Alerts & Updates, and My Account Profile. The main content area is titled 'Benefit Eligibility Details' and contains a form for entering beneficiary information. The form includes a note about data privacy and a list of required fields: First Name, Last Name, Suffix, Medicare Beneficiary ID, Date of Birth, NPI, Date(s) of Service, and Types of Data. There are 'Submit' and 'Clear' buttons at the bottom of the form. A vertical 'FEEDBACK' button is located on the right side of the form area.

Figure 5 – Benefit & Eligibility Input

Enter the following information to complete an eligibility inquiry (*Indicates a required field):

- First Name* (of beneficiary)
- Last Name* (of beneficiary)
- Suffix
- Patient Medicare #*
- Date of Birth
- NPI*
- Date(s) of Service*
- Types of Data – this option may be used to filter the types of data displayed for the patient

The patient's Medicare Beneficiary ID, first and last name are required, and must match. You will need to have this information available to search for eligibility.

Select the **Submit** button displayed in **Figure 5 – Benefit & Eligibility Input**.

The screen shown in **Figure 6 – Benefit & Eligibility Output** will be displayed.

Benefit Eligibility Details Tuesday, June 4, 2019 2:48 PM

To obtain eligibility, you must enter the information as found on the beneficiary's current Medicare card. To protect the privacy of beneficiary data, the subscriber first name, last name and medicare beneficiary id must match the beneficiary's data maintained by Medicare; otherwise, eligibility data will not be returned.

Note: * Indicates a required field. Dates may be entered as MMDDYY or MMDDYYYY. Forward slashes will be populated automatically.

First Name* Last Name*
Suffix Medicare Beneficiary ID*
Date of Birth(MM/DD/YYYY) NPI*
Date(s) of Service* 05/01/2019 TO 06/04/2019 Types of Data All

INQUIRY **BENEFICIARY** **ELIGIBILITY** **DEDUCTIBLE** **MAP** **MSP** **HOSPICE/HOME HEALTH** **PREVENTIVE** **INPATIENT** **QMB**

CMS mailed a Medicare card with a new Medicare Beneficiary Identifier (MBI) to this beneficiary. Medicare providers, please get the new MBI from your patient and save it in your system(s).

Inquiry Information

Subscriber First Name	
Subscriber Last Name	
Subscriber Date of Birth	
Subscriber Medicare #	
Date of Service/Date of Service Range	

Figure 6 – Benefit & Eligibility Output

The information entered will be displayed in the **Inquiry** Tab, as displayed in **Figure 6 – Benefit & Eligibility Output**. When there is data available under a specific category, the tab will be displayed in blue. When there is no data available under a specific category, the tab will be displayed in grey.

To complete another inquiry: Select the Clear button, as displayed in **Figure 6 – Benefit & Eligibility Output**. Enter new inquiry information, and select the Submit button, as displayed in **Figure 6 – Benefit & Eligibility Output**. If the eligibility inquiry transaction fails, an error message will be displayed, as shown in **Figure 7 – Benefit & Eligibility Error Message**.

Benefit Eligibility Details Thursday, March 22, 2018 12:41 PM

To obtain eligibility, you must enter the information as found on the beneficiary's current Medicare card. To protect the privacy of beneficiary data, the subscriber first name, last name and medicare beneficiary id must match the beneficiary's data maintained by Medicare; otherwise, eligibility data will not be returned.

Note: * Indicates a required field. Dates may be entered as MMDDYY or MMDDYYYY. Forward slashes will be populated automatically.

Validation Error(s):

- Medicare Beneficiary ID is Required.

First Name* Last Name*

Suffix Medicare Beneficiary ID*

Date of Birth(MM/DD/YYYY) NPI*

Date(s) of Service* 03/22/2017 TO 03/22/2018 Types of Data All

Figure 7 – Benefit & Eligibility Error Message

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Click to Lookup MBI

To obtain the Medicare Beneficiary Identifier (MBI) of a beneficiary after viewing Eligibility: Select the **Click to Lookup MBI** button as shown in **Figure 6 – Benefit & Eligibility Output**. This will take you directly to the [MBI Lookup](#) feature. The beneficiary First Name, Last Name, and the provider NPI will be populated. You will need to enter the beneficiary's Social Security Number and Date of Birth to complete your MBI Lookup search.

Once-in-a-Lifetime Preventative Services

Novitasphere displays once-in-a-lifetime preventative benefits in the Eligibility feature. If the patient has not yet had one of the once-in-a-lifetime codes, the procedure code will display with the "Next Technical Date" and "Next Professional Date" dates populated. These dates will indicate the next time the patient is eligible for the service. This date may even be a past date if the patient has already been eligible for that service for some time.

Additionally, certain once-in-a-lifetime codes like the initial Welcome to Medicare visit (which is only eligible within the first 12 months of their Medicare coverage) may still display the procedure code within the search results, but with no "next date" populated. This indicates the patient is no longer eligible for that procedure code. Codes such as pneumonia vaccinations and boosters, will display in the Pneumococcal Pneumonia Vaccination (PPV) With Prior Usage section. If the patient has already had one of the codes, the date of service and the billing NPI of the provider that administered the vaccine will be displayed. If the beneficiary has not received a PPV, then no information will display.

4.1.2. Eligibility Tab Definitions

4.1.2.1. Inquiry Tab

Field Name	Information Displayed
Subscriber First Name	First Name the exact way it was typed in the search.
Subscriber Last Name	Last Name the exact way it was typed in the search.
Subscriber Date of Birth (MMDDYYYY)	Date of Birth the exact way it was typed in the search.
Subscriber Medicare #	Patient Medicare number the exact way it was typed in the search.
Date of Service/Date of Service Range	The Date of Service/Date of Service Range as it was typed in the search. See the table below of acceptable query date ranges.

Note – An error message stating "The _____ provided for this Beneficiary does not match what we have on file or is invalid. Please verify this information with the Beneficiary" will generate if the information is not keyed correctly.

4.1.2.2. Table of Acceptable Query Date Ranges

If the Current Month is:	Historical Requests Are Valid Through:	Future Requests Are Valid Through:
January	January, 4 years ago	May of the current year
February	February, 4 years ago	June of the current year
March	March, 4 years ago	July of the current year
April	April, 4 years ago	August of the current year
May	May, 4 years ago	September of the current year
June	June, 4 years ago	October of the current year
July	July, 4 years ago	November of the current year
August	August, 4 years ago	December of the current year
September	September, 4 years ago	January of the following year
October	October, 4 years ago	February of the following year
November	November, 4 years ago	March of the following year
December	December, 4 years ago	April of the following year

4.1.2.3. Beneficiary Tab

Field Name	Information Displayed
Subscriber First Name	First Name of the Beneficiary.
Subscriber Last Name	Last Name of the Beneficiary.
Subscriber Middle Name	Middle Name of the Beneficiary.
Subscriber Address	Address of the Beneficiary
Subscriber Date of Birth (MMDDYYYY)	Date of Birth of the Beneficiary.
Subscriber Medicare #	Medicare number of the Beneficiary.
Subscriber Date of Death	Date of Death of the Beneficiary.
Date of Service/Date of Service Range	The Date of Service/Date of Service Range as it was typed in the search.

4.1.2.4. Eligibility Tab

Field Name	Information Displayed
Medicare Beneficiary Entitlement Reason	One of the following messages will display: Beneficiary insured due to age Old Age & Survivors Insurance (OASI). Beneficiary insured due to disability. Beneficiary insured due to End Stage Renal Disease (ESRD). Beneficiary insured due to disability and current ESRD.
Part A Eligibility - Effective Date	A date that indicates the start of eligibility for Medicare Part A.
Part A Eligibility - Termination Date	A date that indicates termination of eligibility for Medicare Part A. No date in this field means Medicare Part A eligibility has not terminated.
Part B Eligibility - Effective Date	A date that indicates the start of eligibility for Medicare Part B.
Part B Eligibility - Termination Date	A date that indicates termination of eligibility for Medicare Part B. No date in this field means Medicare Part B eligibility has not terminated.

Field Name	Information Displayed
Inactive Periods- Effective Date	A date that indicates the start of the beneficiary's inactive period for Medicare Part A and B.
Termination Date	A date that indicates the termination of the beneficiary's inactive period for Medicare Part A and B. No date in this field means the beneficiary is still in an inactive state for Medicare Part A and B.
End Stage Renal Disease (ESRD) Effective Date	A date that indicates the start of the beneficiary's ESRD coverage period.
End Date	A date that indicates the end of the beneficiary's ESRD coverage period.
Dialysis Start Date	The date dialysis started.
Dialysis End Date	The date dialysis ended.
Transplant Effective Date	The date the transplant occurred.
Acupuncture Benefits Technical Sessions Remaining	The number of technical sessions remaining.
Next Technical Date	The next technical date the beneficiary is eligible.
Professional Sessions Remaining	The number of professional sessions remaining.
Next Professional Date	The next professional date the beneficiary is eligible.

4.1.2.5. Deductible Tab

Field Name	Information Displayed
XXXX Year Part A and B Remaining- Deductible	Remaining Deductible amount associated with the calendar year indicated
Free Services	Deductible Year and deductible. Deductibles do not apply for the following free services: diagnostic lab, home health care, hospice, smoking cessation, alcoholism treatment. They are covered at 100% by Medicare.
Blood Deductible	Calendar year and number of units remaining.
Therapy CAP Occupational, Physical, and Speech Therapy Capitation Amount	The dollar amount used for the current year.
Rehabilitation Sessions Pulmonary Rehabilitation	Total number of sessions remaining.
Cardiac Rehabilitation Intensive Cardiac Rehabilitation	Total number of sessions the beneficiary has had.

4.1.2.6. MAP Tab – Medicare Advantage Plan Information

Field Name	Information Displayed
Contract Name	A descriptive name of the beneficiary's insurance coverage organization
Contractor #	The contract number

Field Name	Information Displayed
Plan No	The plan number (if on file)
Plan Name	The Plan Name
Plan Type	Plan Type Code: 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
MA Bill Opt Code (Medicare Advantage)	The bill option code of the Plan Type. This field only applies to plan types HM, HN, IN, PR, and PS. This field will not be displayed for Part D plan type.
Effective Date	The date that indicates the start of enrollment to the coverage plan
Term 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.
Address	The Coverage Plan's Address
Tel Number	The Coverage Plan's Contract Telephone Number (if on file)

4.1.2.7. MSP Tab – Medicare Secondary Payer Information

Field Name	Information Displayed
Type Code	12 = Medicare Secondary Working Aged Beneficiary or spouse with Employer Group Health Plan 13 = Medicare Secondary End Stage Renal Disease Beneficiary in the 12-month coordination period with an Employer Group Health Plan 14 = Medicare Secondary No-Fault insurance including auto is primary 15 = Medicare Secondary Workers' Compensation 16 = Medicare Secondary Public Health Service (PHS) or another Federal Agency 41 = Medicare Secondary Black Lung 42 = Medicare Secondary Veteran's Administration 43 = Medicare Secondary Disabled Beneficiary Under Age 65 with Large Group Health Plan 47 = Medicare Secondary other liability insurance is primary WC = Workers' Compensation Medicare Set-aside Arrangement
Effective Date	The date that indicates the start of the primary insurer's coverage
Term Date	The date that indicates the termination of the primary insurer's coverage. No date in this field means primary insurance coverage has not terminated.
MSP Diagnosis Code	These are ICD-10 diagnosis codes that are listed on the beneficiaries' MSP file where Medicare is secondary when the services are related to an injury or accident. <i>Note – these will not populate if the MSP file was set up with ICD-9 codes.</i>
Policy Number	Policy Number
Group Number	The group number of the insurance plan.
Patient Relationship	The 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.
Insurer Name	The name of the insurance company.
Address	The address of the insurance company.

4.1.2.8. Hospice/Home Health Tab

Field Name	Information Displayed
Home Health Certification HCPCS Code Certification Date HCPCS Code Recertification Date	<p>The procedure code used for physician certification for Medicare covered home health services.</p> <p>The date of the certification for Home Health Services. The procedure code used for physician re-certification for Medicare covered home health services.</p> <p>The date of the re-certification for Home Health Services.</p>
Home Health Care HHEH Start Date HHEH End Date HHEH DOEBA Date HHEH DOLBA Date Patient Status Code Notice of Admission Indicator (NOA) Provider Number Contract Name Contract Number	<p>The date the 60-day Home Health episode period started.</p> <p>The date that the Home Health episode terminated.</p> <p>The Earliest Billing Date.</p> <p>The Latest Billing Date.</p> <p>This field is used to verify the home health period had ended. 1 = discharged 30 = active</p> <p>This field indicates the type of NOA. 1 = NOA does not fall within an existing admission period 2 = NOA falls within any existing admission period</p> <p>The NPI Number of the Home Health Facility. Medicare Contractor Name. Medicare Contractor Number.</p>
Total Number of Hospice Occurrences	The total Number of Hospice Occurrences.
Hospice Effective Date Termination Date Provider Number Revocation Code	<p>The effective date of the Hospice period.</p> <p>The termination date of the Hospice period.</p> <p>The NPI number of the Hospice Facility.</p> <p>This field is used to verify if the hospice period has ended. 0 = not revoked, open spell 1 = revoked by notice of revocation 2 = revoked by notice of revocation with a non-payment code of "N" and an occurrence code of "42" 3 = revoked by a hospice claim with an occurrence code of "23"</p>

4.1.2.9. Preventative Services Tab

Field Name	Information Displayed
COVID-19 Immunization Data COVID-19 Vaccine Code Immunization Date NPI	<p>This is the procedure code billed for the vaccine and/or administration. <i>Note - Hover over the code to see the definition.</i></p> <p>This is the date of service billed for this vaccination.</p> <p>This is the NPI of the rendering provider.</p>

Field Name	Information Displayed
Smoking Cessation - Remaining Sessions	Number of Smoking Sessions remaining for the beneficiary.
Smoking Cessation – Base Sessions	Number of base Smoking Sessions. This will always be 8.
Smoking Cessation – Initial Session Date	The initial date of the Smoking Session program.
MDPP With No Prior Usage	Procedure codes for MDPP services with no prior usage for the beneficiary.
Services With Prior Usage	Procedure codes for services with usage for the beneficiary, date of service and billing NPI.
Preventive	If beneficiary waived deductible and coinsurance a message will be displayed.
Service Code	Procedure Code
Next Technical Date	The date the beneficiary is eligible for the technical component of the associated procedure code.
Next Professional Date	The date the beneficiary is eligible for the professional component of the associated procedure code.
Calendar Year	Calendar Year
Deductible Applied	Deductible Applied for the Calendar Year.
Deductible Remaining to be met	Deductible Remaining for the Calendar Year.
Coinsurance	Coinsurance Remaining for the Calendar Year.
Cognitive Services	Procedure codes for the Cognitive services with the date of service and NPI of the billing provider.

4.1.2.10. Inpatient Tab

Field Name	Information Displayed
Part A Hospital Stay Spell Information	The date of the earliest/latest billing activity for the spell of illness.
Hospital Stay Start/End Date	The full Hospital stay begin and end dates.
Part A Hospital Data Spell Information	The date of the earliest/latest billing activity for the spell of illness. The full Hospital inpatient days remaining in the spell. The Hospital inpatient co-payment days remaining. The amount of the inpatient co-payment.
Life Time Reserve Days	The number of lifetime reserve days remaining.
Skilled Nursing Facility Data Spell Information	The date of the earliest/latest billing activity for the spell of illness. The full SNF inpatient days remaining in the spell. The SNF inpatient co-payment days remaining. The amount of the inpatient co-payment.

Field Name	Information Displayed
Psychiatric Information	
Life Time Psychiatric Base Days	The Life Time Psychiatric Base Days
Life Time Psychiatric Remaining Days	The remaining Life Time Psychiatric Days

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4.1.2.11. QMB - Qualified Medicare Beneficiary

Field Name	Information Displayed
QMB Medicaid Enrollment	
Effective Date	The date that indicates the start of eligibility for QMB enrollment.
Termination Date	The date that indicates termination of eligibility for QMB enrollment. If the response indicates the QMB enrollment has terminated, please verify the patient's QMB status through the State online Medicaid eligibility systems or other documentation.
Plan Type	
QMB Deductible	
Deductible Year	This field will display the deductible year.
Deductible	This field will always display 0 for a Qualified Medicare Beneficiary.
Remaining	This field will be blank for a Qualified Medicare Beneficiary.
Deductible	
Coinsurance %	This field will always display 0 for a Qualified Medicare Beneficiary.
QMB Inpatient Spell	
DOEBA Date	Earliest Billing Date
DOLBA Date	Latest Billing Date
QMB Hospital Information	
Co-Payment	
Amount	This field will always display 0 for a Qualified Medicare Beneficiary.
Co-Payment Days	
Remaining	The hospital inpatient co-payment days remaining.
Full Days	
Remaining	The full hospital inpatient days remaining in the spell.
QMB SNF Information	
SNF Days	
Remaining	The full SNF inpatient days remaining in the spell.
SNF Co-Payment	
Amount	The amount of the inpatient co-payment. This field will always display 0 for a Qualified Medicare Beneficiary.
SNF Co-Payment	
Days Remaining	The SNF inpatient co-payment days remaining.

4.1.2.12. PBID – Part B Immunosuppressant Drug Benefit

Field Name	Information Displayed
Part B	
Effective Date	The date that indicates the start of eligibility for PBID benefit.
Termination Date	The date that indicates termination of eligibility PBID benefit.

4.2. ACO REACH

This feature provides participants and preferred providers in the Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH) Model (previously named Global and Professional Direct Contracting (GPDC) Model access to their effective payment mechanisms or benefit enhancements.

To obtain ACO REACH Details: Select the **Eligibility** option on the Novitasphere toolbar and then select ACO REACH from the sub-menu options, as shown in **Figure 5 – Benefit & Eligibility Input**.

Verify the prefilled information and add the Demo Code. Select the **Submit** button.

The screen shown in **Figure 7.5 – ACO REACH Participation screen** will be displayed.

ACO ID	NPI	Creation Date	Start Date	Termination Date	Record's Status	Tax Id	View
							View
							View
							View
							View

Figure 7.5 – ACO REACH Participation screen

Select the View button displayed on any line to view details.

ACO ID	CAP
Creation Date	Enhancement Type
Maintenance Date	Model Identifier
NPI	PPA Percentage
Part A Reduction	Part B Reduction
Providers Reduction	Records Demo Code
Start Date	Status
Tax Identification Number	Termination Date
Provider Type	Update Date
Update Status	

Figure 7.8 – ACO REACH Participation Details screen

5. MBI Lookup

Providers must use MBIs for all transactions. The MBI is confidential and should be protected as Personally Identifiable Information (PII) and used only for Medicare related business. Per [CMS MBI education](#), there are three ways to obtain MBIs. This MBI Lookup tool is one of those options.

To obtain the MBI: Select the **MBI Lookup** option on the Novitasphere toolbar, as shown in **Figure 8 – MBI Lookup Input**.

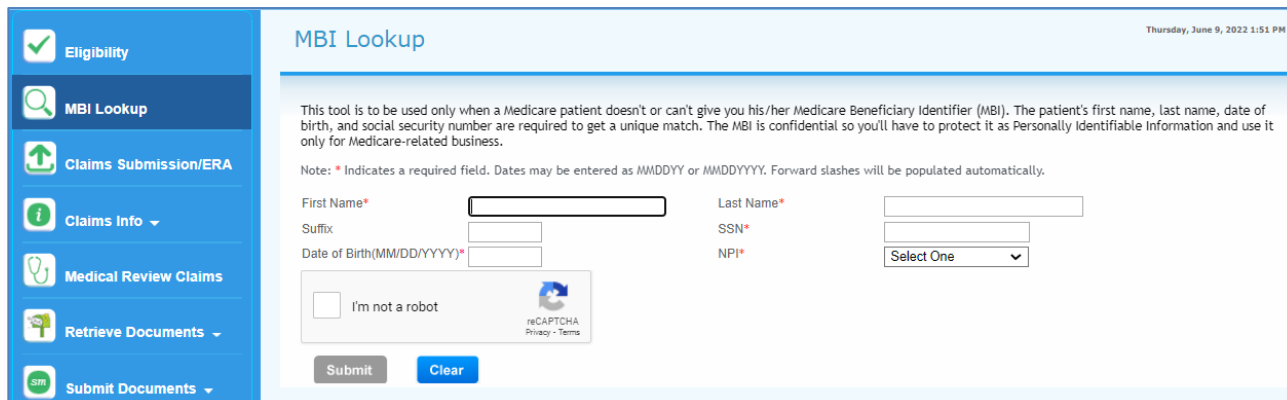


Figure 8 – MBI Lookup Input

Enter the following information to complete the MBI search (*indicates a required field):

- First Name* (of beneficiary)
- Last Name* (of beneficiary)
- Suffix
- Social Security Number (SSN)* - for security purposes, the SSN will be displayed as * when typed
- Date of Birth*
- NPI*

The MBI Lookup requires the patient's first and last names, date of birth, and Social Security number to search. The Social Security number is a CMS required search element as an added security measure and to ensure that the correct patient is located.

Additionally, CMS requires the "I am not a robot" verification once for every five searches. If you are having difficulty verifying the photos, click the icon at the bottom for an audio verification instead. Once you press Play, you will be asked to type the words that are spoken.

Select the Submit button displayed in **Figure 8 – MBI Lookup Input**.

The screen shown in **Figure 9 – MBI Lookup Info** will be displayed when a valid MBI result is found. If the patient is deceased for greater than four years, their information will not be returned.

5.1. Click to View Eligibility

To obtain the beneficiary's eligibility after searching for the MBI: Select the **Click to View Eligibility** button as shown in **Figure 9 – MBI Lookup Info**. This will take you directly to the Eligibility feature. The beneficiary First Name, Last Name, Medicare Beneficiary ID, and the provider NPI will be populated. The Date(s) of Service will default to the current date but may be changed for your Eligibility search.

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6. Claim Submission/ERA

6.1. New Claim Submission/ERA – TIBCO PartnerExpress

The Claims Submission/ERA option allows you to submit electronic claims via batch files (837) and retrieve the electronic reports through TIBCO PartnerExpress.

To open the **Claims Submission/ERA** feature: Select the **Claims Submission/ERA** option on the Novitasphere toolbar as shown in **Figure 11 – Claims Submission/ERA** and click the **Claims Submission/ERA** link.

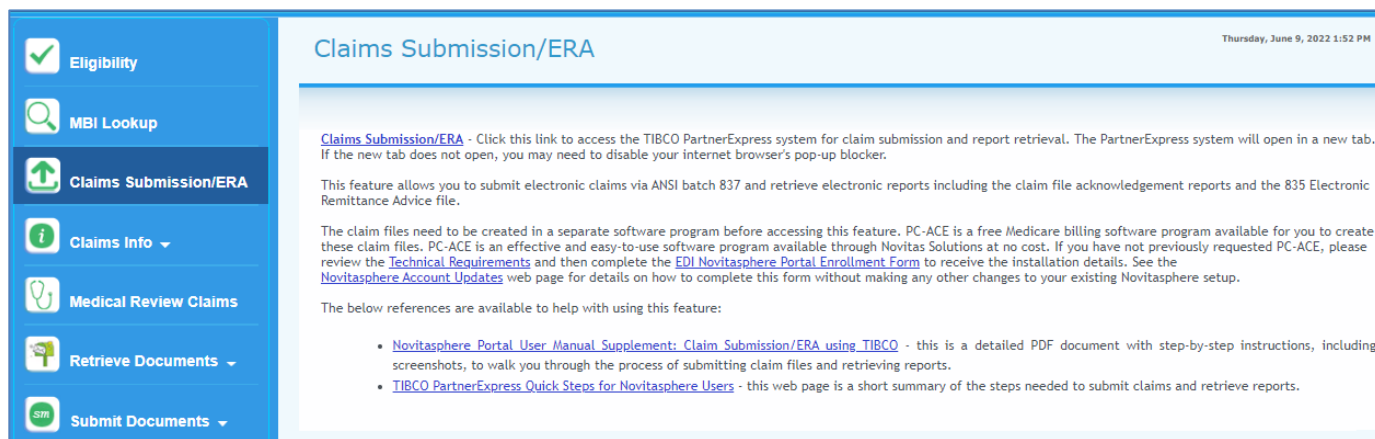


Figure 11 – Claims Submission/ERA

A new browser window will open. If the new window does not open automatically, you may need to turn off your internet browser's pop-up blocker or add the website address to list of the allowed sites. Instructions for turning off the pop-up blocker are in the [Part A Novitasphere Frequently Asked Questions](#).

Detailed information on how to submit claims files and retrieve reports using this feature is available in the [Novitasphere Portal user manual supplement: Claim Submission/ERA using TIBCO](#).

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7. Claims Info

7.1. Financial Info

The Financial Info feature contains the options for Financial Info Search and the Document Control Number (DCN) Lookup Tool. This feature will provide basic payment information for claims processed within 1 year of the current date.

The screen shown in **Figure 27 – Financial Info Options** will be displayed when you select the **Financial Info** option under **Claims Info** on the Novitasphere toolbar.

Figure 27 – Financial Info Options

To obtain check information: Select the Financial Info Search option from the dropdown menu displayed in **Figure 27 – Financial Info Options**.

Select or enter the following data elements to complete a Financial Info Search Inquiry (*Indicates a required field):

- NPI*
- PTAN*
- Check Number
- Check Amount
- Check Status
- Check Issue Date(s)*

Select the **Submit** button.

If you are unable to locate the information initially, we suggest removing extra search criteria, and only searching with the required fields.

NPI	PTAN	Check No	Check Amount	Date Issued	Status Date	Check Status
			\$187.46	10/16/2019	10/17/2019	P
			\$1,603,000.00	08/18/2017	08/21/2017	P
			\$1,603,000.00	08/04/2017	08/07/2017	P
			\$1,603,000.00	07/21/2017	07/24/2017	P
			\$1,603,000.00	07/07/2017	07/10/2017	P

Figure 28 – Financial Info Search Output

The screen shown in **Figure 28 – Financial Info Search Output** will be displayed.

The following information will be displayed.

- NPI
- PTAN
- Check Number
- Check Amount
- Date Issued
- Status Date
- Check Status

Hover your mouse cursor over the Check Status Code to display the definition.

To utilize the DCN Lookup Tool: Select the **DCN Lookup Tool** option from the dropdown menu displayed in **Figure 27 – Financial Info Options**.

This lookup tool provides search options to locate the FISS DCN associated to the HIGLAS DCN (or vice versa) as shown in **Figure 29 - Financial Info DCN Lookup Tool**.

The screenshot shows a web interface titled "Financial Info". Below the title, there is a light blue box containing the following elements:

- A message: "The HIGLAS DCN(s) is found on the Demand Letters. If you receive a 'No data available' error message, verify data entered."
- A note: "Note: * Indicates a required field."
- A "Select One:" dropdown menu with "DCN Lookup Tool" selected.
- Two radio buttons: "HIGLAS TO FISS DCN" (selected) and "FISS TO HIGLAS DCN".
- A text input field labeled "HIGLAS DCN*" with a red asterisk indicating it is a required field.
- Two buttons: "Submit" and "Clear".

Figure 29 – Financial Info DCN Lookup Tool

To convert the HIGLAS DCN to the FISS DCN, select the **HIGLAS TO FISS DCN** radio button.

To convert the FISS DCN to the HIGLAS DCN, select the **FISS TO HIGLAS DCN** radio button.

Then, enter the appropriate DCN per the option selected (**HIGLAS DCN** or **FISS DCN**) and click the **Submit** button. The DCN requested will be provided below the Submit and Clear buttons.

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7.2. Claim Count Summary

The claim count summary feature provides information for how many claims and/or dollars are in specific status locations. The number of claims in any status/locations shown on this screen can change from day to day, since claims process and/or move locations daily.

Note - This feature will not display paid, rejected, or denied claims.

To obtain a claim count summary: Select the **Claim Count Summary** option under Claims Info on the Novitasphere toolbar.

The screen shown in **Figure 30 – Claim Count Summary** will be displayed. You can narrow your view to a particular status/location by entering specific search criteria and clicking **Submit**.

Status	Location	Bill Category	Total Claims	Total Charge Amount	Total Payment
		GT	143	\$379,563.01	\$1,017.01
P	B9996	TC	1	\$9,008.65	\$1,017.01
P	B9996	85	1	\$9,008.65	\$1,017.01
S	MINCO	TC	1	\$19,470.70	\$0.00
S	MINCO	85	1	\$19,470.70	\$0.00
T	B9997	AD	4	\$9,317.22	\$0.00
T	B9997	NM	141	\$351,083.66	\$0.00
T	B9997	TC	141	\$351,083.66	\$0.00
T	B9997	11	8	\$147,988.92	\$0.00
T	B9997	14	17	\$5,419.00	\$0.00

Figure 30 – Claim Count Summary

The following information will be displayed.

- Status
 - P = Pending
 - S = Suspended
 - T = Returned
- Location
 - Identifies where the claim is in the processing cycle
- Bill Category
 - GT = Grand Total
 - TC = Total Count for that location
 - Specific bill types are broken down under this category
 - AD = Adjustments for that location
- Total Claims
 - Represents a total claim count for each specific status/location
- Total Charge Amount
 - Represents the total dollar amount accumulated for each status/location
- Total Payment
 - Represents the total dollar payment amount for claims in the 'P' status location
 - Claims found in the 'S' and 'T' status locations will show zeroes in the total payments

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7.3. Claim Status/Appeal Requests

7.3.1. Claim Status

The claim status feature can be used to obtain status on previously submitted claims.

To obtain Claims Status: Select the **Status & Appeal Requests** option under **Claims Info** on the Novitasphere toolbar, as shown in **Figure 31– Claims Status Input**.

The screenshot shows the 'Claim Search' interface. On the left is a blue sidebar with navigation options: Eligibility, MBI Lookup, Claims Submission/ERA, Claims Info (selected), and Medical Review Claims. Under 'Claims Info', 'Status & Appeal Requests' is highlighted. The main content area has a header with 'Claim Search' and a 'Help' link. Below the header is a text box explaining the search functionality and a note about date formats. The form includes fields for PTAN, State, Medicare Beneficiary ID, DCN, and Date(s) of Service. The 'Date(s) of Service' field is populated with '06/09/2022' and '06/09/2022'. There are 'Submit' and 'Clear' buttons at the bottom of the form.

Figure 31 – Claim Status Input

Select or enter the following data elements to complete a Claim Status Inquiry (*Indicates a required field):

- Medicare Beneficiary ID #*
- Document Control Number (DCN)
- Date(s) of Service*

You can enter the specific Date of Service for the claim you want to view or enter a date range to view all claims for that Medicare Beneficiary ID # for selected Dates of Service.

Select the **Submit** button displayed in **Figure 31 – Claims Status Input**. The screen shown in **Figure 32 – Claims Status Output** will be displayed.

The screenshot shows the 'Claim Search' interface after a search. The sidebar is the same as in Figure 31. The main content area shows the same header and text box. Below the text box, the 'PTAN' field is populated with 'PA'. The 'Medicare Beneficiary ID' field is empty. The 'Date(s) of Service' field is populated with '06/09/2021' and '06/09/2022'. There are 'Submit' and 'Clear' buttons. Below the buttons is a table with the following data:

DCN	NPI	MBI	DOS	Billed Amt	Beneficiary Name	Status	Bill Type	View
			04/20/2022 - 04/20/2022	\$9,008.65		P	851	View
			01/20/2022 - 01/20/2022	\$9,008.65		P	851	View

Payment(S) data is subject to change.

Figure 32 – Claim Status Output

Status code descriptions:

- P - Paid/processed
- R - Rejected
- D - Denied
- S – Suspended
- T - Returned

If multiple pages are returned, you can page forward using the arrows found on the bottom right of the screen.

To view data for an individual claim (or DCN): select **View** on the relevant row from the results tables for the DCN you want to view.

Individual Claim Data/Detailed Claim Data will be displayed as shown in **Figure 33 – Claims Status Output Header Level**.

NPI : Medicare Provider Number : DCN :
Billed Amount : Bill Type : Claim Status :
Claim Location :

PATIENT CLAIM INFO CLAIM INFO PHYSICIAN INFO INSURED INFO PAYER INFO INSURER INFO MSP INFO CODES REMARKS

Name : Sex : Date Of Birth :
Taxonomy Code : Carrier ID : Locality :
Facility ZIP Code : Patient Status : Patient Control Number :
Medical Record Number : Admission Date : Admission Hour :
Admission Type : Admission Source :

< Back View Detail Lines Submit Level 1 Appeal

Figure 33 – Claim Status Output Header Level

Tabs that do not contain claim information will be greyed out, and not accessible. You can select the Back button at any time to go back to the previous screen. Click on the appropriate tabs to view information as detailed below.

Note - click underlined codes on any screen to view a description.

Tab Name	Information Displayed
Patient Claim Info	This tab displays general patient information, patient control number, medical record number, patient status code, admission information, provider zip code, provider carrier, and locality.
Claim Info	<p>This tab displays claim bill type, provider reimbursement amount, dates of service, receipt date of claim, paid date, covered/non-covered days, tape to tape indicator, deductible, and coinsurance amounts.</p> <p>If the claim was cancelled or adjusted, the cancel date and cross ref DCN will display.</p> <p>If the claim processed as a duplicate, the claim duplicate DCN will display.</p>
Physician Info	<p>This tab displays Attending Physician, Operating Physician, Other Physician, Rendering Physician and/or Referring Physician information when reported on the claim.</p> <p>Displays name of physician, NPI and Specialty Code.</p>
Insured Info	This tab displays the order of the insured's information for the selected claim and offsite zip code.
Payer Info	This tab displays the order of the payers for the selected claim.
Insurer Info	This tab displays the Medicare Secondary Payer Insurer address information, if reported on the claim.
MSP	This tab displays the Medicare Secondary Payer information, if reported on the claim.
Codes	<p>This tab displays all coding reported on the claim.</p> <p>A description of the diagnosis codes and/or procedure codes can be viewed by clicking the code. The description will display on screen.</p>
Remarks	This tab displays claim information necessary to process the claim as reported on the claim.

From the Claim Summary screen, you will be able to view claim details by selecting the appropriate Tab or selecting the View Detail Lines.

Click the **View Detail Lines** button to view line level claim information as seen in **Figure 34 – Detail Lines**. The Detail Lines view provides the individual line level payment or denial information.

Claim Summary Detail Lines

Help

Thursday, December 3, 2019 8:41 AM

HIC :

DCN :

CHARGES AND SERVICES

DENIAL REASON

Line Number :

NCD Number :

Medical review Indicator :

HCPC Modifiers :

Prov Reimbursement Ln Amt :

Payment Reduction Amt :

MSP Coinsurance Amt :

1

59

\$59.93

Charges Covered :

ANSI Group :

Units Covered :

Line Item Reason Code :

Total Cont Adj Amt :

Patient Cash Ded. Amt :

Wage Adj Coinsurance Amt :

\$453.00

CO

1.0

\$378.09

\$14.98

HCPC Code :

ANSI Adj Reason :

Org Ln User Action Cd :

Revenue Code :

Patient Resp Amount :

MSP Cash Ded. Amt :

Pay HCPC APC Code :

96360

45

0260

\$14.98

438

Line Number	HCPC Code	Billed Units	Service Date	Total Charges	Rate	Not Covered Charges	View
1	96360	1.0	05/25/2011	\$453.00			View
2	96361	14.0	05/25/2011	\$1,330.00		\$1,330.00	View
3	96361	21.0	05/26/2011	\$1,995.00		\$1,995.00	View
4		1.0	05/25/2011	\$10.00			View
5	G0431	1.0	05/25/2011	\$95.00	95.0		View
6	80053	1.0	05/25/2011	\$63.00	14.87		View
7	82003	1.0	05/25/2011	\$138.00	28.48		View
8	82055	1.0	05/25/2011	\$80.00	15.21		View
9	80196	1.0	05/25/2011	\$51.00	9.98		View
10	85025	1.0	05/25/2011	\$55.00	10.94		View

Payment(\$) data is subject to change.

Back

1

2

3

Figure 34 – Detail Lines

For additional assistance, click the Help link at the top of any Claim Status screen. The description lookup will display as seen in **Figure 35 – Description Lookup**.

Claim Summary

Description Lookup

HIC :

DCN :

CHARGES AND SERVICES

DENIAL REASON

Line Number :

NCD Number :

Medical review Indicator :

HCPC Modifiers :

Prov Reimbursement Ln Amt :

Payment Reduction Amt :

MSP Coinsurance Amt :

1

Charges Covered :

ANSI Group :

Units Covered :

Line Item Reason Code :

Total Cont Adj Amt :

Patient Cash Ded. Amt :

Wage Adj Coinsurance Amt :

\$453.00

CO

1.0

\$378.09

\$14.98

HCPC Code :

ANSI Adj Reason :

Org Ln User Action Cd :

Revenue Code :

Patient Resp Amount :

MSP Cash Ded. Amt :

Pay HCPC APC Code :

96360

45

0260

\$14.98

438

Line Number	HCPC Code	Billed Units	Service Date	Total Charges	Rate	Not Covered Charges	View
1	96360	1.0	05/25/2011	\$453.00			View
2	96361	14.0	05/25/2011	\$1,330.00		\$1,330.00	View
3	96361	21.0	05/26/2011	\$1,995.00		\$1,995.00	View

Payment(\$) data is subject to change.

Back

1

2

3

Figure 35 – Description Lookup

To view the definition of a code, enter the code and click Search.

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7.3.2. Appeal Requests

The Appeal Requests feature can be used to submit a redetermination (Level 1) or a reconsideration request (Level 2) to the Qualified Independent Contractor (QIC). To complete a search, the Medicare Beneficiary Identification number and Dates of Service must be filled in.

To submit an Appeal Request: Select the **Status & Appeal Requests** option under **Claims Info** on the Novitasphere toolbar, as shown in **Figure 36 – Claim Search Input**.

Claim Search [Help](#) Thursday, June 9, 2022 1:57 PM

This screen can be used to perform a claim search, submit a redetermination (Level 1) or submit a reconsideration (Level 2). After searching, if your claim information is not returned, you will need to continue to utilize the IVR to obtain information on them. Claims submitted with an invalid MBI will not be found and will need to be searched using the DCN of the claim.

Note: Dates may be entered as MMDDYY or MMDDYYYY. Forward slashes will be populated automatically.

PTAN: State:

Medicare Beneficiary ID: DCN

Date(s) of Service: To:

Submit **Clear**

Figure 36 – Claim Search Input

Enter the Medicare Beneficiary ID number and dates of service. Select the **Submit** button displayed in **Figure 36 – Claim Search Input**. The screen shown in **Figure 37 – Claim Search Results** will be displayed.

Select **View** on the relevant row from the results screen for the claim you want to view.

Claim Search [Help](#) Thursday, June 9, 2022 2:05 PM

This screen can be used to perform a claim search, submit a redetermination (Level 1) or submit a reconsideration (Level 2). After searching, if your claim information is not returned, you will need to continue to utilize the IVR to obtain information on them. Claims submitted with an invalid MBI will not be found and will need to be searched using the DCN of the claim.

Note: Dates may be entered as MMDDYY or MMDDYYYY. Forward slashes will be populated automatically.

PTAN: State:

Medicare Beneficiary ID: DCN

Date(s) of Service: To:

Submit **Clear**

DCN	NPI	MBI	DOS	Billed Amt	Beneficiary Name	Status	Bill Type	View
			04/20/2022 - 04/20/2022	\$9,008.65		P	851	View
			01/20/2022 - 01/20/2022	\$9,008.65		P	851	View

Payment(\$ data is subject to change.

Figure 37 – Claim Search Results

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7.3.3. Submit a Redetermination Request (Level 1)

After selecting the **View** button displayed in **Figure 37 – Claim Search Results**, select the **Submit Level 1 Appeal** button that is shown in **Figure 38 – Submit Level 1 Appeal** to submit a redetermination request (level 1 appeal).

PATIENT CLAIM INFO CLAIM INFO PHYSICIAN INFO INSURED INFO PAYER INFO INSURER INFO MSP INFO CODES REMARKS

Name :
 Taxonomy Code :
 Facility ZIP Code :
 Medical Record Number :
 Admission Type :

View Detail Lines Submit Level 1 Appeal

Figure 38 – Submit Level 1 Appeal

Complete all applicable selections on the Redetermination and Clerical Error Reopening Request Form shown in **Figure 39 – Level 1 Appeal Input**. The following asterisked (*) fields are required:

- *NPI, PTAN, TIN, Provider Name (auto populated based on the claim selection)
- *Beneficiary Name
- *Beneficiary Medicare Number
- *DCN Document Control Number
- *Date(s) of Service
- *Requestor's Name
- *Requestor's Relationship to Provider
- *Telephone Number and Extension
- *Reason for Redetermination or Clerical Error Reopening Request (limit 250 characters)

Click **Next** to continue to attach supporting documentation. **Figure 40 – Appeal Submission Upload Files/Document** will be displayed.

Redetermination and Clerical Error Reopening Request Form

Note: * Indicates a required field. Dates may be entered as MMDDYY or MMDDYYYY. Forward slashes will be populated automatically.

Please select one of the following jurisdictions and select YES or NO to the questions below:*

☐ AR
 ☐ CO
 ☐ DC
 ☐ DE
 ☐ LA
 ☐ MD
 ☐ MS
 ☐ NJ
 ☐ NM
 ☐ OK
 ☐ PA
 ☐ TX/IHS/Veterans

If this request is due to a Prior-Authorization denial select from the drop down: ▼

Are you requesting a Clerical Reopening? ☐ Yes ☒ No

Does the claim you are appealing involve Medicare Secondary Payer (MSP)? ☐ Yes ☒ No

Should recoupment be stopped for a 935 overpayment? ☐ Yes ☒ No

Does your appeal involve the Recovery Auditor (RA) decision? ☐ Yes ☒ No

Did the claim you are appealing reject with message MA-130? ☐ Yes ☒ No

NPI: *
 PTAN: *
 TIN(last 5 digits): 00000

Provider Name: *
 Beneficiary Name: *

Beneficiary Medicare Number: *
 DCN Document Control Number: *

Date(s) of Service: *
 Requestor's Name (Printed): *

Requestor's Relationship to Provider: *
 Telephone Number and Extension: *

Procedure Code(s) (Required for Outpatient Services only):

Reason for Redetermination or Clerical Error Reopening Request: *

0 Records Found.

← Back
Next

Figure 39 – Level 1 Appeal Input

Appeal Submission Upload Files/Documents

Wednesday, February 10, 2021 2:14 PM

Your redetermination form will be automatically included as part of the submission. Please be sure to upload any supporting documentation with your request.

Note: Record submissions that have been password protected by the provider and are uploaded cannot be processed. You will be Alerted if your submission exceeds the size limit of 50MB for a single file and 200MB for 4 files or more.

Claim Number: *

File to Upload: Browse... Upload File

← Back
Submit

Figure 40 – Appeal Submission Upload Files/Document

On the Appeal Submission Upload Files/Document, use the **Browse** button to select the documentation from your files. Do not attach a Redetermination and Clerical Error Reopening Request form as part of your documentation. This causes duplicate requests to be unnecessarily created and can impact your appeal submission process. The previous screen serves as your request form.

Click **Upload File** to attach file. Upload all documentation to support the request. Documents must be in a PDF format and less than 1500 pages, and multiple documents can be added.

The supporting Documentation uploaded should support the “Reason for the Redetermination or Clerical Error Reopening Request.”

Once the documentation upload is successful, select the **Submit** button as shown in **Figure 30 – Appeal Submission Upload Files/Document**. You will receive an Appeal Number as shown in **Figure 31 – Appeal Request Confirmation Page**, and can be viewed in Submit Documents, Submission History.

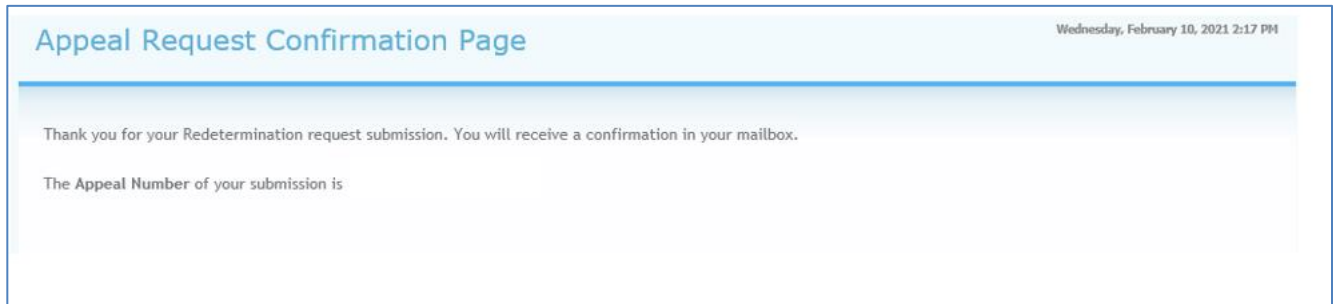


Figure 41 – Appeal Request Confirmation Page

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7.3.4. Submit a Reconsideration Request (Level 2)

After selecting the View button displayed in **Figure 27 – Claim Search Results**, select the **Submit Level 2 Appeal** link that is shown in the bottom half of the screen as displayed in **Figure 32 – Appeal Summary** to submit a reconsideration request (Level 2).

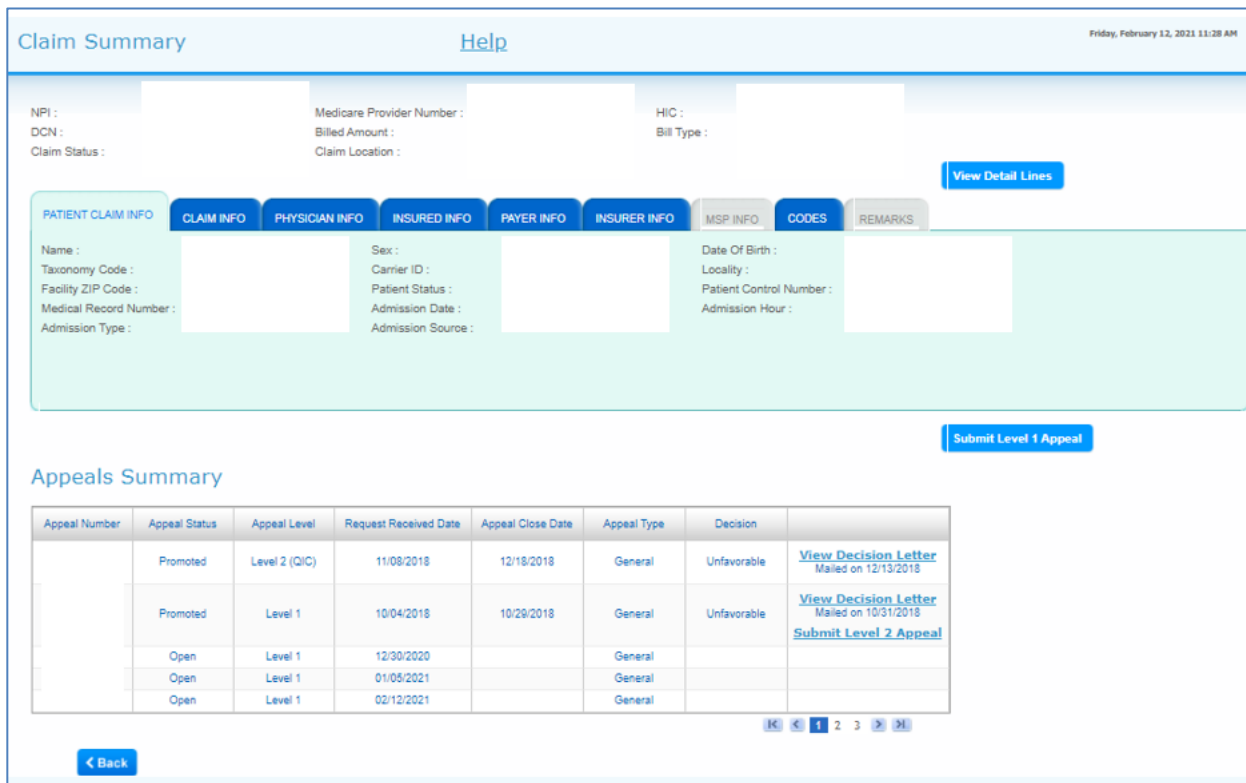


Figure 42 – Appeals Summary

Complete all applicable selections on the form shown in **Figure 43 - Reconsideration (Level 2) Form**. The following asterisked (*) fields are required:

- *NPI, PTAN, TIN, Provider Name (auto populated based on the claim selection)
- *Beneficiary Name
- *Appeal Number, Beneficiary Medicare Number, Document Control Number (auto populated based on the claim selection)
- *Date(s) of Service
- *Requestor's Name
- *Requestor's Address, City, State, Zip Code
- *Requestor's Email
- *Telephone Number and Extension
- *Does your appeal involve an overpayment decision? Yes/No
- *Reason for Redetermination or Clerical Error Reopening Request (limit 250 characters)

Click **Submit**. You will receive an Appeal Number as shown in **Figure 44 – Appeal Request Confirmation Page**, and can be viewed in Submit Documents, Submission History.

Reconsideration (Level 2) Form

Wednesday, February 10, 2021 2:30 PM

Your reconsideration form will be automatically included as part of the submission. Please be sure to upload any supporting documentation with your request.

Note: Record submissions that have been password protected by the provider and are uploaded cannot be processed. You will be Alerted if your submission exceeds the size limit of 50MB for a single file and 200MB for 4 files or more.

NPI:*	PTAN:*	TIN(last 5 digits):
Provider Name:*	Beneficiary Name:*	Appeal Number:*
Medicare Number:*	Document Control Number:*	
Date(s) of Service:*	Procedure Code(s) (Required for Outpatient Services only)	
Requestor's Name (Printed):*	Requestor's Address:*	
City:*	Zip Code:*	
State:*	Requestor's Email:*	
Telephone Number and Extension:*		

Does your appeal involve an overpayment decision?*

☐ Yes ☐ No

Reason for Reconsideration Request:*

File to Upload:

Browse...

Upload File

< Back

Submit

Figure 43 – Reconsideration (Level 2) Form

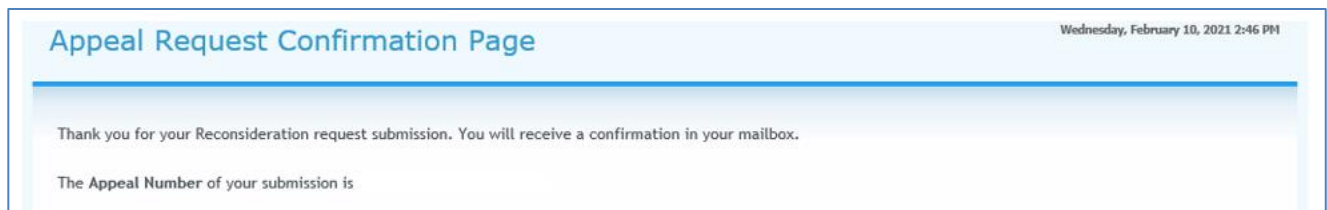


Figure 44 – Appeal Request Confirmation Page

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7.3.4.1. Additional Appeal Documentation (Level 2 Reconsideration Request)

To submit additional documentation on an existing/open appeal or previously submitted Level 2 Reconsideration Request, click on the **Submit Additional Docs** link as shown in **Figure 45 – Appeals Summary**. This screen is received after selecting the View button displayed in **Figure 37 – Claim Search Results**.

Appeal Number	Appeal Status	Appeal Level	Request Received Date	Appeal Close Date	Appeal Type	Decision	
	Promoted	Level 1	10/04/2018	10/31/2018	General	Partially Favorable	View Decision Letter Mailed on 10/31/2018 Submit Level 2 Appeal
	Promoted	Level 1	11/17/2020	01/19/2021	Dismissal		View Decision Letter Mailed on 01/21/2021 Submit Level 2 Appeal
	Requested	Level 2 (QIC)	01/22/2021		General		Submit Additional Docs

Figure 45 – Appeals Summary

On the Additional Appeal Documentation (Level 2) screen, use the **Browse** button to select the documentation from your files. Once the file is selected, you will see the file name next to the Choose File button. Click **Upload File** to attach file. The file will then display in a chart and additional files can be uploaded, as needed. Once all files are uploaded, select **Submit**. Documents must be in a PDF format and less than 1500 pages, and multiple documents can be added. Submitting this documentation will automatically add it to the referenced appeal.

Additional Appeal Documentation (Level 2)

Wednesday, February 10, 2021 2:58 PM

Your additional documentation will automatically be submitted to the appeal number listed below. Please be sure to upload any supporting documentation you want to include with this appeal.

Note: Record submissions that have been password protected by the provider and are uploaded cannot be processed. You will be Alerted if your submission exceeds the size limit of 50MB for a single file and 200MB for 4 files or more.

NPI:*

PTAN:*

State:*

Appeal Number:*

File to Upload:

Browse...

Upload File

< Back

Submit

Figure 46 – Additional Appeal Documentation (Level 2)

Once the additional documentation has been accepted, you will receive an Appeal Number as shown in **Figure 47 – Appeal Request Confirmation Page**, and can be viewed in Submit Documents, Submission History.

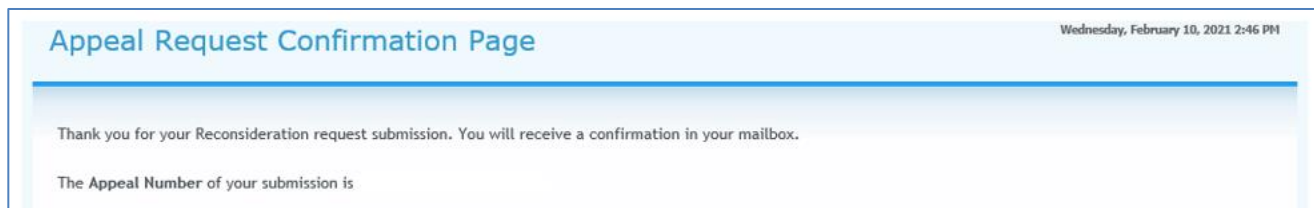


Figure 47 – Appeal Request Confirmation Page

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7.4 Overpayment/Demand Letter

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

To obtain Overpayment/Demand Letter details: Select the **Overpayment/Demand Letter** option under **Claims Info** on the Novitasphere toolbar, as shown in **Figure 47.1 – Overpayment/Demand Letter Details**.

Figure 47.1 – Overpayment/Demand Letter Details

Select or enter the following data elements to complete an Overpayment/Demand Letter Inquiry (*indicates a required field):

- NPI*
- PTAN*
- State*

Select the **Submit** button displayed in **Figure 47.1 – Overpayment/Demand Letter Details**. If you are unable to locate the letter initially, we suggest removing extra search criteria, and only searching with the required fields. The screen shown in **Figure 47.2 – Overpayment/Demand Letter Output** will be displayed.

Overpayment / Demand Letter DetailsWednesday, December

Please enter the required information in the fields below to view overpayment demand letters and corresponding details.

Note: * Indicates a required field.
Dates may be entered as MMDDYY or MMDDYYYY. Forward slashes will be populated automatically.

NPI*

PTAN*

State*

TX

Letter Number:

Outstanding Balance Due:

0.00

TO

Date(s) of Letter*

03/28/2021

TO

12/08/2021

Submit

Clear

NPI	PTAN	Letter Number	Date		
				<div>View Letter</div>	<div>View Letter Details</div>
				<div>View Letter</div>	<div>View Letter Details</div>
				<div>View Letter</div>	<div>View Letter Details</div>
				<div>View Letter</div>	<div>View Letter Details</div>
				<div>View Letter</div>	<div>View Letter Details</div>

Figure 47.2 – Overpayment/Demand Letter Output

If multiple pages are returned, you can page forward using the arrows found on the bottom right of the screen. The Clear button can be used at any time to create a new search.

To view data for an individual letter: select **View Letter** on the relevant row from the results tables. The letters are in PDF format and can be downloaded.

To view the letter details: select **View Letter Details** on the relevant row from the results tables. This will provide the Account Receivable (AR) details for that letter as shown in **Figure 47.3 – View Letter Details**.

Use the page arrows at the bottom of the screen to page forward and backwards to view all ARs. The Back button can be used at any time to go to the previous screen.

Overpayment / Demand Letter Details

Wednesday, December 8, 2021 8:47 AM

Below is additional financial information for the overpayment demand letter selected. Click on the Accounts Receivable Transaction Number to view specific transaction details.

Demand Letter Date:

Letter Number:

Account Receivable Count:

Intent To Refer Date:

13

Principal Activity Amount:	\$0.00	Principal Account Receivable Balance:	\$2,044.80
Interest Accrued Amount:	\$0.00	Interest Activity Amount:	\$0.00
Interest Account Receivable Balance:	\$0.00	Late Fee Amount:	\$0.00
Late Fee Activity Amount:	\$0.00	Late Fee Account Receivable Balance:	\$0.00
Total Balance:	\$2,044.80	Original Transaction Balance:	\$2,044.80

Account Receivable Transaction Number	Total Account Receivable Balance	Account Receivable Original Amount
	\$160.00	\$160.00
	\$156.80	\$156.80
	\$156.80	\$156.80
	\$156.80	\$156.80
	\$156.80	\$156.80
	\$156.80	\$156.80
	\$156.80	\$156.80
	\$156.80	\$156.80
	\$156.80	\$156.80
	\$160.00	\$160.00
	\$156.80	\$156.80

Back

Figure 47.3 – View Letter Details

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7.5 AR Transaction Info

The Account Receivable (AR) Transaction Info feature can be used to obtain financial details on a specific claim or AR transaction number.

To obtain AR Transaction details: Select the **AR Transaction Info** option under **Claims Info** on the Novitasphere toolbar, as shown in **Figure 47.4 – AR Transaction Info**.

✓ Eligibility

🔍 MBI Lookup

📤 Claims Submission/ERA

📄 Claims Info

Financial Info

Claim Count Summary

Status & Appeal Requests

Overpayment / Demand Letter

AR Transaction Info

Account Receivable Transaction Info

Please complete the required fields below to view Account Receivable Transaction Details

Note: * Indicates a required field.

NPI:*

Select One

PTAN:*

Select One

State:*

Select One

Claim Number:

Account Receivable Transaction Number:

Submit

Clear

Figure 47.4 – AR Transaction Info

Select or enter the following data elements to complete an AR Transaction Inquiry (*indicates a required field.)

- NPI*
- PTAN*
- State*
- Number*
 - Claim Number or
 - AR Transaction Number (found on the Overpayment/Demand Letter Details)

If you are unable to locate the information initially, we suggest removing extra search criteria, and only searching with the required fields. The “Accounts Receivable Activity Type” options are:

- Adjustment – monies modified by Novitas (such as write-off, correct, add, appeal, etc.)
- Collection – monies sent in by provider
- Refunded – monies withheld/offset

Select the **Submit** button displayed in **Figure 47.4 – AR Transaction Info**. This will provide the Account Receivable (AR) Transaction Info for that letter as shown in **Figure 47.5 – AR Transaction Info Output**.

The screenshot shows a web form titled "Account Receivable Transaction Info" with a timestamp "Monday, December 13, 2021 3:05 PM". Below the title, it says "Please complete the required fields below to view Account Receivable Transaction Details" and "Note: * Indicates a required field.".

The search criteria section includes:

- NPI* (dropdown menu)
- PTAN* (dropdown menu)
- State* (dropdown menu)
- Claim Number: (text input)
- Account Receivable Transaction Number: (text input)

 Below these are "Submit" and "Clear" buttons.

The results section displays the following information:

- Beneficiary Name:
- Claim Number:
- Date of Service From:
- Date of Service To:
- Original Amount: \$36.60
- Refunded Amount: (\$37.18)
- Adjustment Amount: \$0.00
- Collection Amount: \$0.00
- Account Receivable Transaction Number:
- Account Receivable Transaction Date:
- Account Receivable Status:
- Account Receivable Status Effective Start Date:
- Account Receivable Open / Closed: Closed
- Total Interest Accrued: \$0.58
- Principal Remaining Balance: \$0.00
- Interest Remaining Balance: \$0.00
- Late Fee Remaining Balance: \$0.00
- Account Receivable Activity Type*: Select One (dropdown menu)
- Additional Activity Details (button)

Figure 47.5 – AR Transaction Info Output

To obtain Additional AR Transaction Activity details: Select the **Additional Activity Details** button displayed in **Figure 47.5 – AR Transaction Info Output**. This will provide the AR Transaction Activity Details as shown in **Figure 47.6 – AR Transaction Activity Details**.

The Account Receivable Activity Type field shown in **Figure 47.4 – AR Transaction Info** is required to obtain the additional details. If this was not previously selected, an error message will be displayed.

AR Transaction Activity Details				
Claim Number: Account Receivable Transaction Number: Account Receivable Activity Type: REFUNDED				
Activity Number	Total Activity Amount	Account Receivable Activity Details Info		
	(\$37.18)	Activity Amount	Activity Date	Activity ON
		(\$36.60)	04-OCT-2021	Principal
		(\$0.58)	04-OCT-2021	Interest

Figure 47.6 – AR Transaction Activity Details

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8. Medical Review Claims

The Medical Review Claims feature can be used to perform a search of medically reviewed claims. Searches can be completed based on the case number, claim control number, Medicare Beneficiary identification number, Documentation Response status or date.

To access Medical Review Claims: Select the Medical Review Claims option on the Novitasphere toolbar, as shown in **Figure 48 – Medical Review Claims**.

Figure 48 – Medical Review Claims

Select or enter the following data elements to complete a medical review claim inquiry (* Indicates a required field):

- NPI*
- PTAN*
- State*
- MR Case Number
- Control Number (DCN)
- Medicare Beneficiary ID
- ADR Status
 - Pending
 - Received
- Date search criteria
 - Date of Service
 - Documentation Response Due Date
 - Additional Documentation Response Sent Date

You must provide at least one of the following pieces of information to search: MR Case Number, Control Number, Medicare Beneficiary ID, or Date.

Select the **Submit** button displayed in **Figure 48 – Medical Review Claims**.

The screen shown in **Figure 49 – Medical Review Claims Output** will be displayed.

Medical Review Claims

Monday, April 23, 2018 2:28 PM

This screen can be used to perform a search for medically reviewed claims from 04/12/2018 to present. You must provide at least one of the following pieces of information to search: MR Case Number, Control Number, Medicare Beneficiary ID, or Date.

Note: * Indicates a required field. Dates may be entered as MMDDYY or MMDDYYYY. Forward slashes will be populated automatically.

NPI:*

PTAN:*

State:*

Case Number:

Control Number:

Medicare Beneficiary ID:

ADR Status:

Select One

Search Date By:

ADR Sent Date

From:*

04/01/2018

To:*

04/23/2018

Submit

Clear

Case Number	DCN	Medicare Beneficiary ID	Date of Service From	Date of Service To	View
			04/13/2017	04/16/2017	<div>View</div>
			01/23/2018	01/23/2018	<div>View</div>

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Figure 49 – Medical Review Claims Output

The case number, DCN, Medicare Number, and dates of service will be displayed for the requested data elements.

To view data for an individual claim (DCN): Select the **View** button from the relevant row displayed in the results tables.

Medical Review Claim details will be displayed. The DCN, Medicare Number, Case Number, and dates of service will continue to display at the top of each screen.

Additional Documentation Request (ADR), Claim Review and Education tabs will be displayed. Click on each tab to review the information for the selected DCN.

Medical Review Claim Details
Tuesday, April 10, 2018 12:43 PM

CLAIM INFORMATION

DCN
Medicare Beneficiary ID
Case Number
Date of Service From 01/27/2018
Date of Service To 01/30/2018







ADR

REVIEW

EDUCATION

If an ADR response was not submitted utilizing the standard methods as outlined in the ADR, the status update for the claim may be delayed.

Additional Documentation Request Information

Status	Letter Sent Date	Response/Medical Records Submission Due Date	Received Date	ADR Documents						
Pending	12/16/2019	01/30/2020		<table> <tr> <th>Delivery Mechanism</th> <th>Document</th> </tr> <tr> <td>Electronic</td> <td></td> </tr> <tr> <td>Mail</td> <td></td> </tr> </table>	Delivery Mechanism	Document	Electronic		Mail	
Delivery Mechanism	Document									
Electronic										
Mail										

K < > H

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Figure 50 – Medical Review Claim Details – ADR Tab

The **ADR** tab as shown in **Figure 50 – Medical Review Claim Details – ADR Tab** will display the following information:

- Status of the documentation request
- Received
- Pending
- The date the documentation letter was sent
- The due date of the medical record request
- Received date of the medical records if the status is received
- The ADR delivery mechanism
- A copy of the ADR letter
 - If you have chosen to receive eMDRs through esMD, you will see two PDFs displayed
 - To **view** the ADR letter – **click** on the PDF document
 - When you click on the PDF document, you may receive a pop up advising you not to send this version of the ADR with your medical records as shown in **Figure 29 – Medical Review Claim Details – Helpful Hint**.
 - If you receive this pop up, do not send this version of the ADR letter back with your documentation. It will cause a delay in processing as it does not contain the routing bar codes contained in your original version.
 - Click **OK** to continue.
 - Select **Open** or **Save** when prompted with the question “Do you want to open or save ADR Letter.pdf as shown in **Figure 50 – Medical Review Claim Details – ADR Letter**.

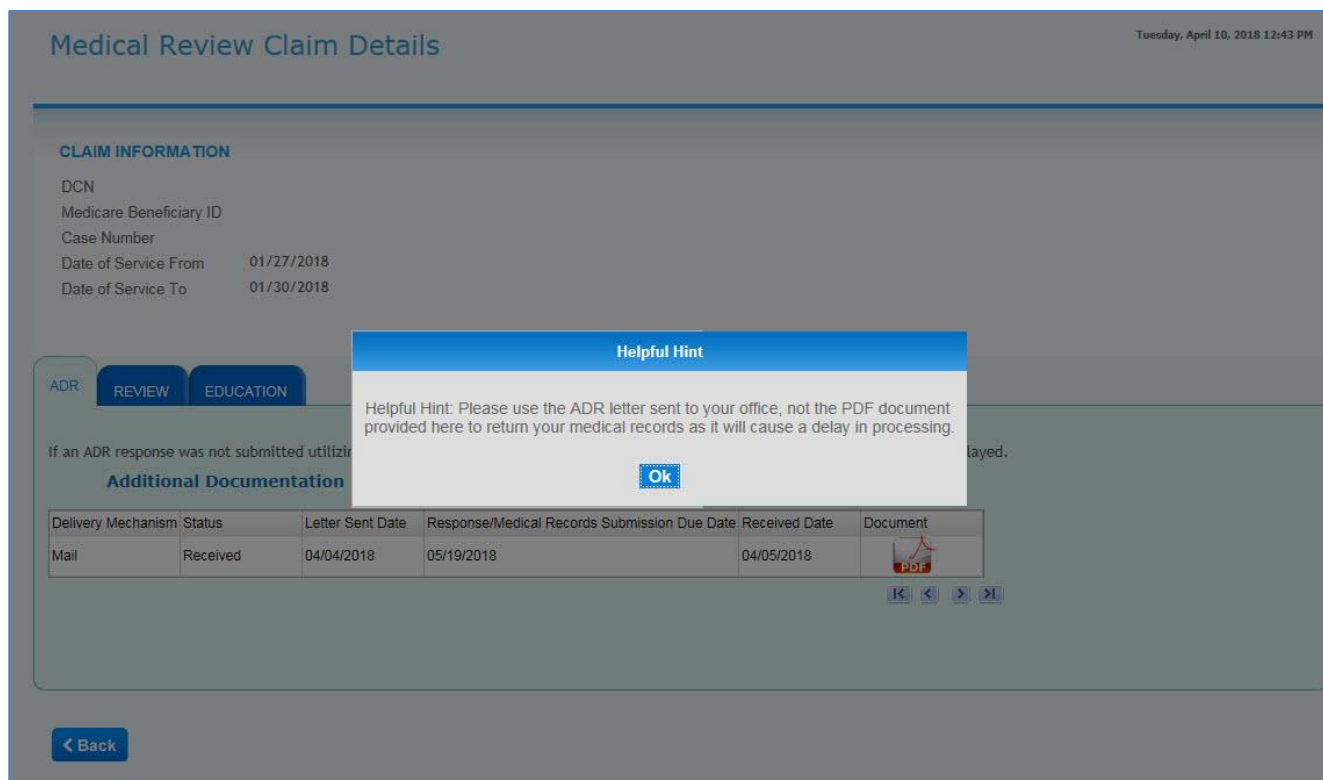


Figure 51 – Medical Review Claim Details – Helpful Hint

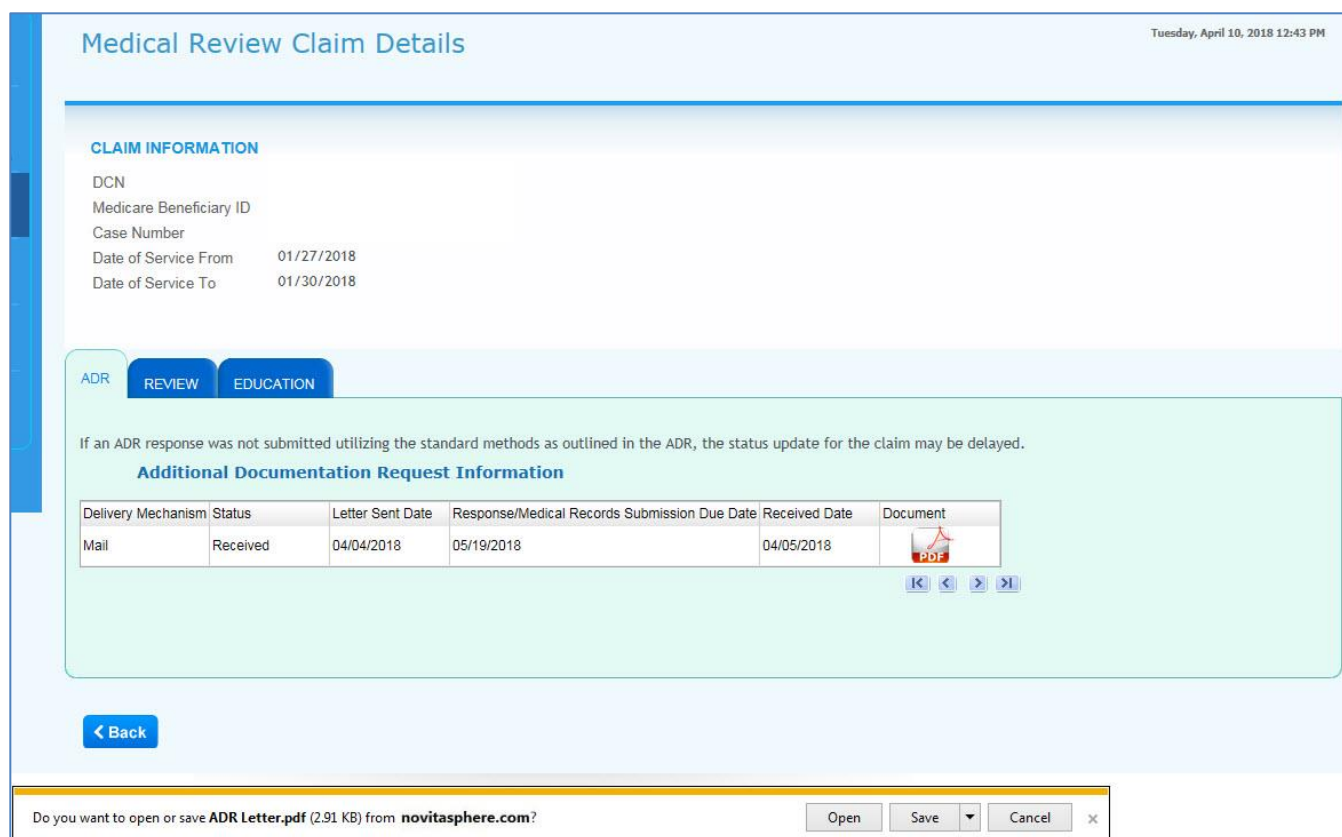


Figure 52 – Medical Review Claim Details – ADR Letter

Select the **Review** tab for more detailed information about the medical review.

Medical Review Claim Details

Tuesday, April 10, 2018 12:44 PM

CLAIM INFORMATION

DCN

Medicare Beneficiary ID

Case Number

Date of Service From

01/27/2018

Date of Service To

01/30/2018

ADR

REVIEW

EDUCATION

Review Information

MR Begin Date	04/05/2018
MR Completed Date	04/05/2018
Review Status	Review Completed
Review Outcome	Full Denial
Review Findings and Rationales	04/05/2018 50174 Full denial. Medical Records do not include sufficient documentation to support medical necessity. No admission order RN/RN
Review Results Sent Date	02/20/2017
Review Results Code	NA
Review Results Code Descriptors	NA

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Figure 53 – Medical Review Claim Details – Review Tab

The **Review** tab as shown in **Figure 53 – Medical Review Claim Details – Review Tab** will display the following information:

- Date the Medical Review began
- Date the Medical Review was completed
- Status of the Review
 - Awaiting ADR Response
 - Review has begun
 - Review Completed
- Outcome of the review:
 - Approved
 - Denied
 - Reduced – Service was reduced to a lower level of care
 - Underpaid – Service was up-coded
- Review Findings and Rationale
- Date the Review results were sent
- Review Results code if applicable
- Review Results code description if applicable

Select the **Education** tab for more information about the type and date of the education offered during the medical review. Only the most recent education that was provided will be displayed.

Medical Review Claim Details

Tuesday, April 10, 2018 12:44 PM

CLAIM INFORMATION

DCN

Medicare Beneficiary ID

Case Number

Date of Service From

01/27/2018

Date of Service To

01/30/2018

ADR

REVIEW

EDUCATION

Education Information

Type of Education

1st Intra-Probe Education Provided - 1:1 telephonic

Date of Educational Call to Provider

03/21/2018

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Figure 54 – Medical Review Claim Details – Education Tab

The **Education** tab as shown in **Figure 54 – Medical Review Claim Details – Education Tab** will display the following information:

- The Type of Education that was provided
- The date of the last educational contact

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9. Retrieve Documents

9.1. Appeal Development Letters

To View Your Appeal Development Letters: Select the **Retrieve Documents** option from the Novitasphere toolbar and then **Appeal Development Letters** as seen in **Figure 55 – Appeal Development Letter**.

Appeal Development Letter

Note: * Indicates a required field.
Dates may be entered as MMDDYY or MMDDYYYY. Forward slashes will be populated automatically.

NPI* PTAN* State*

Case Number: DCN:

Medicare Beneficiary ID: Date(s) of Letter*: TO

Retrieve Documents

- ▶ Appeal Development Letters
- ▶ Mailbox
- ▶ Overpayment Letter
- ▶ Redetermination Notices
- ▶ View Remittance Advice
- ▶ Requested Remittance Advice

Figure 55 – Appeal Development Letter

Select or enter the following data elements to complete an Appeal Development Letter inquiry (*Indicates a required field):

- NPI*
- PTAN*
- State*
- Case Number
- DCN (Document Control Number)
- Medicare Beneficiary ID
- Date(s) of Letter* – (auto-populated with 15 day date range from the current date)
 - You may enter a single date, or range dates, but not a date beyond the 15 day date range
 - Medicare’s expectation is that responses must be returned within 15 days from the date the Appeal Development letter is issued.

Select the Submit button displayed in **Figure 55 – Appeal Development Letter**. The screen shown in **Figure 56 – Appeal Development Letter Results** will be displayed.

Appeal Development Letter

Friday, July 13, 2018 2:43 PM

Note: * Indicates a required field.
 Dates may be entered as MMDDYY or MMDDYYYY. Forward slashes will be populated automatically.

NPI*

PTAN:*

State:*

Case Number:

DCN:

Medicare Beneficiary ID:

Date(s) of Letter:*

06/28/2018

TO

07/13/2018

Submit

Clear

NPI	PTAN	Case Number	DCN	Letter Date	
				2018-07-09 10:40:08.147	View
				2018-07-09 10:40:08.333	View
				2018-07-09 10:40:08.99	View
				2018-07-09 10:40:09.16	View

Figure 56 – Appeal Development Letter Results

Select the **View** button from the relevant row to view the letter. You will be prompted to either open or save the PDF copy.

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9.2. Mailbox

PDF versions of confirmation messages that are generated when submitting documents via Novitasphere and correspondence generated by the Medical Review, Audit & Reimbursement or Prior Authorization departments will be available through the Mailbox feature. The Office Approver/Office Back-Up Approver for the organization will receive an email notification when a new communication is available in the Mailbox.

To View Your Mailbox: Select the **Retrieve Documents** option from the Novitasphere toolbar and then **Mailbox**. Displayed will be a list of your communications as seen in **Figure 57 – Mailbox**.

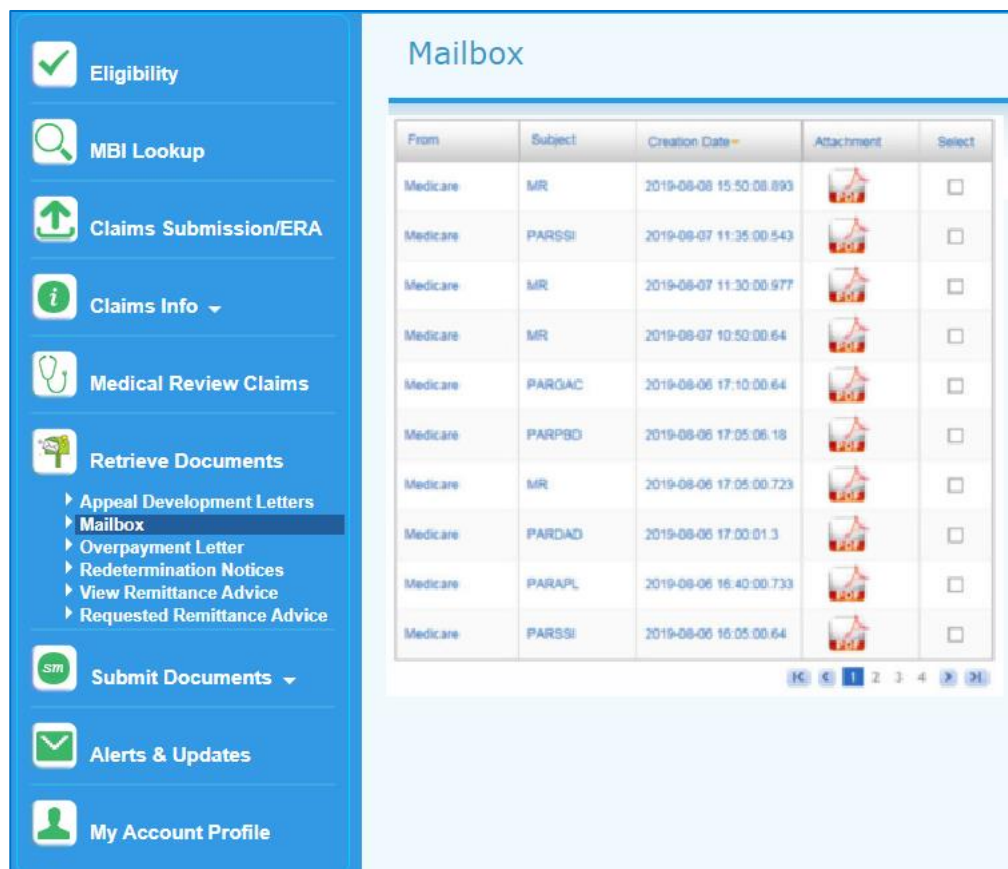


Figure 57 – Mailbox

The following information will be displayed:

- From – Indicates the area where the correspondence originated (i.e. Audit & Reimbursement, Medical Review, etc.) *Note - “Medicare” is the default for confirmation messages for submissions in Novitasphere.*
- Subject – Indicates the subject matter of the message (i.e. Cost Report Reminder Letter, etc.). *Note - “Confirmation” is the default for confirmation messages for submissions in Novitasphere.*
- Creation Date – Indicates the date and time when correspondence/confirmations are received in the Mailbox.
- Attachment – Provides a link to a PDF document of the correspondence.

You may sort these columns by clicking the column heading.

A copy of the acknowledgement PDF attachment is shown in **Figure 58 – Acknowledgement PDF**.

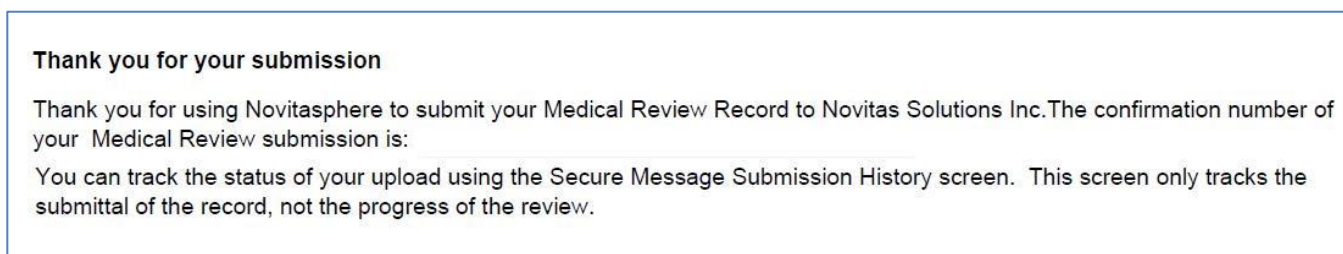


Figure 58 – Acknowledgement PDF

Mailbox Confirmations for Appeal Requests, Audit & Reimbursement submissions, Credit Balance Report submission, Immediate Recoupment requests, Prior Authorization requests, and Medical Review Records submission will remain available for 90 days from the date it was issued.

Medical Review post pay letters will remain available for 30 days after they have been viewed, or 90 days from the date it was issued if not viewed.

Prior Authorization Response letters are issued within 10 days and are available in the Mailbox.

All Mailbox communications have the option to be manually deleted at any time.

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9.3. Overpayment Letter

The Overpayment Letter feature allows you to view Overpayment Letters that have been issued within the last 255 days.

To View your Overpayment Letters: Select the **Retrieve Documents** option from the Novitasphere toolbar and then **Overpayment Letter** from the drop down as shown in **Figure 59 – Overpayment Letter**.

Overpayment / Demand Letter Details

Please enter the required information in the fields below to view overpayment demand letters and corresponding details.

Note: * Indicates a required field.
Dates may be entered as MMDDYY or MMDDYYYY. Forward slashes will be populated automatically.

NPI* PTAN* State*

Letter Number: Outstanding Balance Due: TO

Date(s) of Letter* TO

Figure 59 – Overpayment Letter

Select or enter the following data elements to complete an Overpayment Letter request (*Indicates a required field):

- NPI*
- PTAN*
- State
- Letter Number
- Outstanding Balance Due
 - When using the Outstanding Balance Due fields, the beginning balance will be prepopulated with \$0.00. Insert the full amount of the Overpayment Letter you are trying to retrieve in the TO field. If you are unaware of the amount for the full Overpayment Letter, enter a dollar amount greater than the amount anticipated on the Overpayment Letter. Portal will retrieve all Overpayment Letters between the dollar amount span queried.
- Date(s) of Letter*

Select the **Submit** button as shown in **Figure 59 – Overpayment Letter**.

All letters that match the information populated in the Overpayment Letter Request will be displayed as shown in **Figure 60 – Overpayment Letter Results**.

To view the Overpayment Letter: Select the **View** button next to the letter you wish to review. The Overpayment Letter will be populated in the PDF format for your review. You will be prompted to either open or save the PDF copy.

Overpayment Letter Tuesday, July 31, 2018 2:26 PM

Note: * Indicates a required field.
Dates may be entered as MMDDYY or MMDDYYYY. Forward slashes will be populated automatically.

NPI* PTAN* State*

Letter Number: Outstanding Balance Due: TO

Date(s) of Letter:* TO

NPI	PTAN	Letter Number	Date	
			12/06/2017	<input type="button" value="View"/>
			12/06/2017	<input type="button" value="View"/>
			12/06/2017	<input type="button" value="View"/>

Figure 60 – Overpayment Letter Results

If you wish to request an additional Overpayment Letter, select the Clear button on the Overpayment Letter form and complete a new query.

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9.4. Redetermination Notices

All electronic Medicare Redetermination Notices (e-MRNs) are available in Novitasphere – even if Novitasphere was not used to submit the Appeal.

To View your e-MRNs: Select the **Retrieve Documents** option from the Novitasphere toolbar and then **Redetermination Notices** from the drop down as shown in **Figure 61 – e-MRN**.

e-MRN(Medicare Redetermination Notices)

Note: * Indicates a required field.
Dates may be entered as MMDDYY or MMDDYYYY. Forward slashes will be populated automatically.

NPI:* PTAN:* State:*

Case Number: DCN:

Medicare Beneficiary ID: Date(s) of Letter:* TO

Figure 61 – e-MRN

Select or enter the following data elements to complete an e-MRN inquiry (* Indicates a required field):

- NPI*
- PTAN*
- State*
- Case Number
- DCN (Document Control Number)
- Medicare Beneficiary ID
- Date(s) of Letter* – You may enter a single date, or range dates

Select the **Submit** button displayed in **Figure 61 – e-MRN**. The screen shown in **Figure 62 – e-MRN Results** will be displayed.

e-MRN(Medicare Redetermination Notices)

Friday, July 13, 2018 2:57 PM

Note: * Indicates a required field.
Dates may be entered as MMDDYY or MMDDYYYY. Forward slashes will be populated automatically.

NPI:*

PTAN:*

State:*

Case Number:

DCN:

Medicare Beneficiary ID:

Date(s) of Letter:*

TO

06/01/2018

07/13/2018

Submit

Clear

NPI	PTAN	Case Number	DCN	Date Closed	
				12/06/2017	View

Figure 62 – e-MRN Results

Select the **View** button from the relevant row to view the letter. You will be prompted to either open or save the PDF copy.

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9.5. View Remittance Advice

Obtain copies of your remittance advice for your records via the View Remittance Advice feature. This file is not an Electronic Remittance Advice (ERA), but rather a PDF copy like the standard paper remittance.

To View Remittance Advice: Select the **Retrieve Documents** option on the Novitasphere toolbar, then **View Remittance Advice** as shown in **Figure 63 – View Remittance Advice Input**.

View Remittance Advice Tuesday, June 14, 2022 1:51 PM

Remittance advice finalized on or after June 6, 2019 that were issued in paper format can be viewed through the View Remittance Advice Feature. Remittance advice finalized on or after August 1, 2019 that were issued via Electronic Remittance Advice (ERA) can be viewed through the View Remittance Advice Feature. For remittance advices finalized prior to these dates or larger than 350 pages, you must call the Customer Contact Center at 1-877-235-8073.

Note: * Indicates a required field.
Dates may be entered as MMDDYY or MMDDYYYY. Forward slashes will be populated automatically.
For best results, only complete the required fields and put a range of dates in the Date(s) of Remittance fields.

NPI*

Check Number

Check Amount

Date(s) of Remittance* TO

FEEDBACK

Figure 63 – View Remittance Advice Input

Select the following data elements to complete a Remittance query (*Indicates a required field):

- NPI*
- Check Number
 - For EFT checks, you will need to enter 'EFT' prior to the numbers
- Check Amount
- Date of Remittance* ("From")
- Date of Remittance* ("To")

Select the Submit button displayed in **Figure 63 – View Remittance Advice Input**.

If you are unable to locate the remittance initially, we suggest removing extra search criteria, and only searching with the required fields.

Following the Remittance query, the following results may be returned:

- Where the date range selected is within the last 45 days, and there is a match with the NPI selected, 1 or more Remittances will be available for **View**.
- Where the date range selected extends beyond the last 45 days, and there is a match with the NPI selected, 1 or more Remittances will be available for **Request**.

Note - For remittance advices finalized prior to June 6, 2019 for paper remits, or August 1, 2019 for electronic remits, or larger than 350 pages, you will need to contact the Customer Contact Center.

View/Request results will be displayed as shown in **Figure 64 – View Remittance Advice Output**.

Only remittance advices finalized on or after June 6, 2019 can be viewed through the View Remittance Advice Feature.
For remittance advices finalized prior to June 6, 2019 or larger than 350 pages, you must call the Customer Contact Center, 1-855-252-8782

Note: * Indicates a required field.
Dates may be entered as MMDDYY or MMDDYYYY. Forward slashes will be populated automatically.
For best results, only complete the required fields and put a range of dates in the Date(s) of Remittance fields.

NPI*

Check Number

Check Amount

Date(s) of Remittance* TO

NPI	Check No	Date	Check Amount	
		06/18/2019	\$44,335.80	<input type="button" value="View"/>
		06/18/2019	\$4,886.75	<input type="button" value="Request"/>
		06/18/2019	\$48,216.00	<input type="button" value="View"/>
		06/18/2019	\$3,539.27	<i>Requested</i>
		06/18/2019	\$94.91	<input type="button" value="View"/>
		06/18/2019	\$1,578.46	<input type="button" value="View"/>

Figure 64 – View Remittance Advice Output

Where a query returns many matching Remittances, you will be able to page through results in the table. You may sort these columns by clicking the column heading. Remittances will be displayed in date order by default.

To View a Remittance: Select the **View** button displayed in **Figure 64 – View Remittance Advice Output** for the appropriate Remittance record. Remittance information will be displayed in PDF format. If you wish to download the ERA file that can be imported into PC-ACE or PC Print, please review File Status and Reports.

To Request a Remittance: Select the Request button displayed in **Figure 64 – View Remittance Advice Output** for the appropriate Remittance record.

Select the **Yes** button on the Request Confirmation pop-up, as shown in **Figure 65 – Remittance Request Confirmation Message**.

Dates may be entered as MMDDYY or MMDDYYYY. Forward slashes will be populated automatically.
For best results, only complete the required fields and put a range of dates in the Date(s) of Remittance fields.

NPI*

Check Number

Check Amount

Date(s) of Remittance* 06/01/2018

Submit

Request Confirmation

You are about to request a remittance advice. Are you sure?

Yes **No**

NPI	Check No	Date	Amount	Action
		06/18/2019		
		06/18/2019	\$4,886.75	Request
		06/18/2019	\$48,216.00	View
		06/18/2019	\$3,539.27	<i>Requested</i>
		06/18/2019	\$51,641.00	Request

Figure 65 - Remittance Request Confirmation Message

Note - Requested Remittances will be made available the next day via the Requested Remittance Advice feature.

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9.6. Requested Remittance Advice

To view a requested remittance advice: Select the **Retrieve Documents** option on the Novitasphere toolbar, and then select **Requested Remittance Advice**.

Select the following data elements to complete a search for your previously requested remittance advices (*Indicates a required field):

- NPI*
- Check Number
- Check Amount
- Date of Remittance* ("From")
- Date of Remittance* ("To")

Select the **Submit** button displayed in **Figure 66 – Requested Remittance Advice Input**.

Figure 66 – Requested Remittance Advice Input

A list of your requested remittance advices will display as seen in **Figure 67 – Requested Remittance Advices**.

You may sort these columns by clicking the column heading. You can page through the different Remittance Advice records using the arrow buttons provided at the bottom of the page.

NPI	Check No	Date	Check Amount	View	Delete
		06/18/2019	\$1,578.46	View	<input type="checkbox"/>
		06/18/2019	\$94.91	View	<input type="checkbox"/>
		06/18/2019	\$3,539.27	View	<input type="checkbox"/>
		06/18/2019	\$48,216.00	View	<input type="checkbox"/>
		06/18/2019	\$4,886.75	View	<input type="checkbox"/>
		06/18/2019	\$44,335.80	View	<input type="checkbox"/>

Figure 67 – Requested Remittance Advices

Select an individual Remittance Advice by selecting **View** beside the appropriate Remittance Advice.

A PDF of the Remittance Advice data will display. You will need Adobe Acrobat Reader to view. You can print or save the Remittance Advice record using the browser settings at the top of the page.

You can also delete Remittance Advice records once they have been viewed by selecting the appropriate radio button next to the relevant Remittance Advice and then selecting the **Delete** button.

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10. Submit Documents

The Submit Documents feature will allow you to submit secure documents to Novitas Solutions or review the history of submissions sent via Novitasphere.

10.1. Appeal Requests

The Appeal Requests feature is used to complete Redetermination and Clerical Error Reopening requests for finalized claims.

- As a reminder, do not submit appeal requests for rejected claims or claims that were returned as unprocessable, e.g., claims where the remittance notice displays MOA Code MA130. Rejected claims must be resubmitted with the corrected information.

To Perform an Appeal Request: Select the **Submit Documents** option from the Novitasphere toolbar and then select **Appeal Requests** from the drop down.

Enter the DCN and select the **Submit** button shown in **Figure 68 – Appeal Requests Input**. The results will be displayed as shown in **Figure 69 – Appeal Requests Results**.

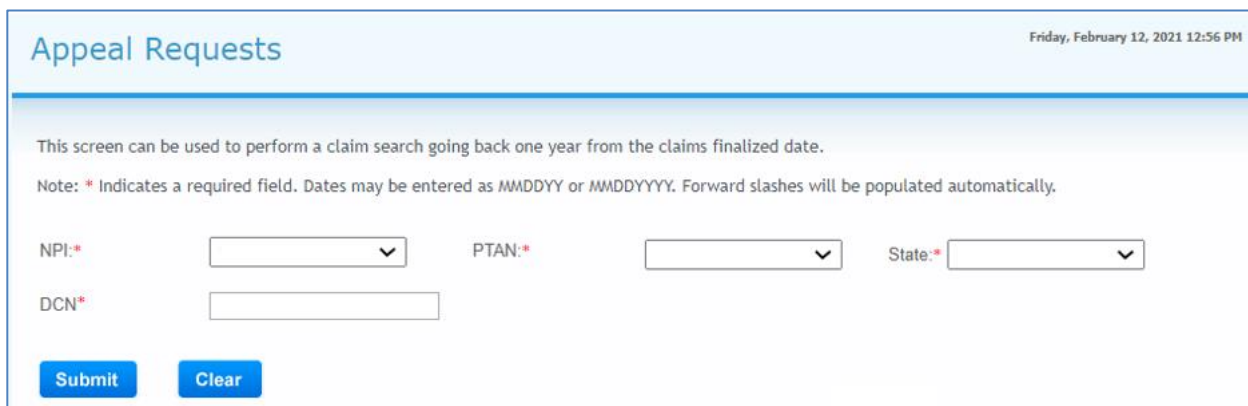


Figure 68 – Appeal Requests Input

DCN	NPI	DOS	Billed Amt	Beneficiary Name	Status	Bill Type	View
							View

Payment(\$ data is subject to change.

Figure 69 – Appeal Request Results

Select View on the relevant row from the results screen for the claim you want to view.

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10.1.1. Submit a Redetermination Request (Level 1)

After selecting the View button displayed in **Figure 69 – Appeal Request Results**, select the **Submit Level 1 Appeal** button that is shown in **Figure 70 – Submit Level 1 Appeal** to submit a redetermination request (level 1 appeal).

PATIENT CLAIM INFO	CLAIM INFO	PHYSICIAN INFO	INSURED INFO	PAYER INFO	INSURER INFO	MSP INFO	CODES	REMARKS
Name :		Sex :				Date Of Birth :		
Taxonomy Code :		Carrier ID :				Locality :		
Facility ZIP Code :		Patient Status :				Patient Control Number :		
Medical Record Number :		Admission Date :				Admission Hour :		
Admission Type :		Admission Source :						

[View Detail Lines](#) [Submit Level 1 Appeal](#)

Figure 70 – Submit Level 1 Appeal

Complete all applicable selections on the Redetermination and Clerical Error Reopening Request Form shown in **Figure 71 – Appeal Input**. The following asterisked (*) fields are required:

- *NPI, PTAN, TIN, Provider Name (auto populated based on the claim selection)
- *Beneficiary Name
- *Beneficiary Medicare Number
- *DCN Document Control Number
- *Date(s) of Service
- *Requestor's Name
- *Requestor's Relationship to Provider
- *Telephone Number and Extension
- *Reason for Redetermination or Clerical Error Reopening Request (limit 250 characters)

Click **Next** to continue to attach supporting documentation. **Figure 72 – Appeal Submission Upload Files/Document** will be displayed.

Note: * Indicates a required field. Dates may be entered as MMDDYY or MMDDYYYY. Forward slashes will be populated automatically.

Please select one of the following jurisdictions and select YES or NO to the questions below.*

☐ AR
 ☐ CO
 ☐ DC
 ☐ DE
 ☐ LA
 ☐ MD
 ☐ MS
 ☐ NJ
 ☐ NM
 ☐ OK
 ☒ PA
 ☐ TX/IHS/Veterans

If this request is due to a Prior-Authorization denial select from the drop down:

Are you requesting a Clerical Reopening? ☐ Yes ☒ No
 Does the claim you are appealing involve Medicare Secondary Payer (MSP)? ☐ Yes ☒ No
 Should recoupment be stopped for a 935 overpayment? ☐ Yes ☒ No
 Does your appeal involve the Recovery Auditor (RA) decision? ☐ Yes ☒ No
 Did the claim you are appealing reject with message MA-130? ☐ Yes ☒ No

NPI:* PTAN:* TIN(last 5 digits):

Provider Name:* Beneficiary Name:.*
 Beneficiary Medicare Number:* DCN Document Control Number:*

Date(s) of Service:* Requestor's Name (Printed):.*
 Requestor's Relationship to Provider:* Telephone Number and Extension:*
 Procedure Code(s) (Required for Outpatient Services only):
 Reason for Redetermination or Clerical Error Reopening Request:.*

0 Records Found.

Figure 71 – Appeal Input

Appeal Submission Upload Files/Documents Wednesday, February 10, 2021 2:14 PM

Your redetermination form will be automatically included as part of the submission. Please be sure to upload any supporting documentation with your request.

Note:Record submissions that have been password protected by the provider and are uploaded cannot be processed. You will be Alerted if your submission exceeds the size limit of 50MB for a single file and 200MB for 4 files or more.

Claim Number:.*

File to Upload:

Figure 72 – Appeal Submission Upload Files/Documents

On the Appeal Submission Upload Files/Documents screen, use the **Browse** button to select the documentation from your files. Do not attach a Redetermination and Clerical Error Reopening Request form as part of your documentation. This causes duplicate requests to be unnecessarily created and can impact your appeal submission process. The previous screen serves as your request form.

Click **Upload File** to attach file. Upload all documentation to support the request. Documents must be in a PDF or TIF format and less than 1500 pages, and multiple documents can be added.

The supporting Documentation uploaded should support the “Reason for the Redetermination or Clerical Error Reopening Request.”

Once the documentation upload is successful, select the Submit button as shown in **Figure 72 – Appeal Submission Upload Files/Document**. You will receive an Appeal Number as shown in **Figure 73 – Appeal Request Confirmation Page**, and can be viewed in Submit Documents, Submission History.

Figure 73 – Appeal Request Confirmation Page

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10.1.2. Submit a Reconsideration Request (Level 2)

After selecting the View button displayed in **Figure 69 – Appeal Request Results**, select the **Submit Level 2 Appeal** link that is shown in **Figure 74 – Appeals Summary** to submit a reconsideration request (Level 2).

To submit a level 2 reconsideration request, click on the **Submit Level 2 Appeal** link.

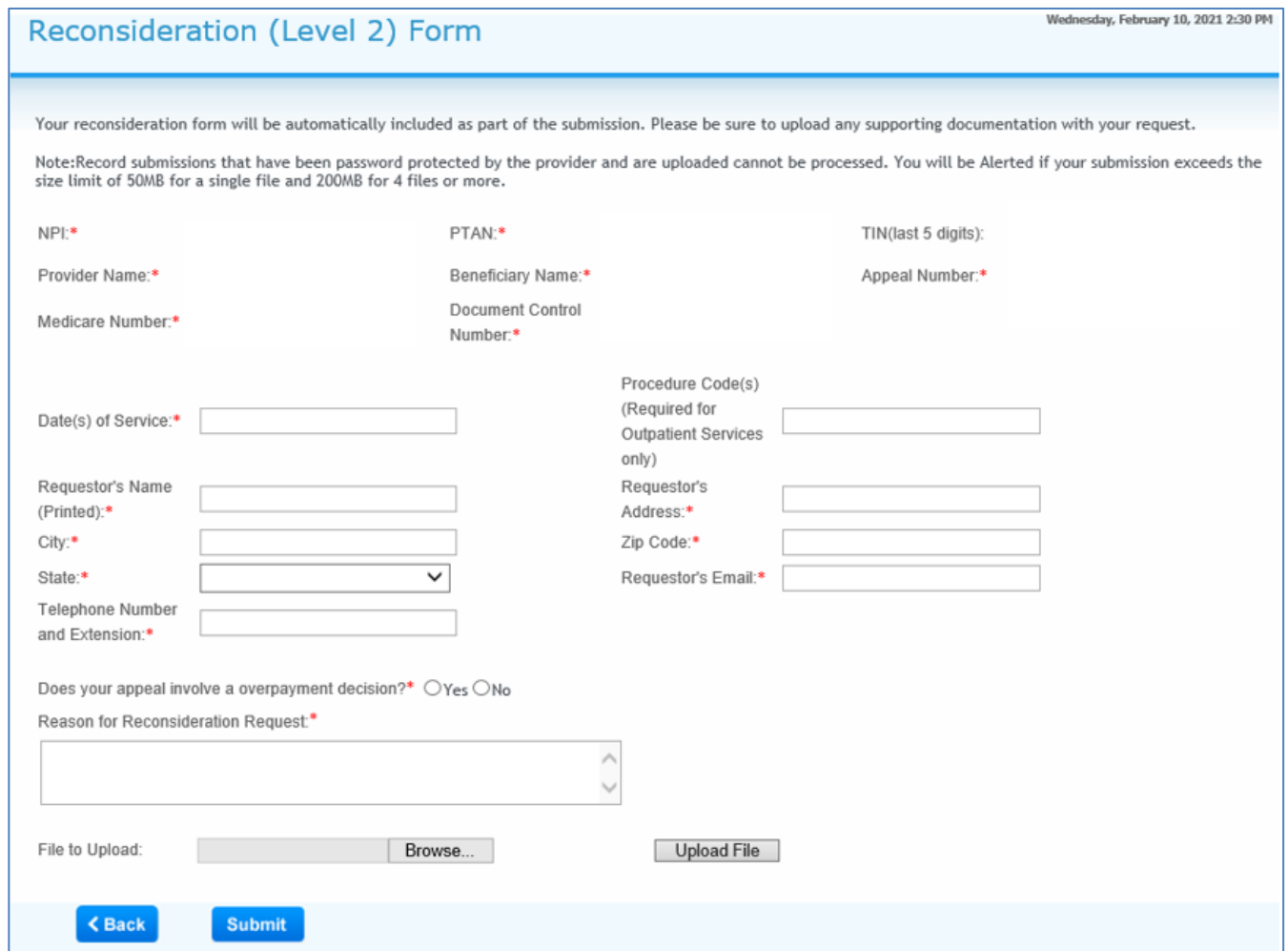
Appeals Summary							
Appeal Number	Appeal Status	Appeal Level	Request ReceivedDate	Appeal CloseDate	Appeal Type	Decision	
	Promoted	Level 2 (QIC)	11/08/2018	12/18/2018	General	Unfavorable	View Decision Letter Mailed on 12/13/2018
	Promoted	Level 1	10/04/2018	10/29/2018	General	Unfavorable	View Decision Letter Mailed on 10/31/2018 Submit Level 2 Appeal
	Open	Level 1	12/30/2020		General		
	Open	Level 1	02/10/2021		General		
	Requested	Level 2 (QIC)	01/25/2021		General		Submit Additional Docs

Figure 74 – Appeals Summary

Complete all applicable selections on the form shown in **Figure 75 - Reconsideration (Level 2) Form**. The following asterisked (*) fields are required:

- *NPI, PTAN, TIN, Provider Name (auto populated based on the claim selection)
- *Beneficiary Name
- *Appeal Number, Beneficiary Medicare Number, Document Control Number (auto populated based on the claim selection)
- *Date(s) of Service
- *Requestor's Name
- *Requestor's Address, City, State, Zip Code
- *Requestor's Email
- *Telephone Number and Extension
- *Does your appeal involve an overpayment decision? Yes/No
- *Reason for Redetermination or Clerical Error Reopening Request (limit 250 characters)

Click **Submit**. You will receive an Appeal Number as shown in **Figure 76 – Appeal Request Confirmation Page**, and can be viewed in Submit Documents, Submission History.

The image shows a web form titled "Reconsideration (Level 2) Form" with a timestamp of "Wednesday, February 10, 2021 2:30 PM". The form contains several sections: a header with instructions, a note about file size limits, and multiple input fields for personal and medical information. The fields are organized into three columns. The first column includes NPI, Provider Name, Medicare Number, Date(s) of Service, Requestor's Name (Printed), City, State (dropdown), and Telephone Number and Extension. The second column includes PTAN, Beneficiary Name, Document Control Number, and Procedure Code(s) (Required for Outpatient Services only). The third column includes TIN (last 5 digits), Appeal Number, Requestor's Address, Zip Code, and Requestor's Email. There are also radio buttons for "Does your appeal involve a overpayment decision?" (Yes/No) and a text area for "Reason for Reconsideration Request". At the bottom, there is a "File to Upload" section with a "Browse..." button and an "Upload File" button. The form concludes with a blue "Back" button and a blue "Submit" button.

Reconsideration (Level 2) Form

Wednesday, February 10, 2021 2:30 PM

Your reconsideration form will be automatically included as part of the submission. Please be sure to upload any supporting documentation with your request.

Note:Record submissions that have been password protected by the provider and are uploaded cannot be processed. You will be Alerted if your submission exceeds the size limit of 50MB for a single file and 200MB for 4 files or more.

NPI: * PTAN: * TIN(last 5 digits):

Provider Name: * Beneficiary Name: * Appeal Number: *

Medicare Number: * Document Control Number: *

Date(s) of Service: * Procedure Code(s) (Required for Outpatient Services only)

Requestor's Name (Printed): * Requestor's Address: *

City: * Zip Code: *

State: * Requestor's Email: *

Telephone Number and Extension: *

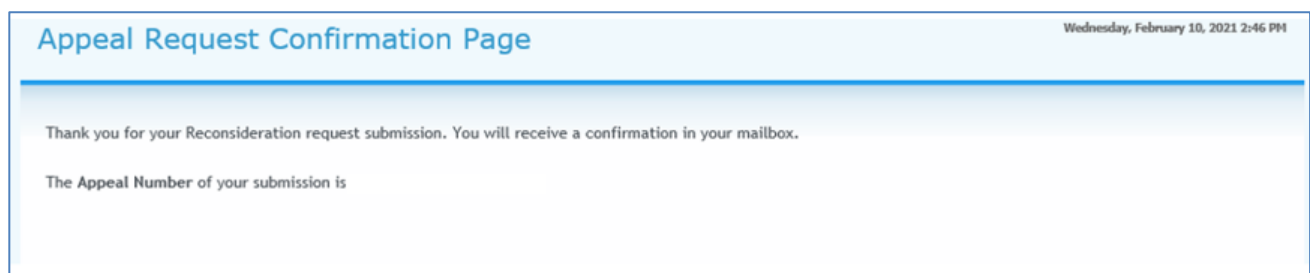
Does your appeal involve a overpayment decision? * ☐ Yes ☐ No

Reason for Reconsideration Request: *

File to Upload: Browse... Upload File

< Back Submit

Figure 75 – Reconsideration (Level 2) Form

The image shows a web page titled "Appeal Request Confirmation Page" with a timestamp of "Wednesday, February 10, 2021 2:46 PM". The page has a light blue header and a white main content area. It contains a thank you message and a label for the appeal number, followed by a large empty space for the number itself.

Appeal Request Confirmation Page

Wednesday, February 10, 2021 2:46 PM

Thank you for your Reconsideration request submission. You will receive a confirmation in your mailbox.

The Appeal Number of your submission is

Figure 76 – Appeal Request Confirmation Page

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10.1.2.1. Additional Appeal Documentation (Level 2 Reconsideration Request)

To submit additional documentation on an existing/open appeal or previously submitted Level 2 Reconsideration Request, click on the **Submit Additional Docs** link as shown in **Figure 77 – Appeals Summary**. This screen is received after selecting the View button displayed in **Figure 69 – Appeal Search Results**.

Appeals Summary							
Appeal Number	Appeal Status	Appeal Level	Request ReceivedDate	Appeal CloseDate	Appeal Type	Decision	
	Promoted	Level 2 (QIC)	11/08/2018	12/18/2018	General	Unfavorable	View Decision Letter Mailed on 12/13/2018
	Promoted	Level 1	10/04/2018	10/29/2018	General	Unfavorable	View Decision Letter Mailed on 10/31/2018 Submit Level 2 Appeal
	Open	Level 1	12/30/2020		General		
	Requested	Level 2 (QIC)	02/10/2021		General		Submit Additional Docs
	Requested	Level 2 (QIC)	01/25/2021		General		Submit Additional Docs

Figure 77 – Appeals Summary

On the screen shown in **Figure 68 - Additional Appeal Documentation (Level 2)**, use the **Browse** button to select the documentation from your files. Once the file is selected, you will see the file name next to the Choose File button. Click **Upload File** to attach file. The file will then display in a chart and additional files can be uploaded, as needed. Once all files are uploaded, select **Submit**. Submitting this documentation will automatically add it to the referenced appeal.

Additional Appeal Documentation (Level 2)
Wednesday, February 10, 2021 2:58 PM

Your additional documentation will automatically be submitted to the appeal number listed below. Please be sure to upload any supporting documentation you want to include with this appeal.

Note: Record submissions that have been password protected by the provider and are uploaded cannot be processed. You will be Alerted if your submission exceeds the size limit of 50MB for a single file and 200MB for 4 files or more.

NPI: *
PTAN: *
State: *

Appeal Number: *

File to Upload:
Browse...

Figure 78 – Additional Appeal Documentation (Level 2)

Once the additional documentation has been accepted, you will receive an Appeal Number as shown in **Figure 76 – Appeal Request Confirmation Page**, and can be viewed in Submit Documents, Submission History.

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10.2. Audit & Reimbursement

To submit information related to Medicare Cost Reports: Select the **Submit Documents** option from the Novitasphere toolbar and then select **Audit & Reimbursement** from the drop down as show in **Figure 79 – Provider Audit and Reimbursement Form**.

Figure 79 – Provider Audit and Reimbursement Form

The selections in the Document Type dropdown will allow you to submit a wide variety of documentation to the Audit & Reimbursement department. The following list is a brief overview of the options available.

Document Type	Description
Reopening	Used for the submission of reopening requests for a cost report after it has been settled.
PRRB (Cost Report) Appeals	Used for the submission of supporting documents for cost reports that are under appeal
SSI Realignment Request (DSH)	Used to request an update to a provider's disproportionate share statistics
Provider-Based Determination	Used to request initial setup or change in a unit's provider-based status
Wage Index/Occupational Mix Submissions	Used to upload documentation for the yearly wage index and occupational mix audits
Desk Review/Audit Additional Documentation	Used to upload documentation requested by the Novitas audit staff during the time of a desk review and/or audit

Document Type	Description
Submit FOIA Request	Used to submit a Freedom of Information Act request for Medicare cost reports
Submit PS&R Request	Used to submit a Provider Statistical & Reimbursement report request for fiscal years not covered on the CMS PS&R online system. Providers may utilize this selection if they are currently experiencing PS&R access issues as well.
General Correspondence	<p>Used to submit documentation for items not covered in the above-mentioned table selections. Such items include the following:</p> <ul style="list-style-type: none"> • Request for Interim Rate Change • Request for Tentative Settlement Change • TEFRA Exception Request • SCH Low Volume Request • Request for Change in Statistical Basis • CMS Tie-In Notice • Bankruptcy • Other Supporting Documentation • 50% Reduction Request

To submit a document: Select the appropriate option from the drop down as show in **Figure 79 – Provider Audit and Reimbursement Form**. Click **Next**.

The following screen as seen in **Figure 80 – Provider Audit & Reimbursement Form** allows you to upload electronic documents according to fiscal period, except for FOIA requests.

Provider Audit & Reimbursement Form Thursday, June 21, 2018 2:26 PM

Please enter the required information in the fields below. Cost reports are processed within 30 business days of receipt.
Note: You will be alerted if your submission exceeds the size limit of 200MB.
 * Indicates a required field.

*Fiscal Period:
 07/01/2017-06/30/2018 ▼

If you cannot locate the provider fiscal period you are searching for, please email the following contact:

- **JL Providers:** settlement@novitas-solutions.com
- **JH Providers:** JHsettlement@novitas-solutions.com

*Supporting Documentation:

Cover Letter ▼ Browse... [Clear](#)

[Add More Documentation](#)

Comment:

*Requester Name:
 Electronic signature

☐ I certify the information I provided on and in connection with this submission is true, accurate, and correct.

[Submit](#) [Reset Form](#)

Figure 80 – Provider Audit & Reimbursement Form

Enter the following information to submit additional documentation. (*Indicates a required field):

- *FISCAL PERIOD
 - Select the Fiscal Period from the dropdown. If you cannot locate the fiscal period you are searching for, utilize the contact emails provided on this screen.
- *SUPPORTING DOCUMENTATION
 - Select the Sub Document Type from the dropdown. A description of the Sub Document Type can be seen by hovering your cursor over each selection as seen in **Figure 81 –Provider Audit and Reimbursement Documentation Sub Document Type Descriptions**. The list of available documents varies depending on the initial Document Type being requested.
 - Utilize the Browse button to select the documentation from your files.
Note - all file formats are acceptable (e.g. Excel, Word, PDF, TIFF, GIF).

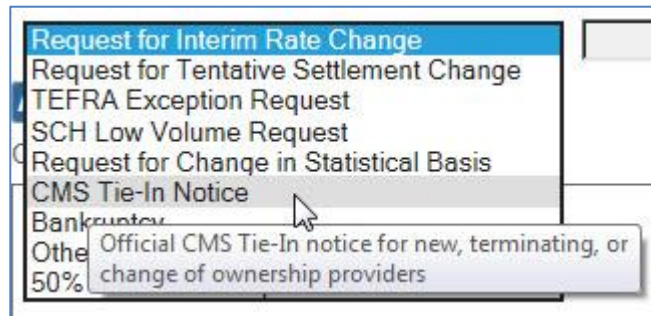


Figure 81 – Provider Audit and Reimbursement Documentation Sub Document Type Descriptions

- ADD MORE DOCUMENTATION
 - The Add More Documentation button will create another line entry with each click, which allows multiple files to be included in a single submission.
- COMMENT
 - Add additional comments in the Comments section to clarify what is being uploaded.
- *REQUESTER NAME
 - Enter your name and click the radio checkbox before clicking Submit to finalize the submission.

Once you have completed this screen, select the **Submit** button displayed in **Figure 82 – Completed Provider Audit and Reimbursement Documentation Submission Form**.

Provider Audit & Reimbursement Form

Friday, June 22, 2018 1:51 PM

Please enter the required information in the fields below. Cost reports are processed within 30 business days of receipt.
Note: You will be alerted if your submission exceeds the size limit of 200MB.

* Indicates a required field.

*Fiscal Period:
07/01/2017:06/30/2018

If you cannot locate the provider fiscal period you are searching for, please email the following contact:

- JL Providers: settlement@novitas-solutions.com
- JH Providers: JHsettlement@novitas-solutions.com

*Supporting Documentation:

CMS Tie-In Notice

File name here

Browse...

Clear

Bankruptcy

File name here

Browse...

Delete

Add More Documentation

Comment:
Enter your comments here

*Requester Name:
John Doe

☒ I certify the information I provided on and in connection with this submission is true, accurate, and correct.

Submit [Reset Form](#)

Figure 82 – Completed Provider Audit and Reimbursement Documentation Submission Form

You will receive a submission acknowledgement and confirmation numb as shown in **Figure 83 –Provider Audit and Reimbursement Documentation Submission Acknowledgement.**

Thank you for your submission

Thank you for using Novitasphere to submit your secure message to Novitas Solutions Inc. The confirmation number of your submission is:

Remember, you can track the status of your submission using this confirmation number.

Figure 83 –Provider Audit and Reimbursement Documentation Submission Acknowledgement

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10.3. CMS-838 Credit Balance Report

When a provider receives an improper or excess payment for a claim, it is reflected in their accounting records (patient accounts receivable) as a “credit”. However, Medicare Credit Balances include money due to the program regardless of its classification in a provider’s accounting records.

Providers are required to submit quarterly Credit Balance reports to identify whether credits exist. The detailed instructions below outline submission of quarterly reports through the Portal.

To Submit a CMS-838 Credit Balance Report: Select the **Submit Documents** option from the Novitasphere toolbar and then select **CMS-838 Credit Balance Report** from the drop down as shown in **Figure 84 – Credit Balance Report.**

CMS-838 Credit Balance Report Tuesday, June 14, 2022 1:56 PM

To begin, print the Credit Balance Report Form, complete it and include it as part of the documentation that you will be uploading.

If you have credits to report, the Credit Balance detail page(s) must be included in your upload.

If you would like to check the processing status of your Credit Balance Submission, please use the Credit Balance Tool on the Self-Service Tools Tab.

Note: Record submissions that have been password protected by the provider and are uploaded cannot be processed. You will be alerted if your submission exceeds the size limit of 200MB.

Contact Name:*

This information should match what is submitted on your report.

Telephone Number:*

This information should match what is submitted on your report.

Quarter End Date:*

This information should match what is submitted on your report and should reflect only 03/31/2022, 06/30/2022, 09/30/2022 or 12/31/2022 format.

Credit Balance Report Form: [Medicare Credit Balance Certification \(CMS-838\)](#)

File to Upload: No file chosen

FEEDBACK

Figure 84 – Credit Balance Report

A link to the CMS-838 Credit Balance Report is provided if needed. Please ensure that all aspects of the Certification and detail pages (if applicable) are complete and accurate. Refer to our Credit Balance resources page ([JL](#))([JH](#)) if additional instructions are needed about reporting.

If credits are being reported, the CMS-838 Detail Pages must accompany your submission and must be included, along with any other supporting documentation, in the upload process. Once the report is completed in full and has been signed, it is ready to upload.

Credit Balances being repaid by check should not be submitted through the Portal. They must be received by mail only. The check must accompany the CMS-838 Certification and Detail Pages along with supporting documentation. The physical address can be found using the links above to our Credit Balance Resources page.

Enter the following information to submit your Credit Balance Report (*Indicates a required field):

- **COMPLETE CONTACT NAME***
 - This should be the same information as entered at the bottom of your CMS-838 Credit Balance Certification
- **COMPLETE TELEPHONE NUMBER***
 - This should be the same as entered at the bottom of your CMS-838 Credit Balance Certification. 10-digit telephone numbers are required with no dashes
- **COMPLETE QUARTER END DATE**
 - This should be in 03/31/20XX, 06/30/20XX, 09/30/20XX or 12/31/20XX format only and should match what was entered on your CMS-838 Credit Balance Certification. The slashes will be auto-populated.
- **FILE TO UPLOAD**
 - Utilize the BROWSE button to locate and attach your report. Once file is added, click Upload File.
- Click Submit.
- Correct errors, if any, and click Submit.

Once you have completed these fields and attached your documentation, select the **Submit** button displayed in **Figure 84 – Credit Balance Report**.

Once submitted, please use our [Online Status Tool](#) to verify receipt within 24-hours to 48-hours of your submission for Certifications indicating no credits, and ten business days if credits are reported. If there are questions or concerns with your submission, please contact creditbalanceinquiries@novitas-solutions.com.

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10.4. Immediate Recoupments

The immediate recoupment process is for providers who have received an overpayment demand letter from Medicare. You may elect to have your overpayment(s) repaid through the immediate recoupment process and avoid paying by check or waiting for the standard recoupment that begins 41 days from the date of the initial demand letter. Novitas Solutions specifies on the Immediate Recoupments Coversheet the options available along with the required documentation that is needed to process your Immediate Recoupment Request.

To Submit an Immediate Recoupments Request: Select the **Submit Documents** option from the Novitasphere toolbar and then select **Immediate Recoupments** from the drop down as shown in **Figure 85 – Immediate Recoupments Input**.

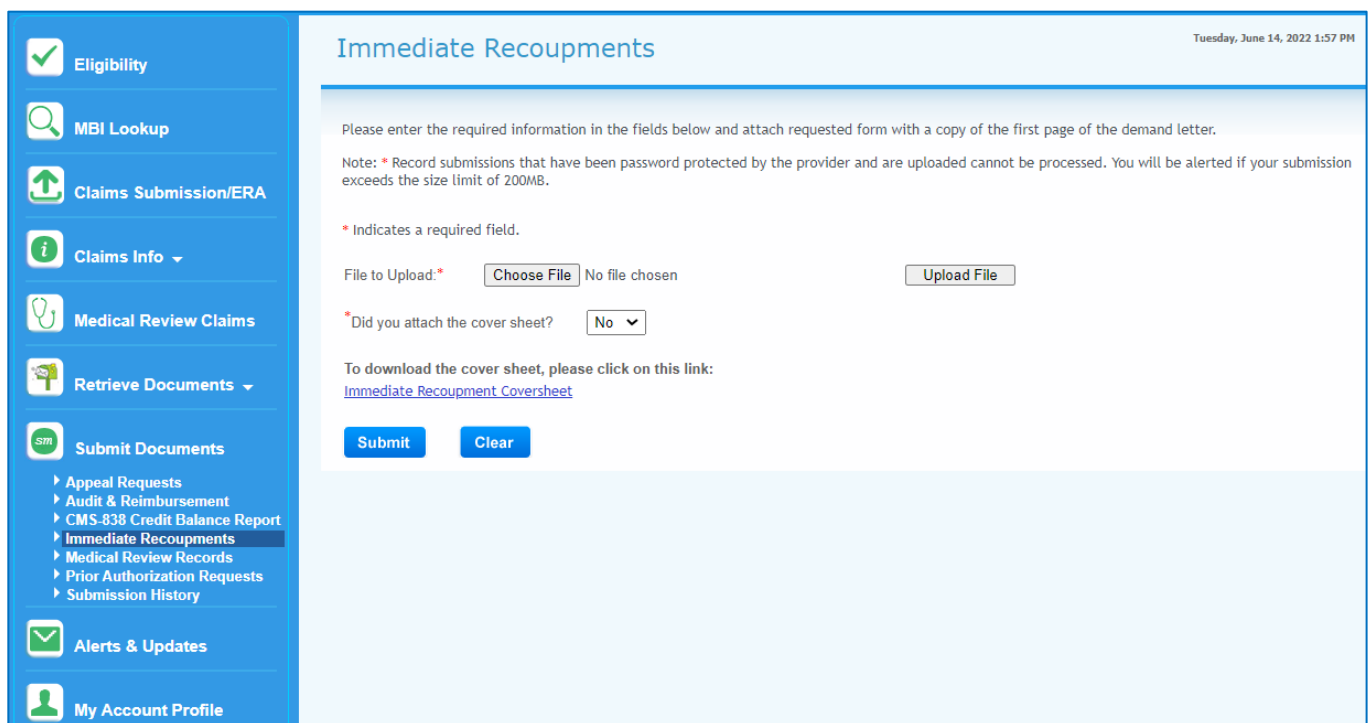


Figure 85 – Immediate Recoupments Input

Download and complete the Immediate Recoupment Coversheet.

Enter the following information to submit your immediate recoupment request (*Indicates a required field):

- ***FILE TO UPLOAD**
 - Utilize the BROWSE button to select the completed Immediate Recoupment Coversheet from your files.
 - The acceptable document formats are TIFF and PDF.
 - Password protected documents cannot be processed and will not be accepted.
- **ADD MORE DOCUMENTATION**
 - Utilize this button if your documentation is in separate files.
- ***Did you attach the cover sheet?**
 - Select Yes. Your request will not be able to be submitted if this field is not changed from No to Yes.

Once you have completed these fields and attached your documentation, select the **Submit** button displayed in **Figure 85 – Immediate Recoupments Input**.

You will receive a record submission acknowledgement shown in **Figure 86 – Immediate Recoupments Confirmation**.

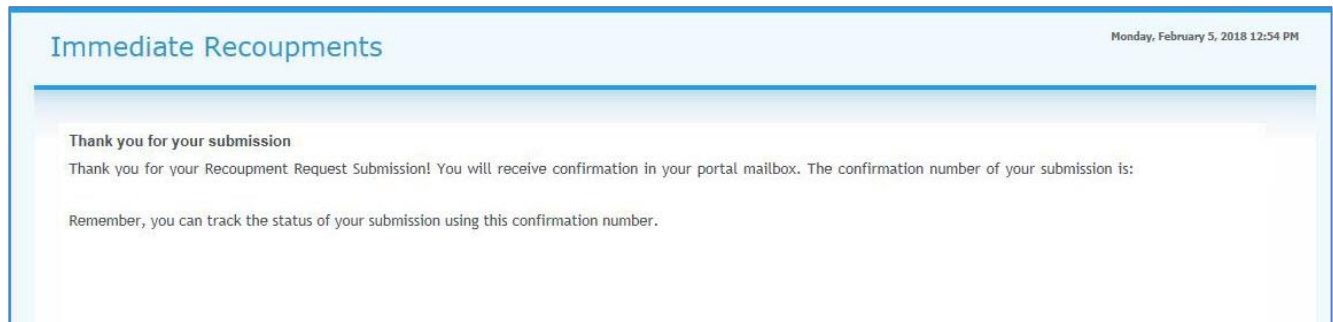


Figure 86 – Immediate Recoupments Confirmation

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10.5. Medical Review Records

The process whereby a contractor requests additional documentation after claim receipt is known as "development". When a coverage or coding determination cannot be made based upon the information on the claim and its attachments (e.g., due to a medical review of the service/claim), contractors may solicit for more information by issuing an Additional Documentation Request (ADR). Novitas Solutions specifies in the development letter or ADR, a description of the type of documentation that is needed to make the coverage or coding determination, along with the date of service. Make sure you review the ADR letter carefully, as the ADR letter may request multiple types of documentation.

This feature may only be used to respond to a Medical Review ADR for pending claims. If the claim has been finalized or denied, please submit a Redetermination Request with medical records if you would like to dispute the claim decision. This feature may not be used to submit medical documentation for initial electronic claims as part of the PWK process. Please review Chapter 8 of the EDI Billing Guide for information on this process ([JL](#))([JH](#)).

To Submit Medical Review Records: Select the **Submit Documents** option from the Novitasphere toolbar and then select **Medical Review Records**.

Figure 87 – Medical Review Record Submission

Enter the following information to submit your medical review record documentation. Include the ADR letter or fax cover sheet as the first page of your attached documentation. (*Indicates a required field):

- *DCN
- *FILE TO UPDLOAD
 - Utilize the Choose File button to select the documentation from your files.
 - the acceptable document formats are TIFF and PDF.
 - password protected documents cannot be processed and will not be accepted.
- Comment
 - Use this field at your discretion. The review is based on the medical documentation that you submit.

Once you have completed these fields and attached your documentation, select the **Submit** button displayed in **Figure 87 – Medical Review Record Submission**.

You will receive a record submission acknowledgement shown in **Figure 88 – Medical Review Record Submission Confirmation**.

Figure 88 – Medical Review Record Submission Confirmation

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10.6. Prior Authorization Request Submissions

Prior Authorization requests are currently only available for the following services and locations: for Medicare Part A – Outpatient Department (OPD) in Pennsylvania, New Jersey, Maryland, Delaware, the Washington D.C. Metro Area, Arkansas, Colorado, Louisiana, Mississippi, New Mexico, Oklahoma, and Texas. The prior

authorization is a program implemented by Medicare that providers can utilize to receive provisional affirmations (approval) before rendering the specific service. This program is required for all OPD procedure codes listed in the [final list](#) of OPD services.

For OPD-exempt providers, Additional Documentation Request (ADR) responses may be submitted under this feature. For detailed instructions, refer to the “Compliance Check for Continued Exemption Status” letter found in the Novitasphere Mailbox feature under Retrieve Documents.

For information on coverage and documentation requirements for Medicare Part A - Outpatient Department (OPD) prior authorization requests please review the [Prior Authorization](#) page on the Novitas Solutions website.

To Submit Prior Authorization Requests: Select the **Submit Documents** option from the Novitasphere toolbar and then select **Prior Authorization Requests** from the drop down as show in **Figure 89 – Prior Authorization Request Submission**.

The screenshot shows the 'Prior Authorization Requests' page in the Novitasphere interface. On the left is a blue sidebar with navigation options: Eligibility, MBI Lookup, Claims Submission/ERA, Claims Info, Medical Review Claims, Retrieve Documents, Submit Documents (selected), Appeal Requests, Audit & Reimbursement, CMS-838 Credit Balance Report, Immediate Recoupments, Medical Review Records, Prior Authorization Requests, Submission History, Alerts & Updates, and My Account Profile. The main content area is titled 'Prior Authorization Requests' and includes instructions, a list of eligible services, a file upload section, a dropdown for 'Did you attach a fully completed coversheet?', and links for downloading cover sheets. A 'Submit' button is at the bottom. A 'FEEDBACK' button is on the right edge.

Prior Authorization Requests Tuesday, June 14, 2022 2:07 PM

Use the required field below to attach the prior authorization request. Please submit ONE (1) Prior Authorization for each request for which documentation is being submitted.

Prior Authorization requests are currently only available for the following services and locations:

- Certain Hospital Outpatient Department (OPD) services in Pennsylvania, New Jersey, Maryland, Delaware, Washington D.C., Arkansas, Colorado, Louisiana, Mississippi, New Mexico, Oklahoma, and Texas. These services fall within the following categories: Blepharoplasty, Botulinum Toxin injections, Panniculectomy, Rhinoplasty, and Vein Ablation, Cervical Fusion with Disc Removal, and Implanted Spinal Neurostimulators.
- Please review the list of related procedure codes before submitting a request to ensure the requested code(s) require prior authorization.
- Please refer to our website for additional information regarding services, Local Coverage Determinations (LCDs), webcasts, and more.

Note: Record submissions that have been password protected by the provider and are uploaded cannot be processed. You will be alerted if your submission exceeds the size limit of 200MB.

* Indicates a required field.

File to Upload:* No file chosen

* Did you attach a fully completed coversheet?

Note: Blank or incomplete coversheets may delay and/or invalidate your request.

To download the cover sheet, please click on this link:

- [Standard OPD coversheet](#)
- [Expedited OPD coversheet](#)

Important: The Prior Authorization departments responses are based on the PTAN used within your Novitasphere account to submit the request and not the PTAN on your coversheet. Therefore you must select the same PTAN within your Novitasphere account when retrieving the response from your mailbox. After submitting your Prior Authorization request, a response letter should be received in the mailbox within 10 business days.

FEEDBACK

Figure 89 – Prior Authorization Request Submission

Enter the following information to submit your prior authorization request. Include the cover sheet as the first page of your attached documentation:

- ***FILE TO UPLOAD**
 - Utilize the BROWSE button to select the documentation from your files.
 - the acceptable document formats are TIFF and PDF.
 - password protected documents cannot be processed and will not be accepted.
- **ADD MORE DOCUMENTATION**
 - Utilize this button if your documentation is in separate files.
- ***Did you attach the cover sheet?**
 - Select yes if you attached a coversheet. The request will not be accepted until yes is selected indicating that there is a coversheet in the submission.

Once you have completed these fields and attached your documentation, select the **Submit** button displayed in **Figure 89 – Prior Authorization Request Submission**.

You will receive a record submission acknowledgement shown in **Figure 90 – Prior Authorization Request Submission Confirmation**. A Prior Authorization response letter will be issued within 10 days after submission and can be in the Mailbox feature. The Mailbox is located under the Retrieve Documents option in Novitasphere.

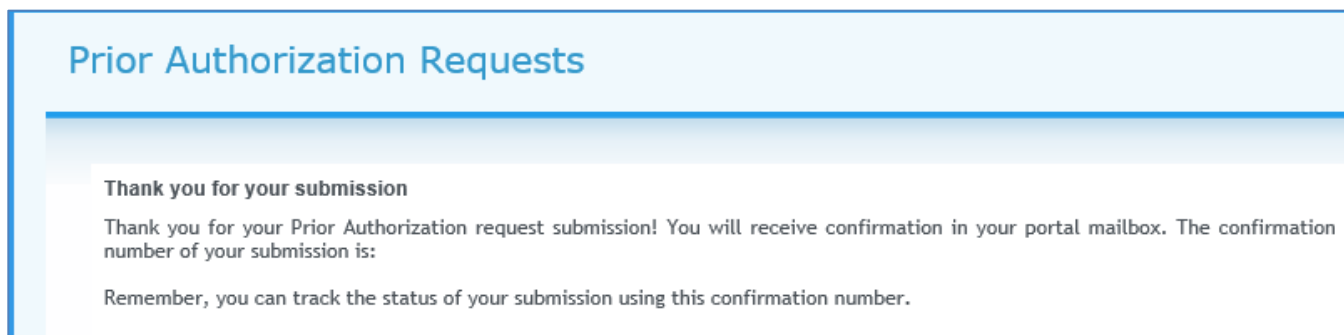


Figure 90 – Prior Authorization Request Submission Confirmation

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10.7. Submission History

You may check the status of documents submitted via Submit Documents by using the Submission History feature. You can search by entering the date range or confirmation identification number as show in **Figure 91 - Submission History – Search by Date Range** and **Figure 92 - Submission History – Search by Confirmation ID**.

To view your Submission History: Select the **Submit Documents** option from the Novitasphere toolbar and then **Submission History**.

Enter the following information (*Indicates a required field):

- SUBMISSION TYPE
 - Select Medical Review Submission, Audit & Reimbursement, Prior Authorization Submission, Immediate Recoupments, or Appeal Requests.
- SEARCH CRITERIA
 - Select Date Range or Confirmation ID.

Depending on the search criteria, enter:

- *DATES OF SUBMISSION
 - Dates may be entered as MMDDYY or MMDDYYYY. Forward slashes will be populated automatically.
- *CONFIRMATION ID
 - Enter the confirmation ID that appears on your acknowledgement PDF.

The screenshot shows the 'Submission History' page. On the left is a blue sidebar with navigation links: Eligibility, MBI Lookup, Claims Submission/ERA, Claims Info, Medical Review Claims, Retrieve Documents, Submit Documents (with a sub-menu including Appeal Requests, Audit & Reimbursement, CMS-838 Credit Balance Report, Immediate Recoupments, Medical Review Records, Prior Authorization Requests, and Submission History), Alerts & Updates, and My Account Profile. The main content area has a title 'Submission History' and a search section with two dropdown menus: 'Submission Type: Select One' and 'Search Criterion: Select One'. Below these are 'Search >' and 'Clear' buttons.

Figure 91 – Submission History – Search by Date Range

This screenshot shows the 'Submission History' page with a different search criterion. The 'Search Criterion' dropdown is set to 'Confirmation ID'. Below the dropdowns, there is a text input field labeled 'Confirmation ID: *'. The 'Search >' and 'Clear' buttons are still present. The page header includes the title 'Submission History' and a timestamp 'Monday, June 11, 2018 1:31 PM'.

Figure 92 – Submission History – Search by Confirmation ID

While the documents are being uploaded to the imaging system, it will show “Processing.” Once the documentation has been imported and accepted by our imaging system, the status will change to “Received,” as shown in **Figure 93 – Submission History –Submission Results**. If there are any errors in uploading the file, it will show “Upload Fail*” and you will need to resubmit your file.

Note - password protected documents cannot be processed. If you attempt to upload a password protected document, it will initially be accepted and may show the “Processing” status. However, once our imaging system attempts to import the document, it will reject, and the status will change to “Rejected.”

Submission History

Thursday, December 28, 2017 2:14 PM

Submission Type: Medical Review Submission

Search Criterion: Date Range

Please select a Date Range below, to view your documentation submission history:
 Note: * Indicates a required field. Dates may be entered as MMDDYY or MMDDYYYY. Forward slashes will be populated automatically.

Date(s) of Submission:* 01/01/2017 To: 12/01/2017

Search > Clear

Confirmation ID	Form	Status	Submission Date
Confirmation IDs	Medical Review Submission - ()	Received	2017-08-01 14:18:44.497
	Medical Review Submission - ()	Received	2017-07-10 10:54:06.607
	Medical Review Submission - ()	Received	2017-05-17 14:03:24.553
	Medical Review Submission - ()	Received	2017-04-07 10:18:27.34
	Medical Review Submission - ()	Received	2017-04-06 13:50:40.197
	Medical Review Submission - ()	Received	2017-01-10 12:21:40.17

Figure 93 –Submission History –Submission Results

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11. Alerts & Updates

You can access to relevant Medicare Communications about Novitasphere and related functionality via the Alerts & Updates feature. For example, this feature will be used to post information about system downtime for maintenance or new/modified functionality.

We encourage you to access the Alerts & Updates feature upon logging into Novitasphere for any new Novitasphere related information. However, this does not replace the www.novitas-solutions.com website for general Medicare updates.

To view Alerts & Updates messages: Select the **Alerts & Updates** option on the Novitasphere toolbar as seen in **Figure 94 – Alerts & Updates**.

View any communications which have been published by clicking the **View** button. You may print a copy of the message by using the PDF button displayed once a message has been selected.

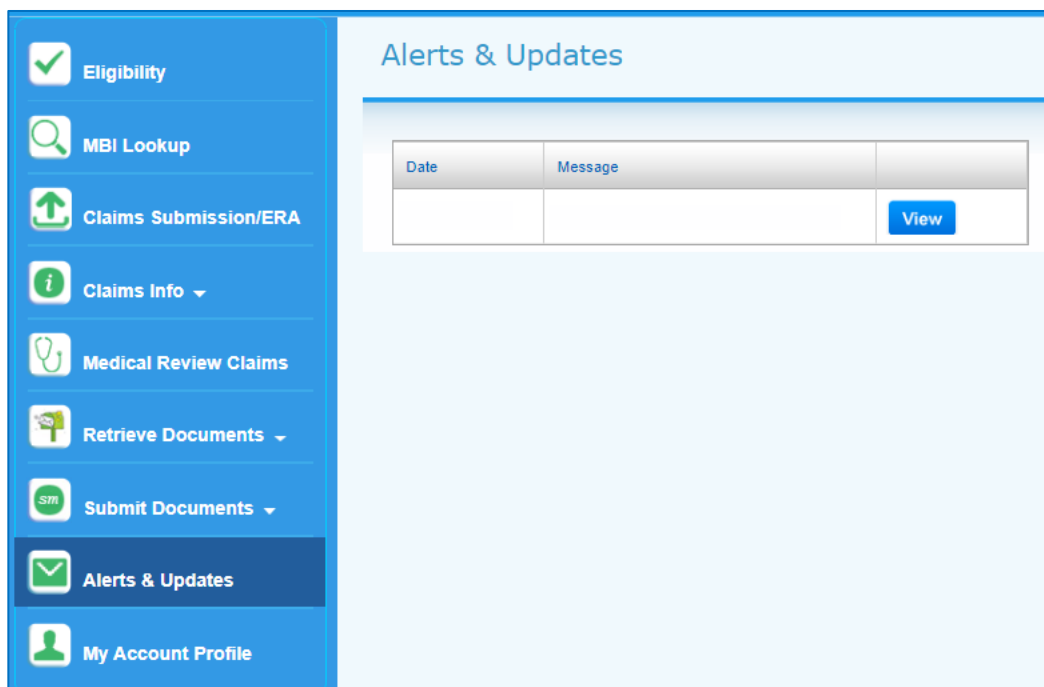


Figure 94 – Alerts & Updates

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12. My Account Profile

To change your password, add or remove Multi-Factor Authentication (MFA) devices, or for additional staff to request their own access to Novitasphere, a link to the IDM system is available under the My Account Profile option. The My Account Profile feature also provides additional information as seen in **Figure 95 – My Account Profile**.

- User Name
- User ID
- Organization Name
- Organization Submitter ID (Novitasphere Submitter ID)

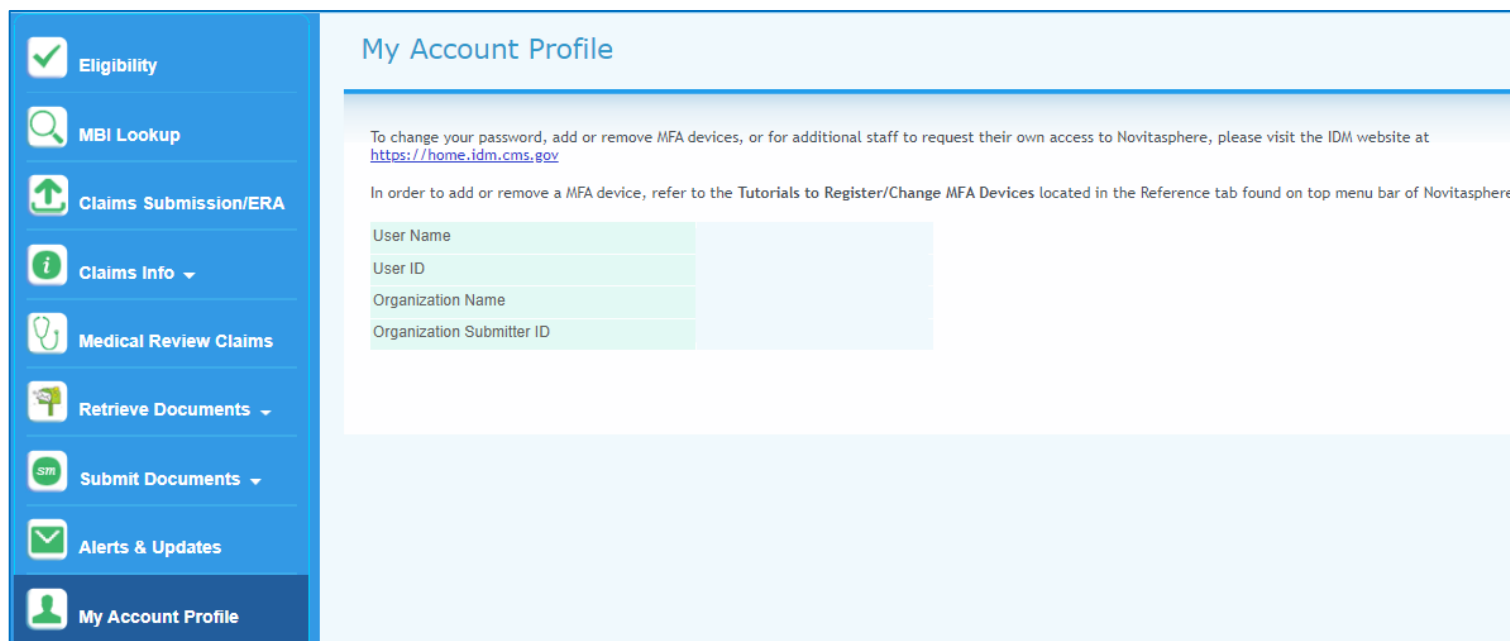


Figure 95 – My Account Profile

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13. Novitasphere Help

3.1. Reference

You can access reference information for Novitasphere use at any point during a Novitasphere session.

To view Reference Materials: Select the **Reference** option on the horizontal Novitasphere toolbar. The Reference Materials available will be displayed as seen in **Figure 96 – Reference**.

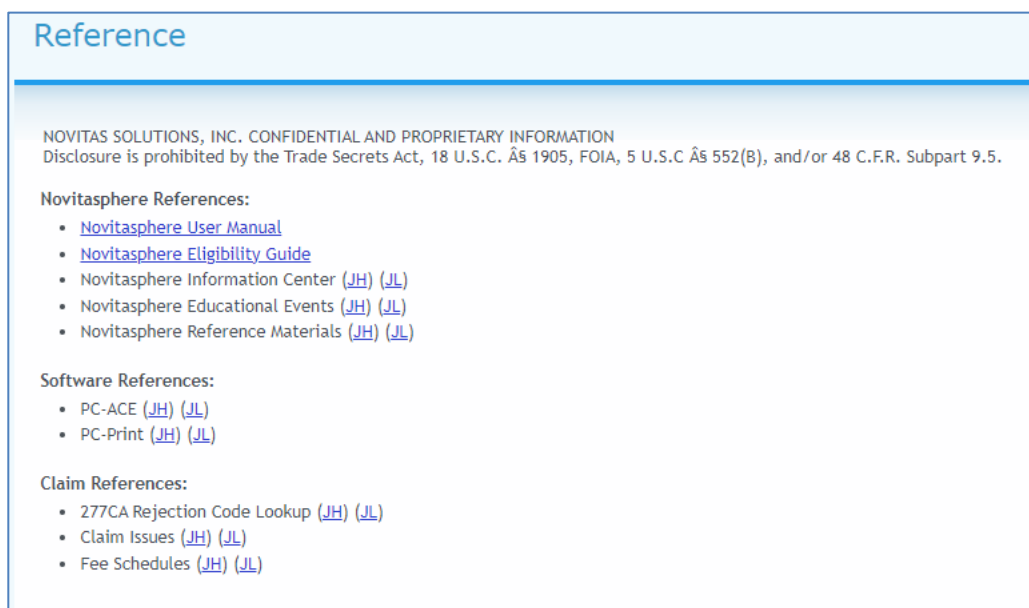


Figure 96 – Reference

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13.2. Self Service Tools

You can access links to the self-service tools available on the Novitas Solutions website at any point during a Novitasphere session as seen in **Figure 97 – Self Service Tools**.

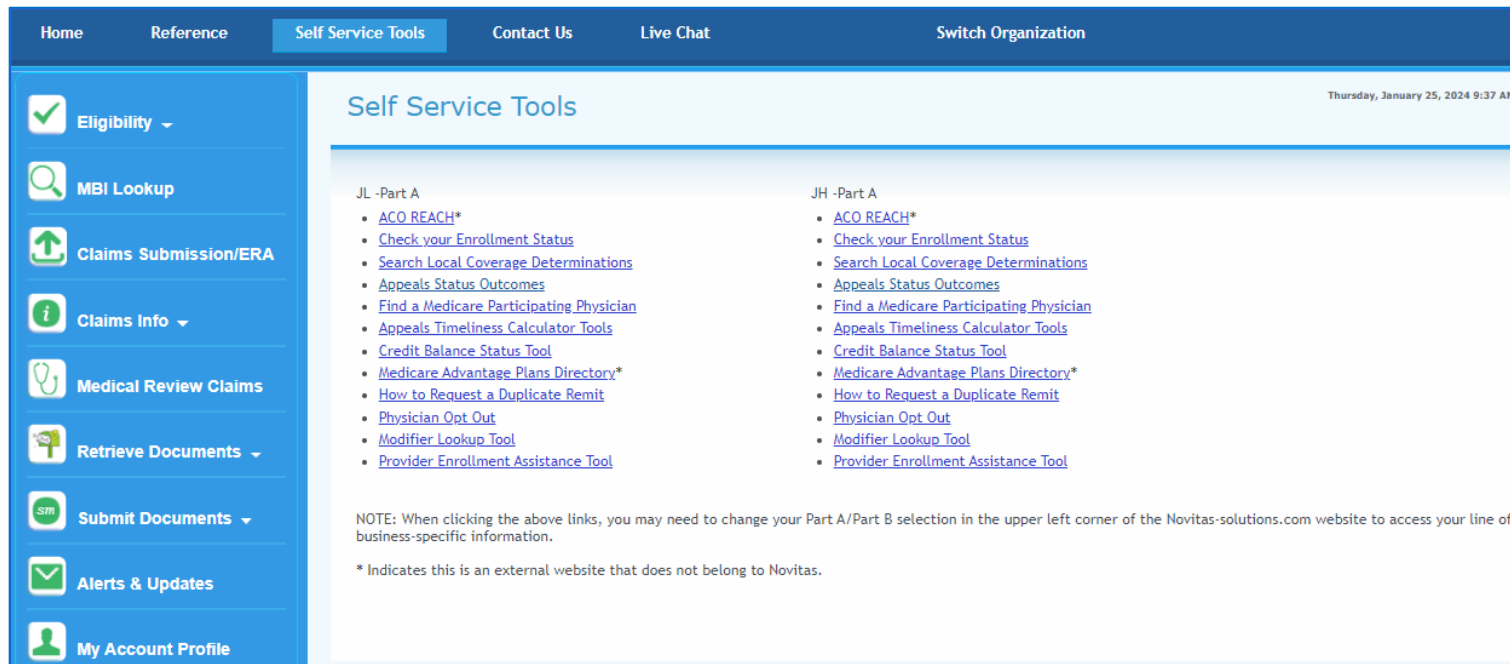


Figure 97 – Self Service Tools

13.2.1. Appeal Status Outcomes

Appeal status can be obtained within the Self Service Tools option.

To view Appeals Status: Select the **Self Service Tools** option from the Novitasphere toolbar at the top of the screen and then select **Appeal Status Outcomes** from the links under your Jurisdiction as shown in **Figure 97 – Self Service Tools**.

The screenshot shows the 'Appeal Status' form in Novitasphere. The form has a title 'Appeal Status' and a timestamp 'Friday, May 10, 2019 3:46 PM'. Below the title is a paragraph: 'Novitasphere, a secure internet portal, provides additional appeal details not available through the Appeals Status Tool found on the www.novitas-solutions.com website.' followed by a note: 'Note: * Indicates a required field. Dates may be entered as MMDDYY or MMDDYYYY. Forward slashes will be populated automatically.' The form contains several input fields: 'Appeal Number:' (text box), 'Claim Number:' (text box), 'Status:' (dropdown menu with 'Select One'), 'Case Type:' (dropdown menu with 'Select One'), 'Medicare ID:*' (text box), 'Outcome:' (dropdown menu with 'Select One'), 'Date(s) of Service:*' (text box with '05/10/2019'), and 'To:' (text box with '05/10/2019'). At the bottom are two buttons: 'Submit' and 'Clear'.

Figure 98 - Appeal Status

Enter the following information (*Indicates a required field):

- Appeal Number – The case number of the appeal.
- Claim Number – The Document Control Number (DCN).
- Medicare Beneficiary ID* – The Medicare Beneficiary Number or Health Insurance Claim Number tied to

- the claim.
- Date(s) of Service*

Select the Submit button displayed in **Figure 98 – Appeal Status**. The screen shown in **Figure 99 – Appeal Status Search Results** will be displayed.

Appeal Status

Friday, May 10, 2019 3:46 PM

Novitasphere, a secure internet portal, provides additional appeal details not available through the Appeals Status Tool found on the www.novitas-solutions.com website.

Note: * Indicates a required field. Dates may be entered as MMDDYY or MMDDYYYY. Forward slashes will be populated automatically.

Appeal Number:

Claim Number:

Status:

Select One ▾

Case Type:

Select One ▾

Medicare ID:*

Outcome:

Select One ▾

Date(s) of Service:*

05/01/2018

To:

05/10/2019

Submit

Clear

Appeal Number	Medicare Beneficiary ID	Claim Number	Date From	Date To	Status	Closed Date	Receipt Date	Outcome
			08/20/2018	08/20/2018	Final	11/12/2018	10/29/2018	Unfavorable

Figure 99 – Appeal Status Search Results

The following information will be displayed:

- Appeal Number: The case number of the appeal
 - Medicare Beneficiary ID
 - Claim Number: The Document Control Number (DCN) for the claim
 - Date From/Date To: The earliest and latest date of service listed on the claim.
 - Status: Status of the appeal
 - Blank – Cases that are still under review
 - Final – Closed cases
 - Closed Date: Date the appeal decision was finalized
 - Receipt Date: The date the case was received
 - Outcome: The outcome of the Appeal Decision once finalized. The following outcomes are available within this appeal status feature:
 - Appt of Rep Incomplete or Absent
 - Duplicate
 - Failure to File Timely
 - Favorable
 - Inquiry
 - Internal Routing Error – Transfer to Novitas Part B Appeals
 - Medical Review Reopening
 - No Disposition – Pending Status
 - No Right to Appeal
 - Partially Favorable
 - Party Fail to Make Valid Appeal
 - Unfavorable
 - Contract Name – Transfer of request to correct Contractor (e.g. MAC, QIC).
- Note - An appeal initially received in JH for a JL claim will show two appeal numbers: one for the JH appeal and another for the new appeal number under JL.*

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13.3. Contact Us

You can access contact information for Novitas Solutions at any point during a Novitasphere session.

To access contact information: Select the **Contact Us** option on the horizontal Novitasphere toolbar. Contact Information will be displayed as seen in **Figure 100 – Contact Us**.

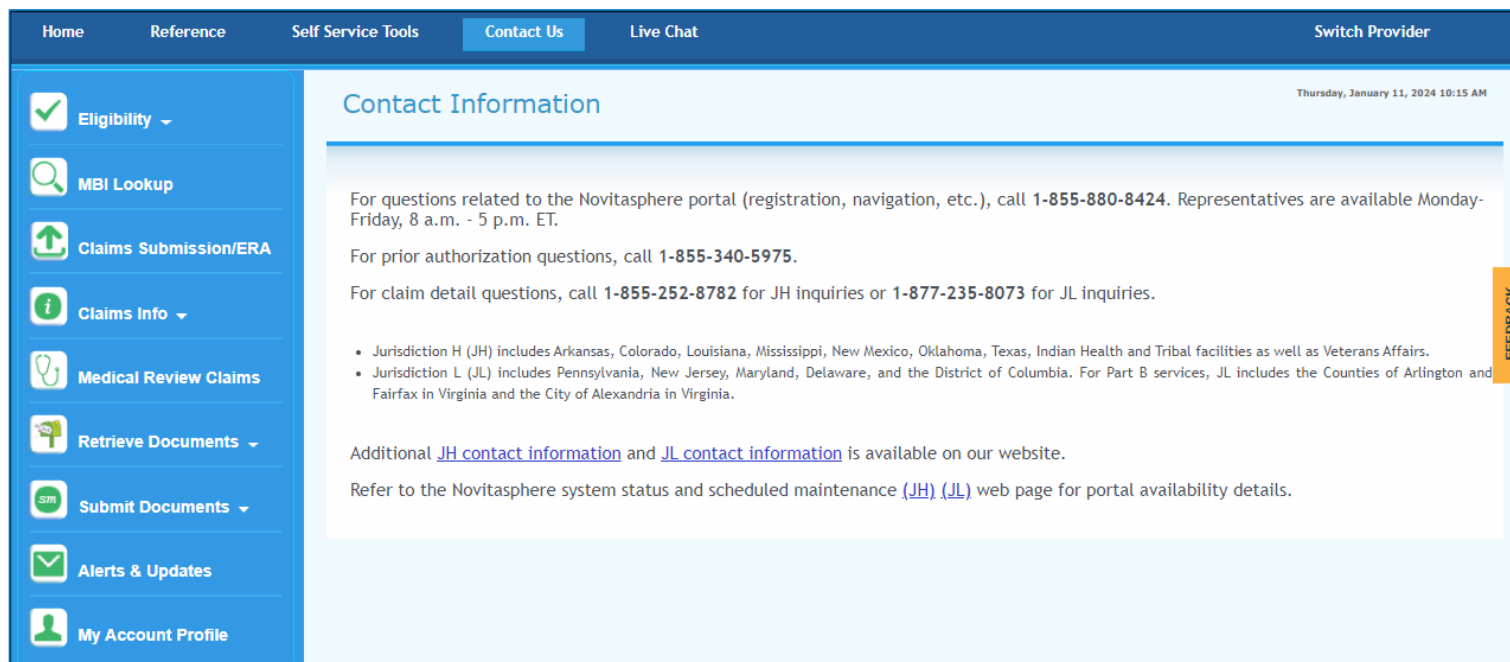


Figure 100 – Contact Us

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13.4. Live Chat

You can connect with a live chat agent for questions about Novitasphere Navigation, Novitasphere Enrollment, and IDM Registration related questions.

Web Chat for Novitasphere support is available **Monday-Friday from 10:00 AM Eastern Time (ET) – 2:00 PM ET**, excluding observed Novitas holidays.

Live chat agents will be able to answer many of your questions through this fast and easy option; however, questions regarding password resets, or which require additional Personally Identifiable Information (PII) data to research (such as claim-specific questions) will need to be directed to the Novitasphere Help Desk for assistance. This is to protect your information as well as your patients! Any chat discussions that include PII will be terminated for privacy purposes.

To initiate a chat: Select the **Live Chat** option on the horizontal Novitasphere toolbar as seen in **Figure 101 – Live Chat**.

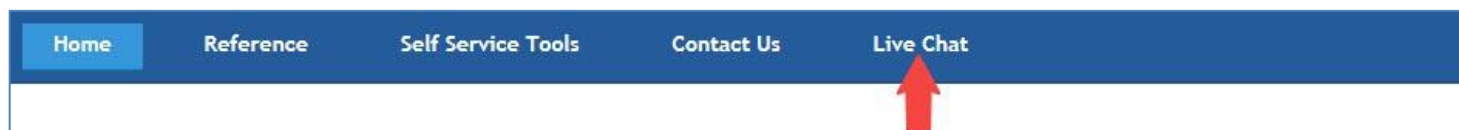


Figure 101 – Live Chat

Click the **Click here to begin Chat** button in the new window. Enter the following data elements to begin the

chat (*Indicates a required field):

- Your Name*
- Email Address
- Reason for your chat*
- Area of interest*

Click **Submit** as shown in **Figure 102 – Pre-chat Information**.

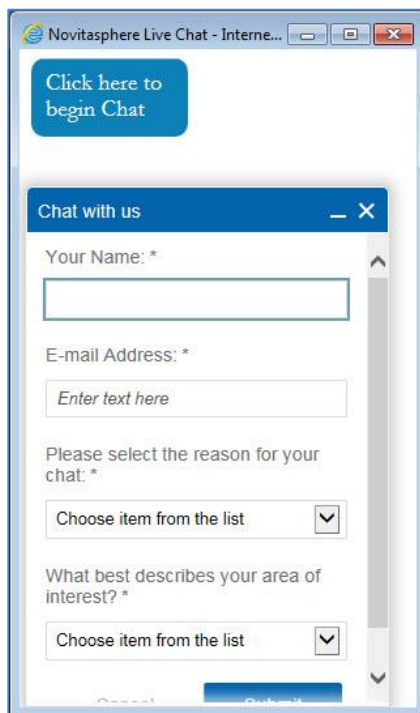
The image shows a web browser window titled "Novitasphere Live Chat - Interne...". Inside the window, there is a blue button that says "Click here to begin Chat". Below this, there is a "Chat with us" dialog box. The dialog box contains four required fields: "Your Name: *" with a text input field, "E-mail Address: *" with a text input field containing the placeholder "Enter text here", "Please select the reason for your chat: *" with a dropdown menu showing "Choose item from the list", and "What best describes your area of interest? *" with a dropdown menu also showing "Choose item from the list". At the bottom of the dialog box, there is a blue "Submit" button.

Figure 102 – Pre-chat Information

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14. Feedback

You are encouraged to submit Feedback at any point during a Novitasphere session.

To submit Feedback: Select the **Feedback** option on the right side of the Novitasphere screen. You will be invited to respond to a series of questions.

Note - Comments should be limited to information related to your Novitasphere portal experience.