NOVITAS SOLUTIONS

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.

https://www.novitasphere.com

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.

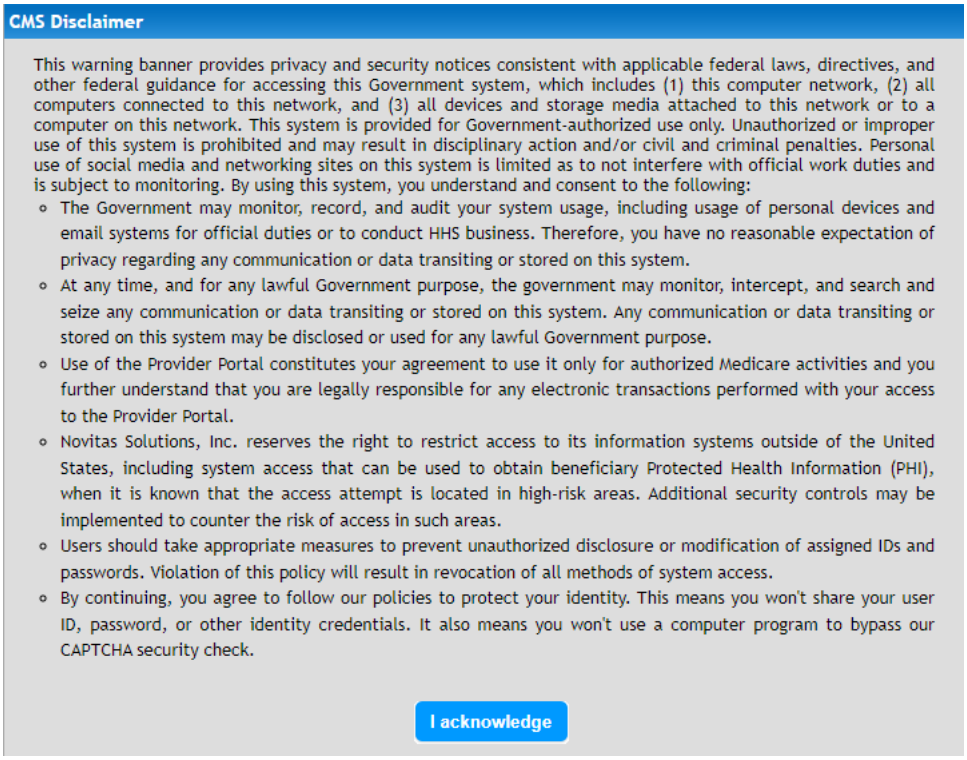

Figure 1 – Novitasphere Disclaimer

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.

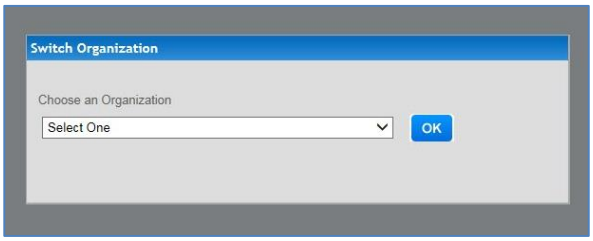

Figure 2 - Switch Organization

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

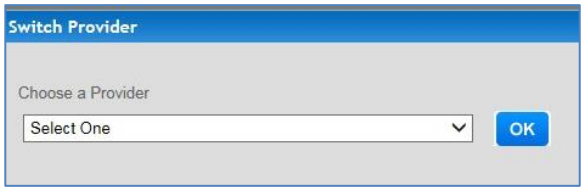

Figure 3 – Switch Provider

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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.**

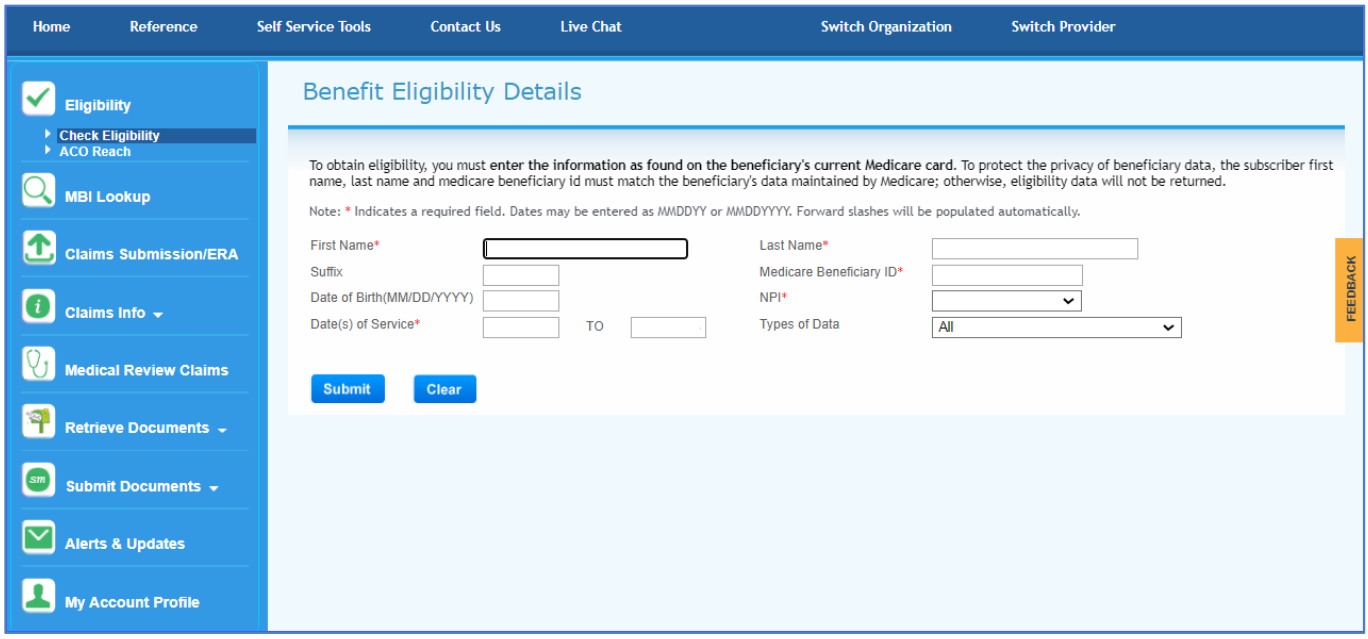

Figure 5 – Benefit & Eligibility Input

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.

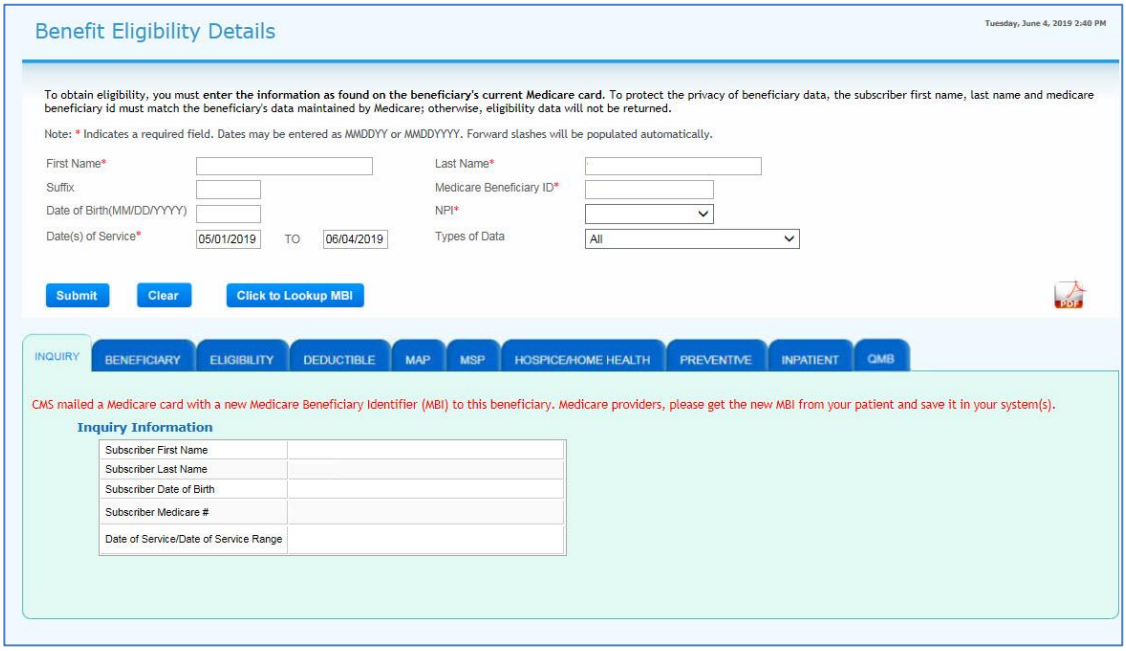

Figure 6 – Benefit & Eligibility Output

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.**

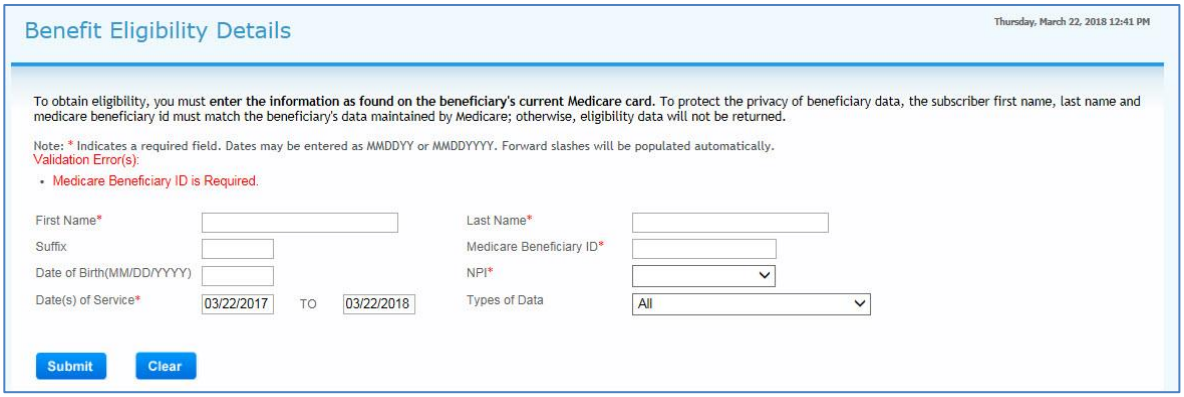

Figure 7 – Benefit & Eligibility Error Message

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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. *Note – these will not populate if the MSP file was set up with ICD-9 codes.*
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.

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4.1.2.8. Hospice/Home Health Tab

Field Name	Information Displayed
Home Health Certification	
HCPCS Code	The procedure code used for physician certification for Medicare covered home health services.
Certification Date HCPCS Code	The date of the certification for Home Health Services. The procedure code used for physician re-certification for Medicare covered home health services.
Recertification Date	The date of the re-certification for Home Health Services.
Home Health Care	
HHEH Start Date	The date the 60-day Home Health episode period started.
HHEH End Date	The date that the Home Health episode terminated.
HHEH DOEBA Date	The Earliest Billing Date.
HHEH DOLBA Date	The Latest Billing Date.
Patient Status Code	This field is used to verify the home health period had ended. 1 = discharged 30 = active
Notice of Admission Indicator (NOA)	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
Provider Number	The NPI Number of the Home Health Facility.
Contract Name	Medicare Contractor Name.
Contract Number	Medicare Contractor Number.
Total Number of Hospice Occurrences	The total Number of Hospice Occurrences.
Hospice	
Effective Date	The effective date of the Hospice period.
Termination Date	The termination date of the Hospice period.
Provider Number	The NPI number of the Hospice Facility.
Revocation Code	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”

4.1.2.9. Preventative Services Tab

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

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 Remaining Deductible	This field will always display 0 for a Qualified Medicare Beneficiary. This field will be blank for a Qualified Medicare Beneficiary.
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.

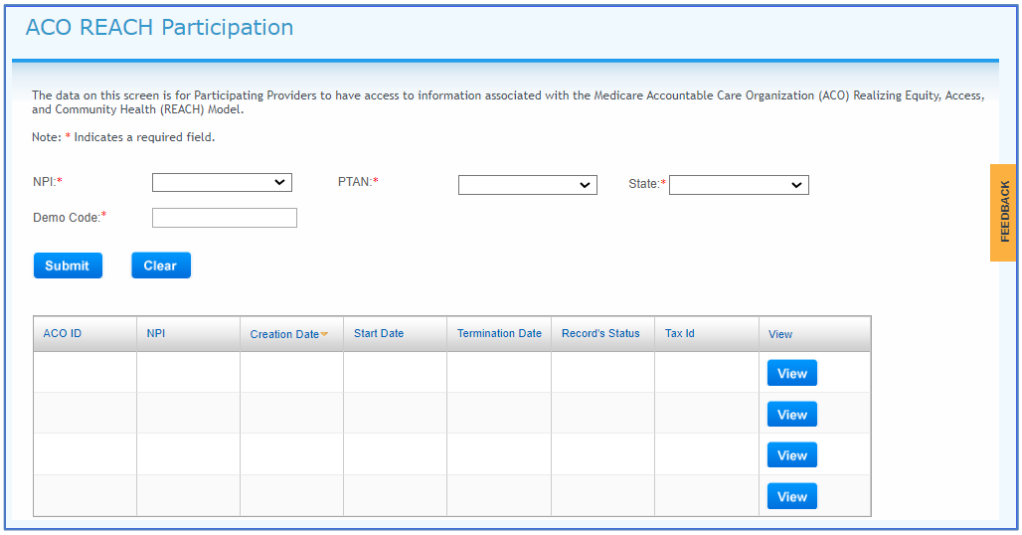

Figure 7.5 – ACO REACH Participation screen

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

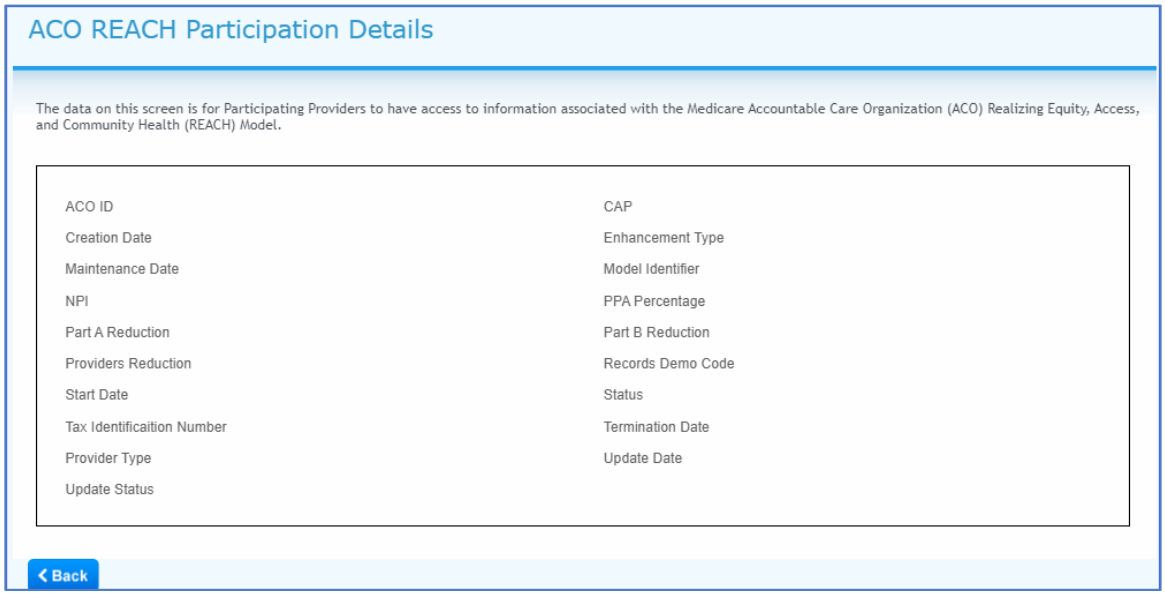

Figure 7.8 – ACO REACH Participation Details screen

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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.**

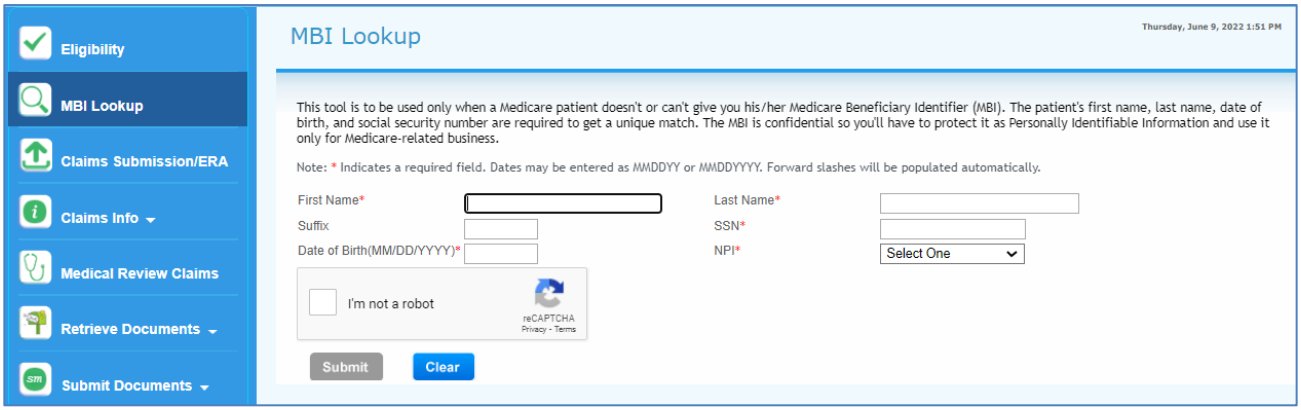

Figure 8 – MBI Lookup Input

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.

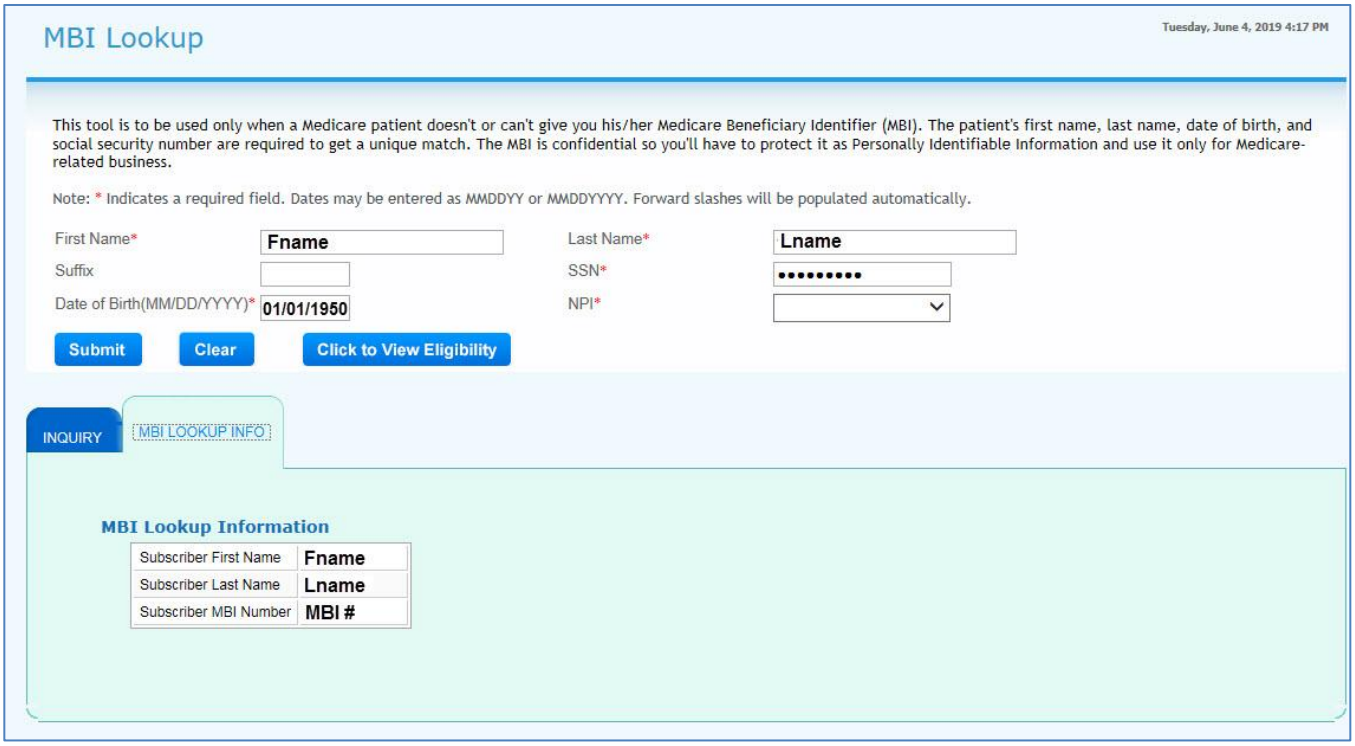

Figure 9 – MBI Lookup Info

If no search results are found, the MBI Lookup Info tab will be greyed out.

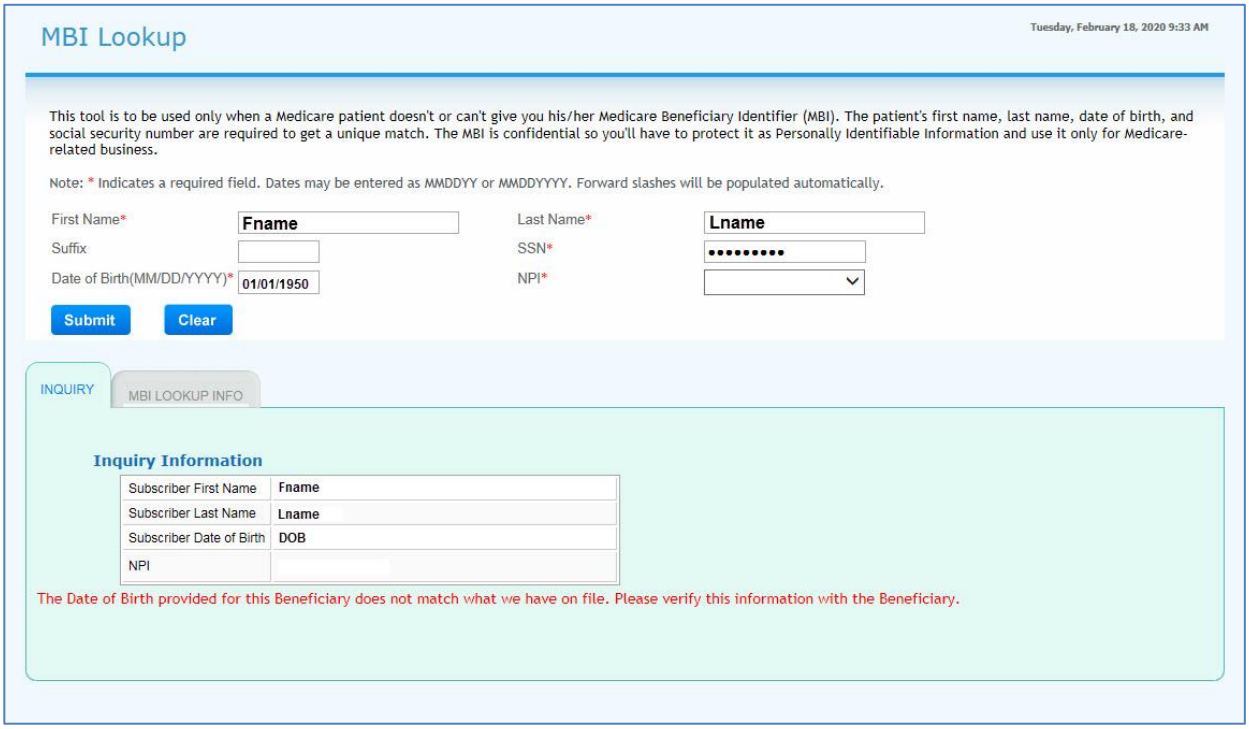

Figure 10 – MBI Lookup Output

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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**.

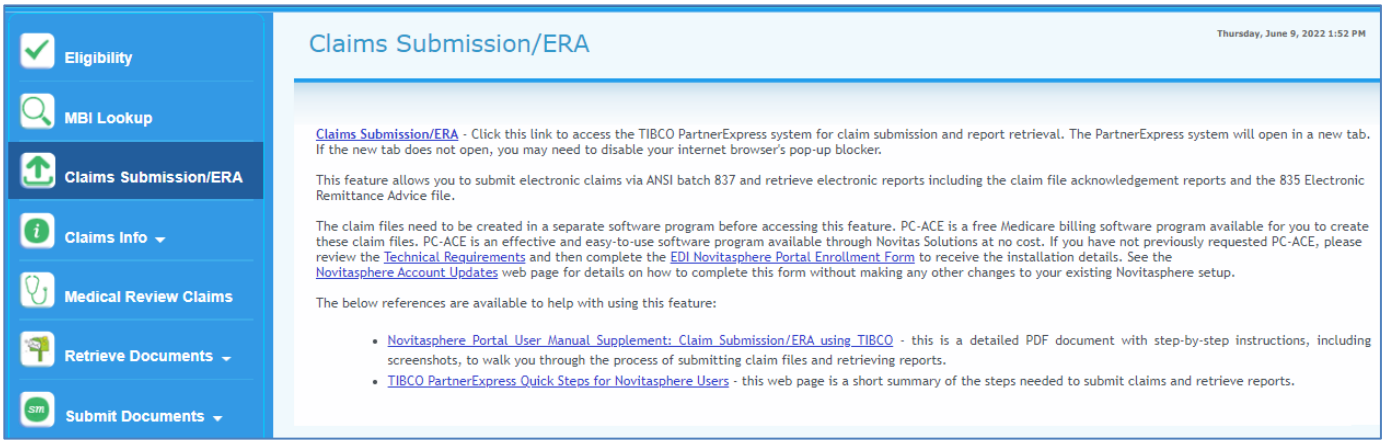

Figure 11 – Claims Submission/ERA

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.

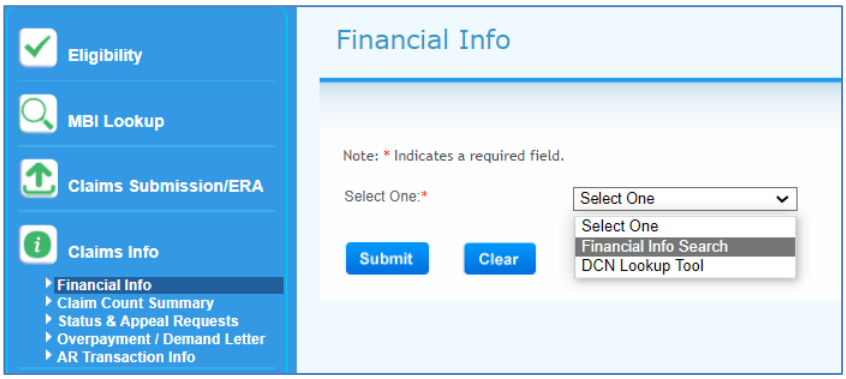

Figure 27 – Financial Info Options

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.

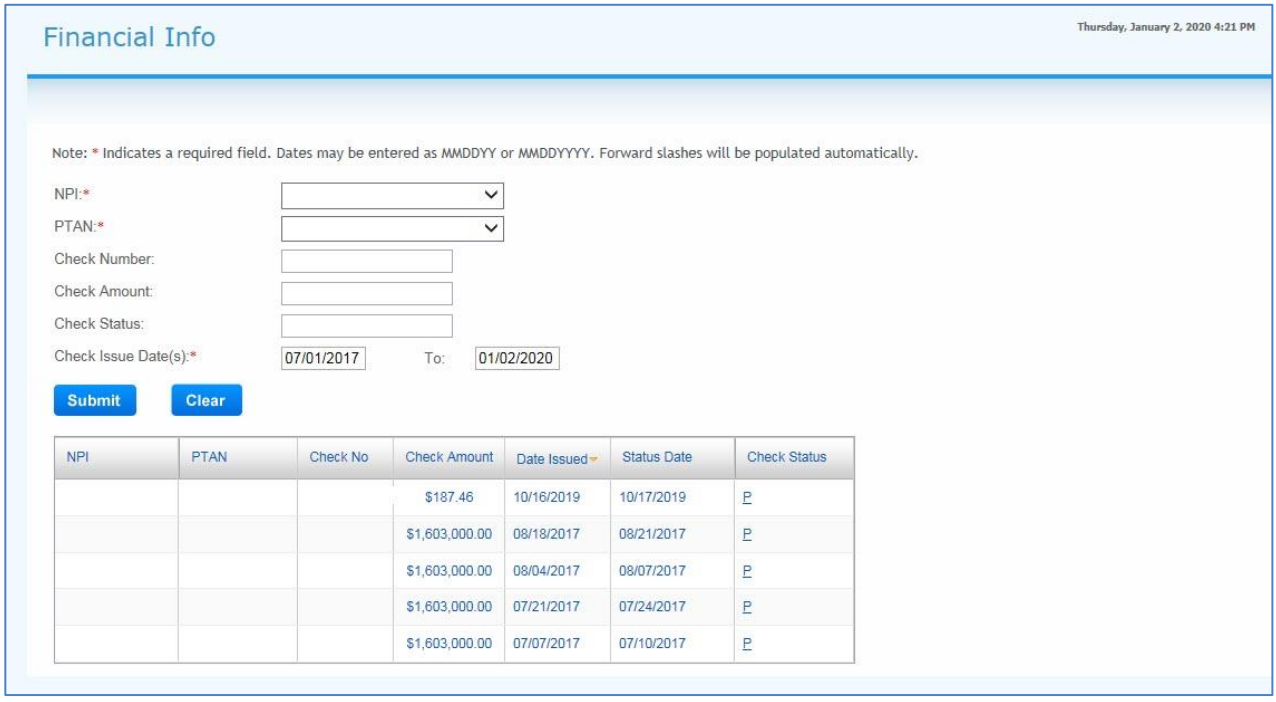

Figure 28 – Financial Info Search Output

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.**

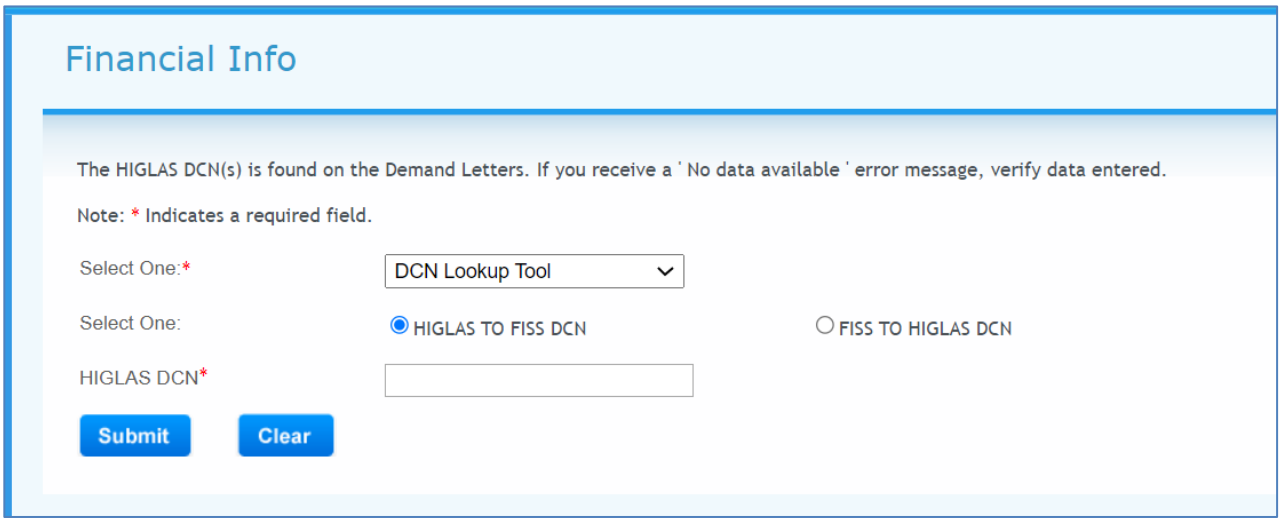

Figure 29 – Financial Info DCN Lookup Tool

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**.

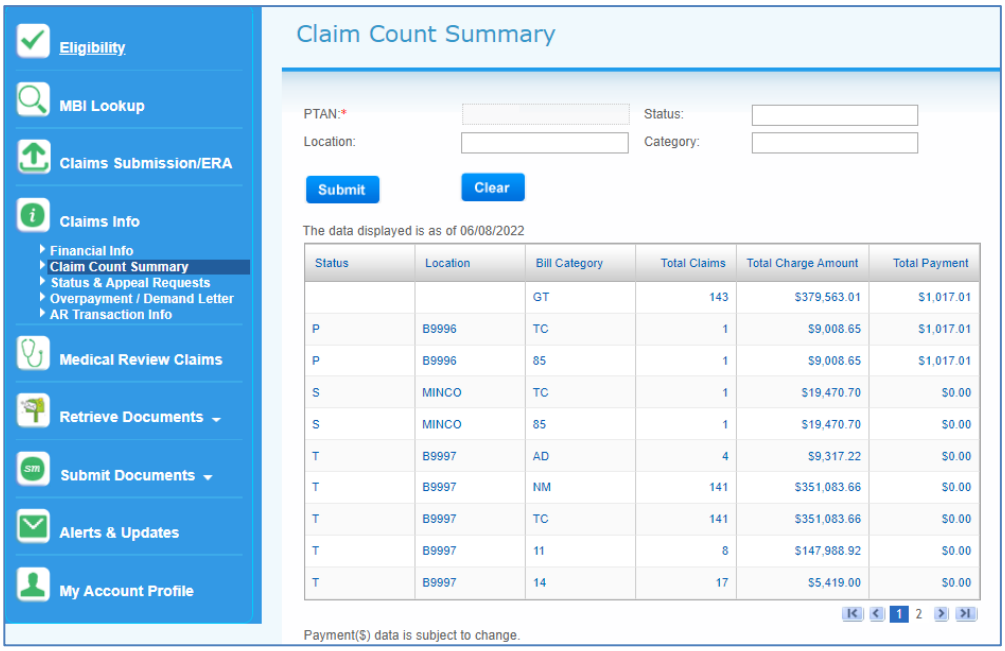

Figure 30 – Claim Count Summary

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.**

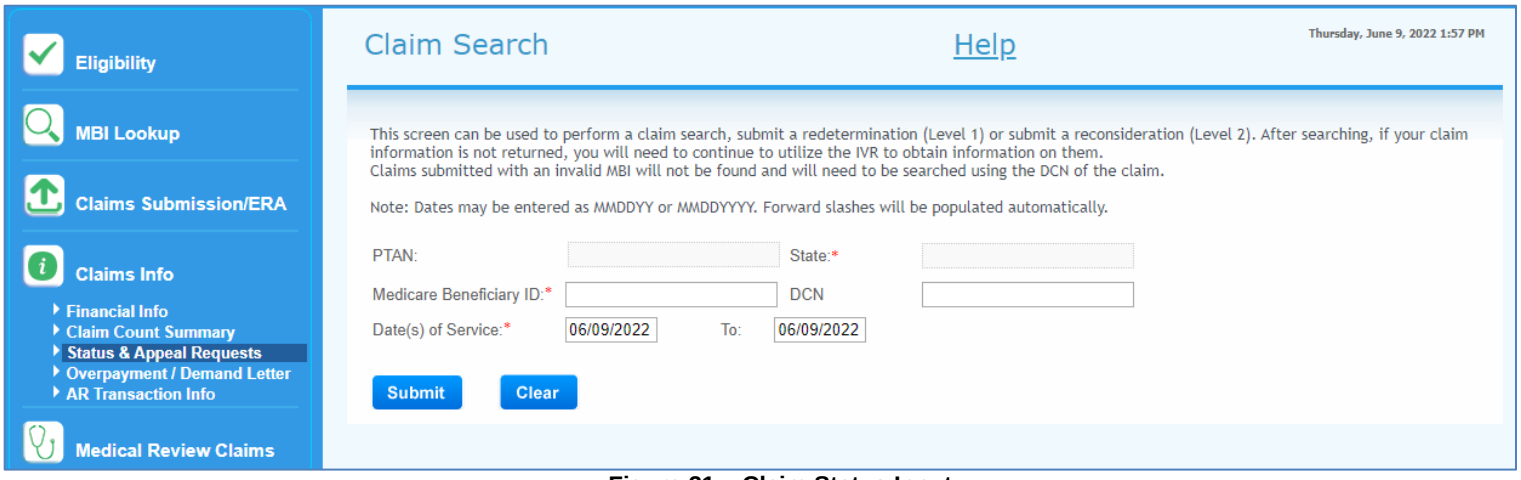

Figure 31 – Claim Status Input

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.

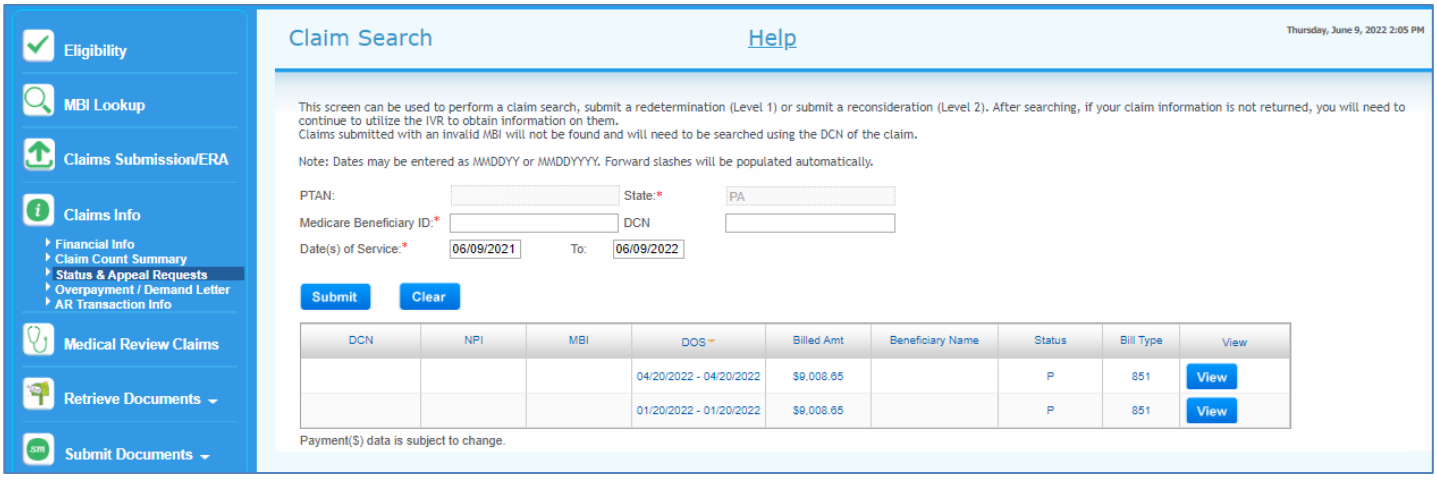

Figure 32 – Claim Status Output

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.**

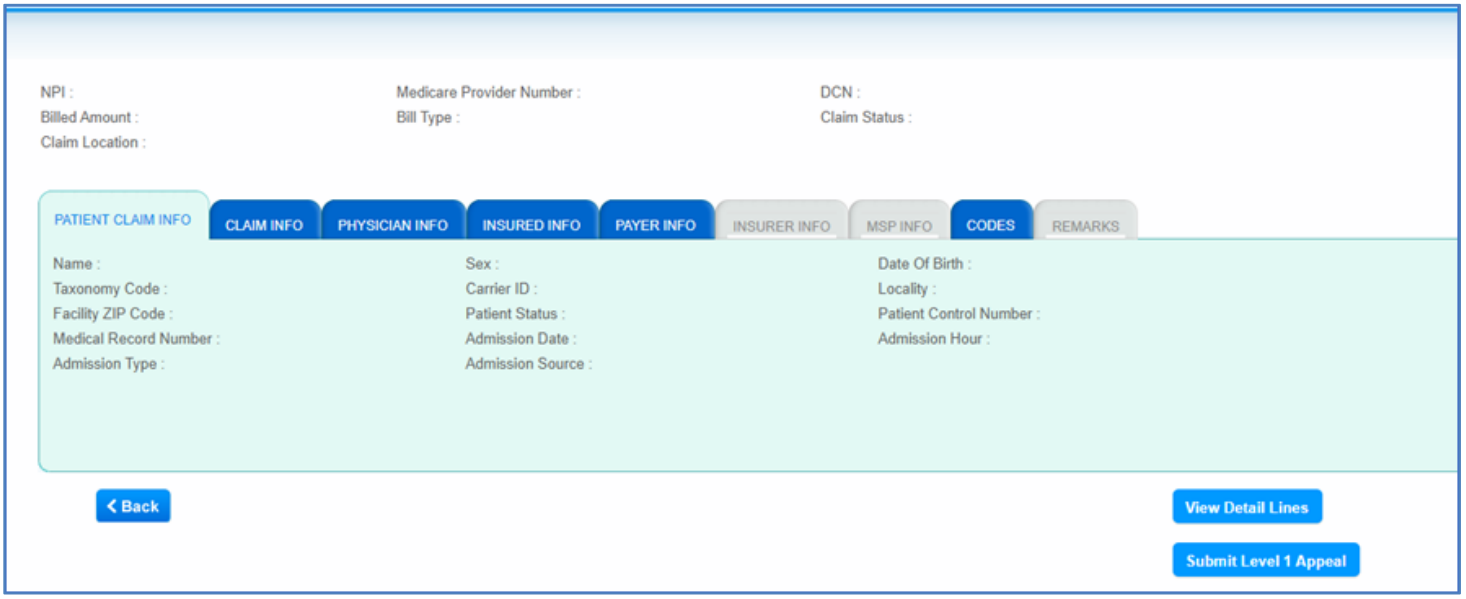

Figure 33 – Claim Status Output Header Level

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	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. If the claim was cancelled or adjusted, the cancel date and cross ref DCN will display. If the claim processed as a duplicate, the claim duplicate DCN will display.
Physician Info	This tab displays Attending Physician, Operating Physician, Other Physician, Rendering Physician and/or Referring Physician information when reported on the claim. Displays name of physician, NPI and Specialty Code.
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	This tab displays all coding reported on the claim. A description of the diagnosis codes and/or procedure codes can be viewed by clicking the code. The description will display on screen.
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.

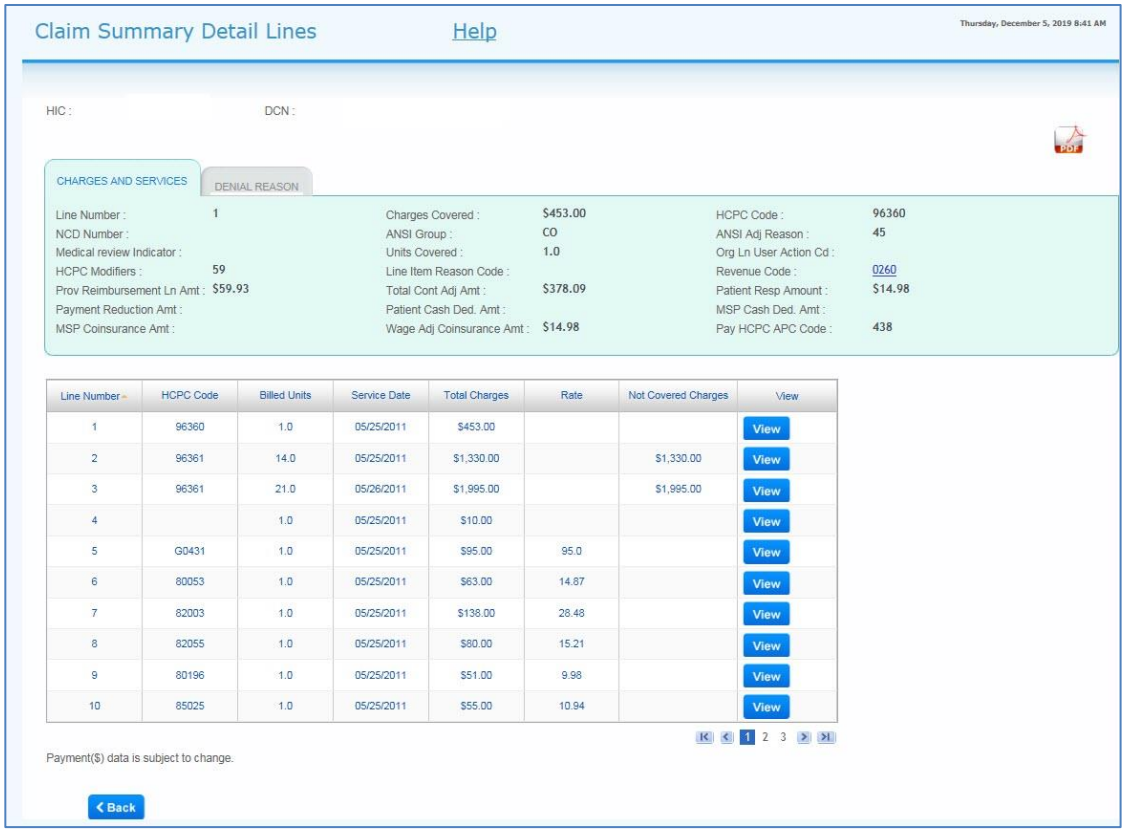

Figure 34 – Detail Lines

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**.

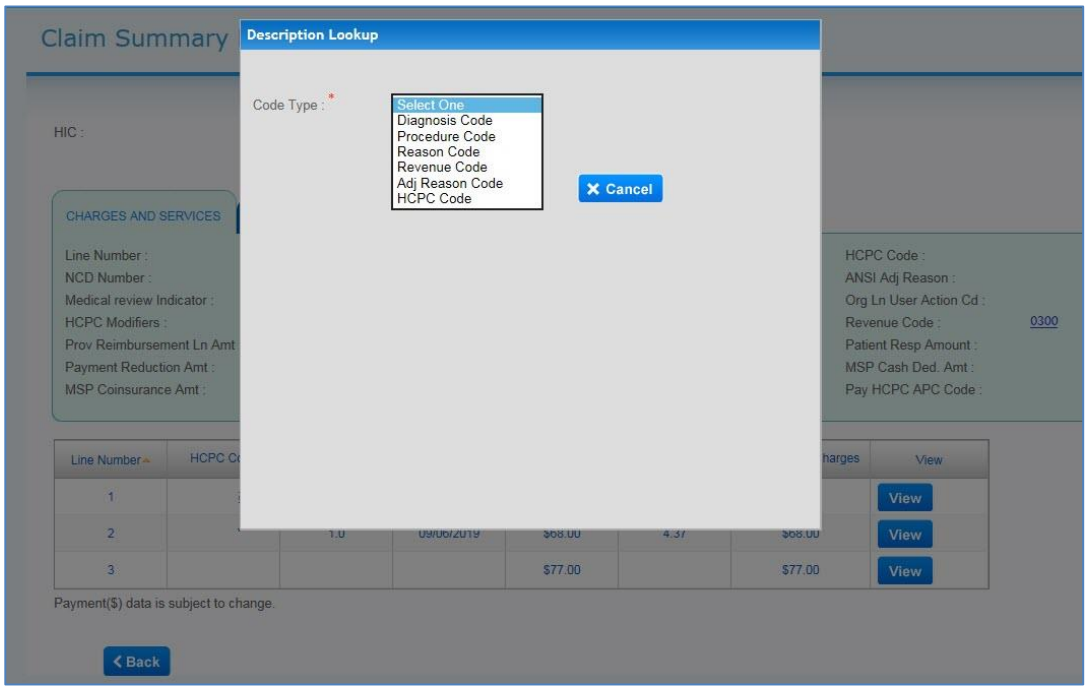

Figure 35 – Description Lookup

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**.

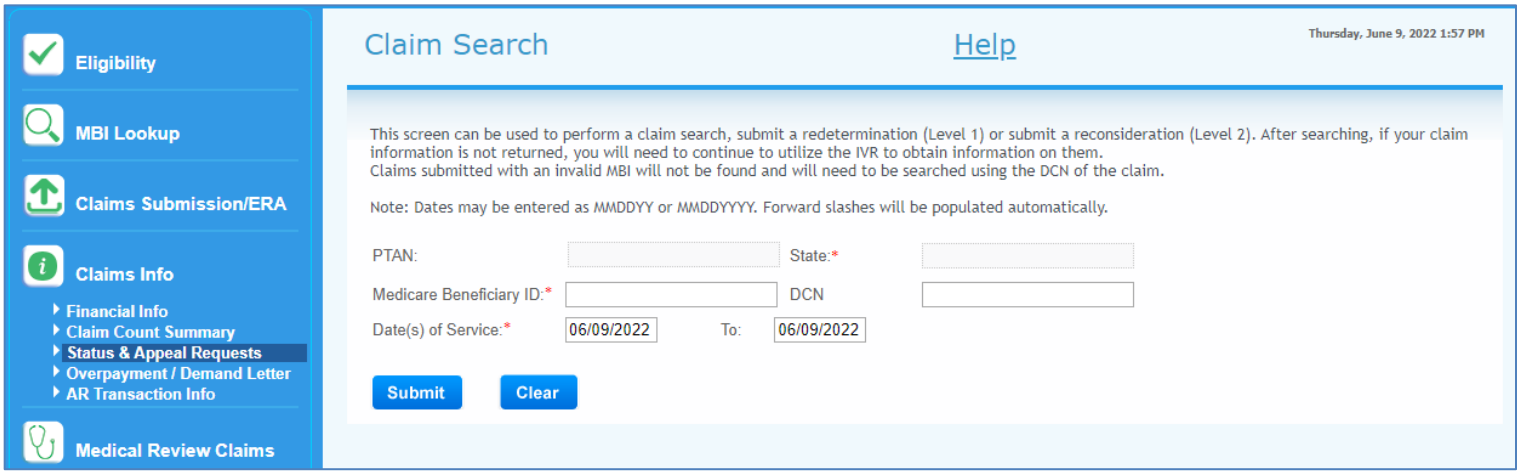

Figure 36 – Claim Search Input

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.

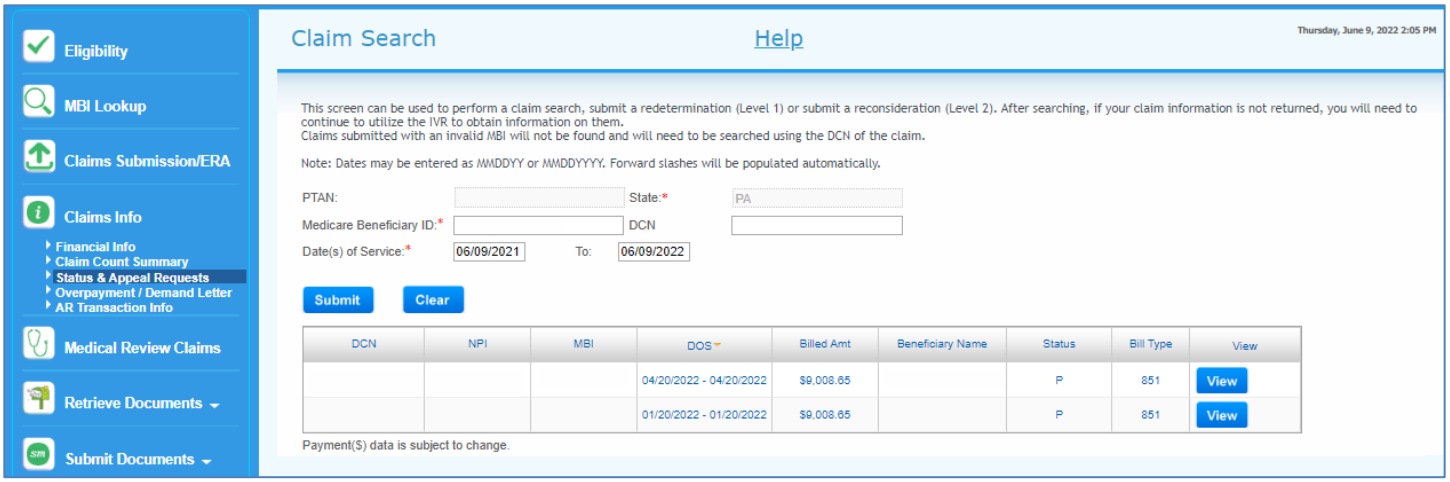

Figure 37 – Claim Search Results

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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).

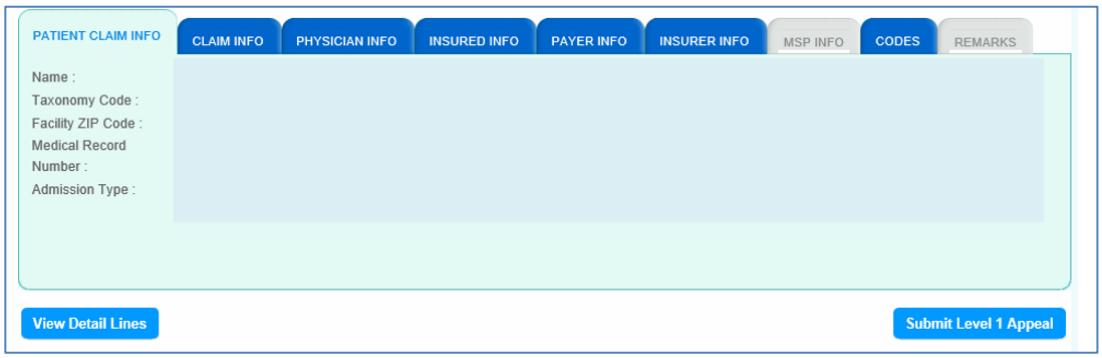

Figure 38 – Submit Level 1 Appeal

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.

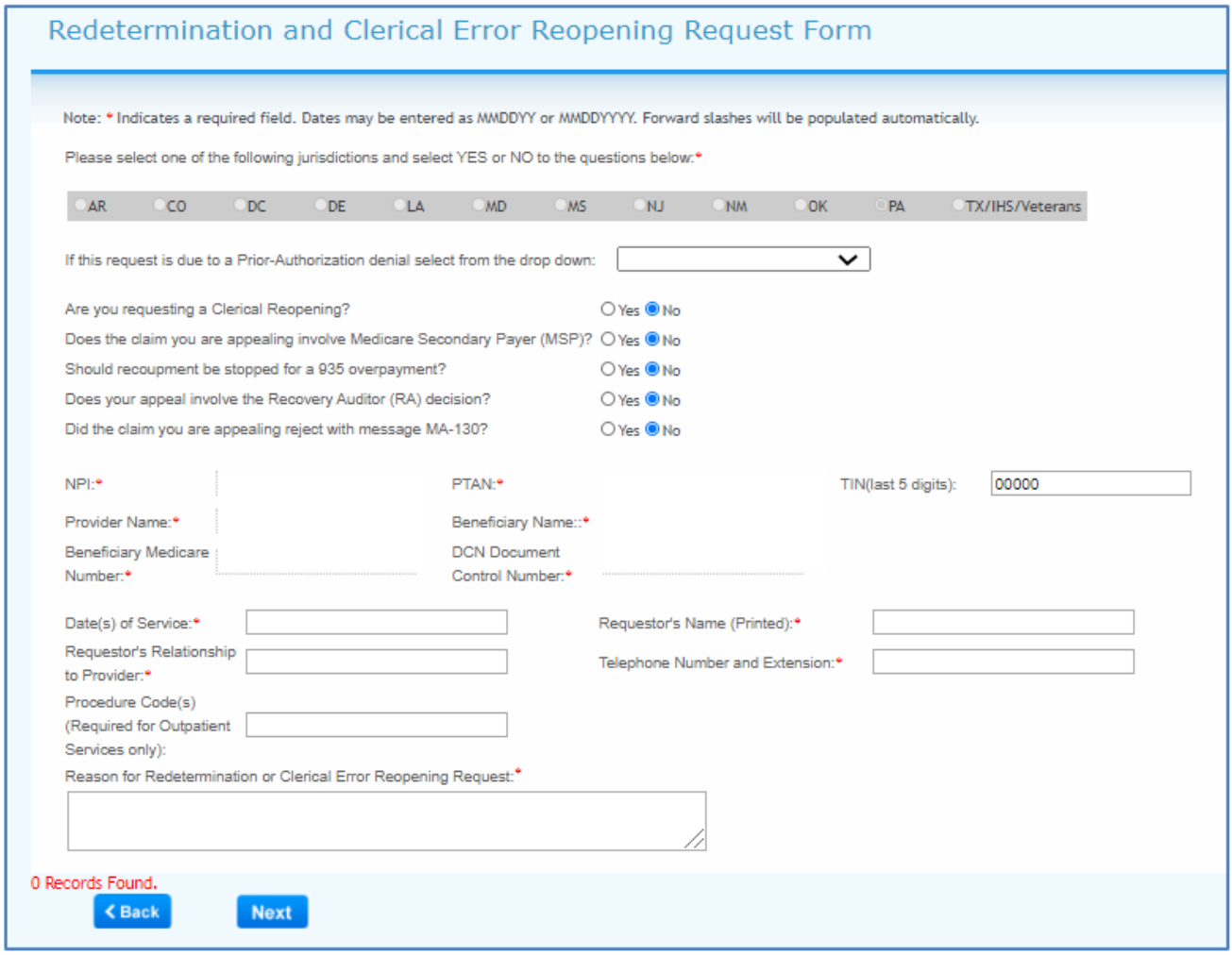

Figure 39 – Level 1 Appeal Input

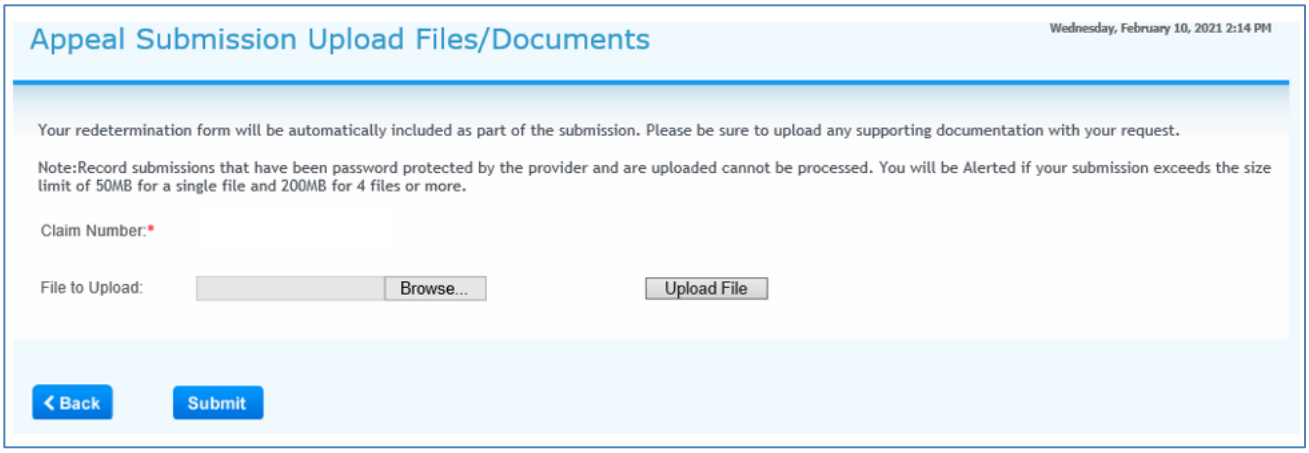

Figure 40 – Appeal Submission Upload Files/Document

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.

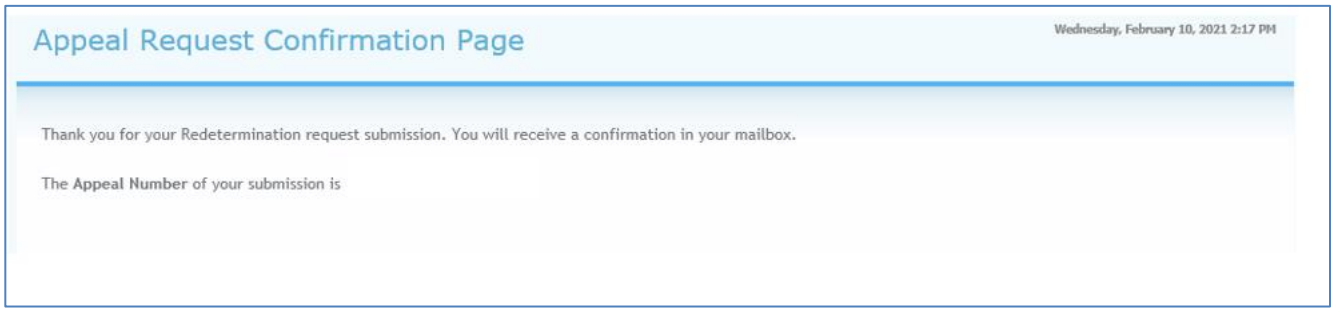

Figure 41 – Appeal Request Confirmation Page

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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).

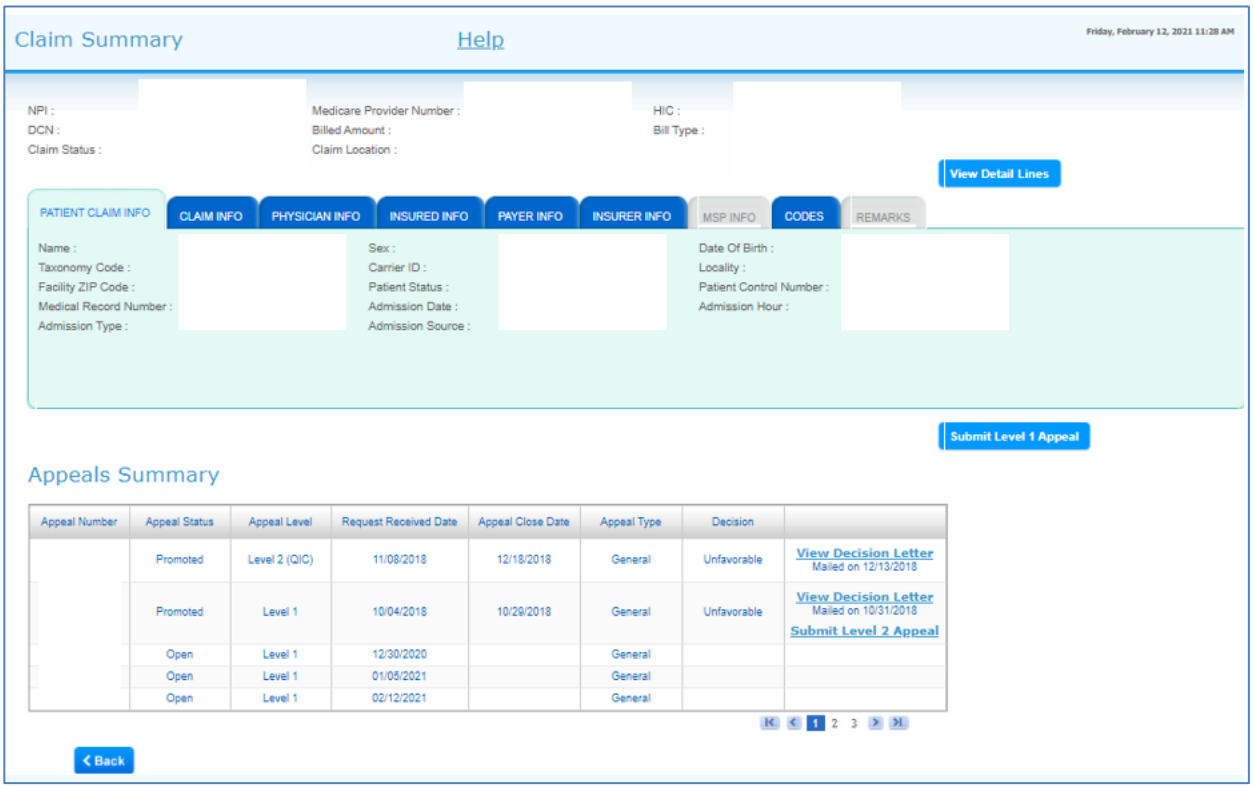

Figure 42 – Appeals Summary

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.

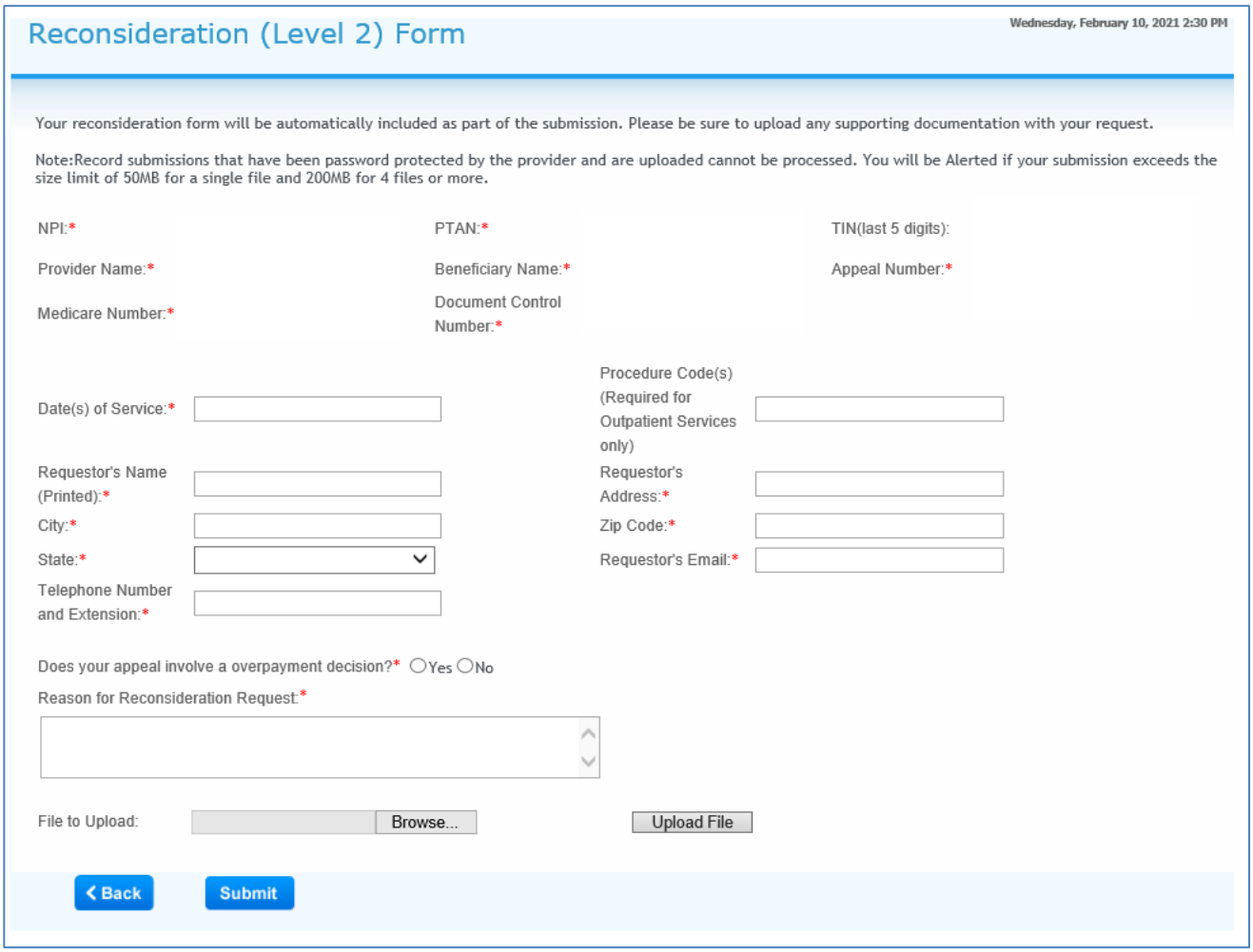

Figure 43 – Reconsideration (Level 2) Form

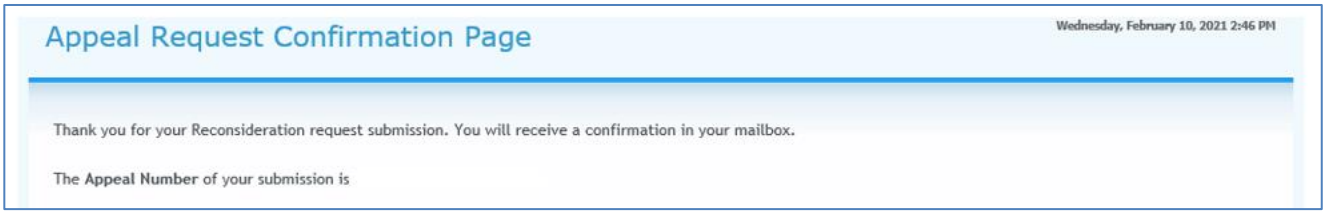

Figure 44 – Appeal Request Confirmation Page

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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**.

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.

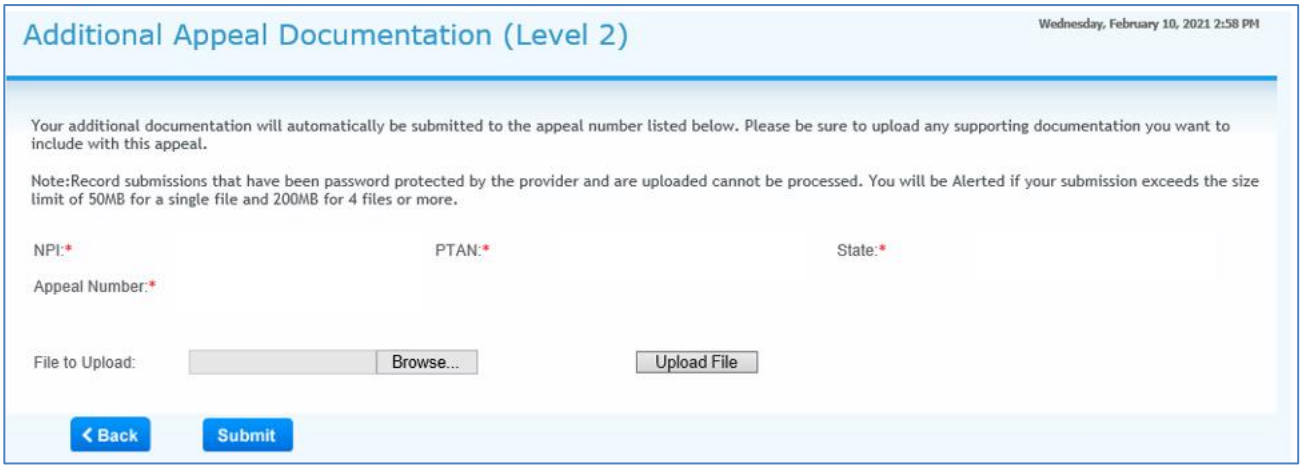

Figure 46 – Additional Appeal Documentation (Level 2)

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.

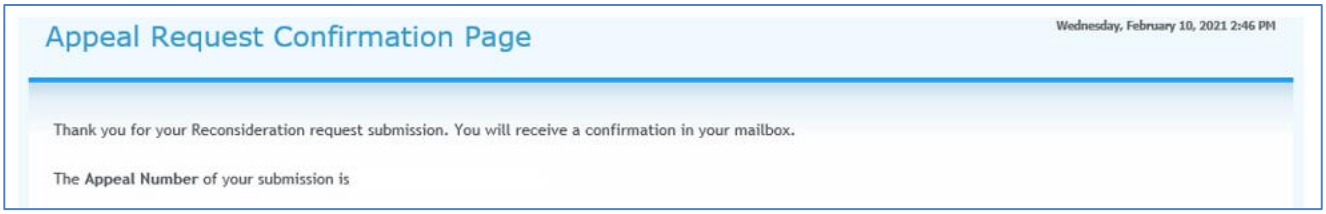

Figure 47 – Appeal Request Confirmation Page

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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.**

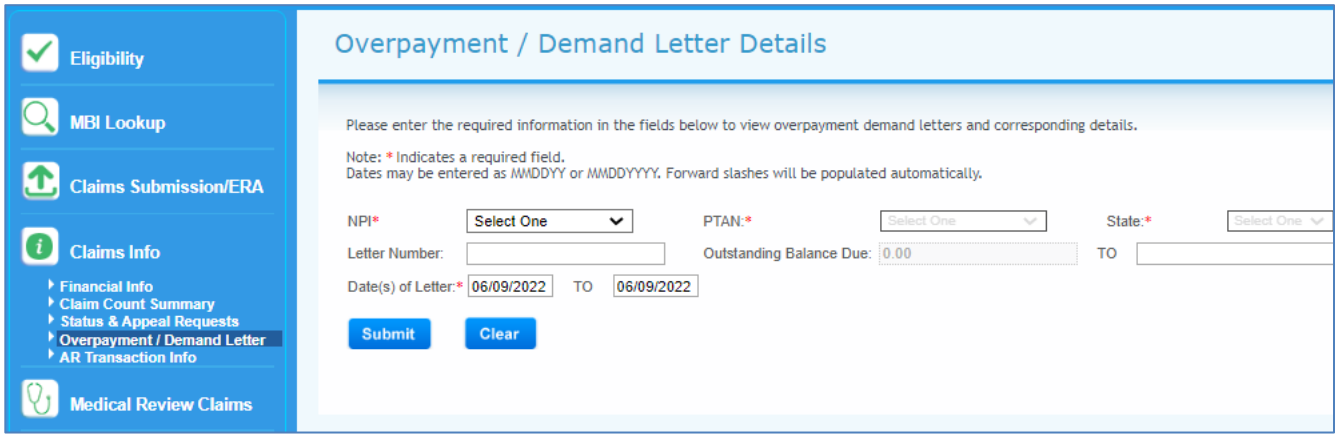

Figure 47.1 – Overpayment/Demand Letter Details

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.

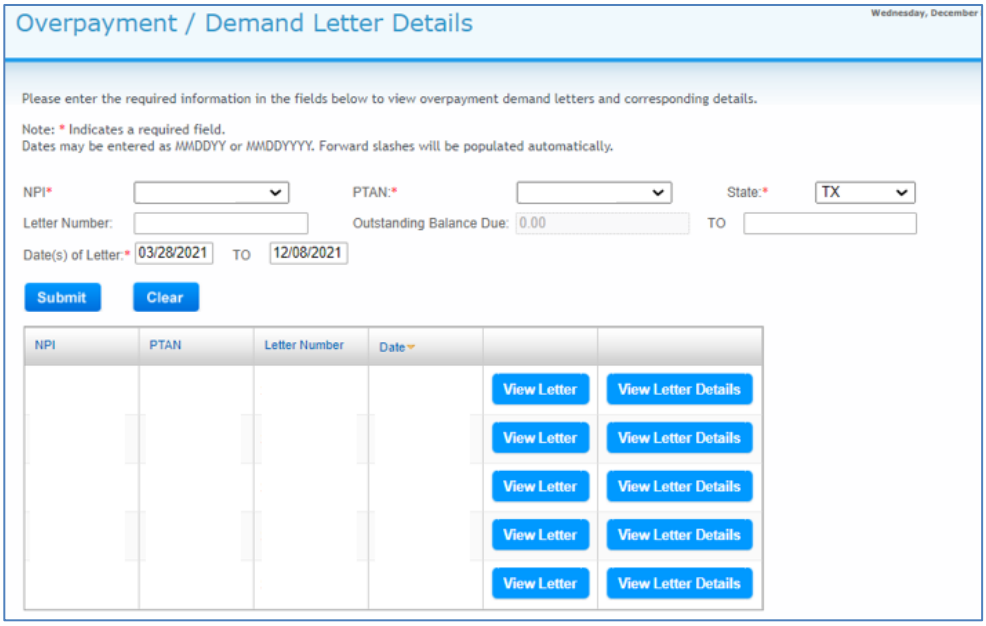

Figure 47.2 – Overpayment/Demand Letter Output

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.

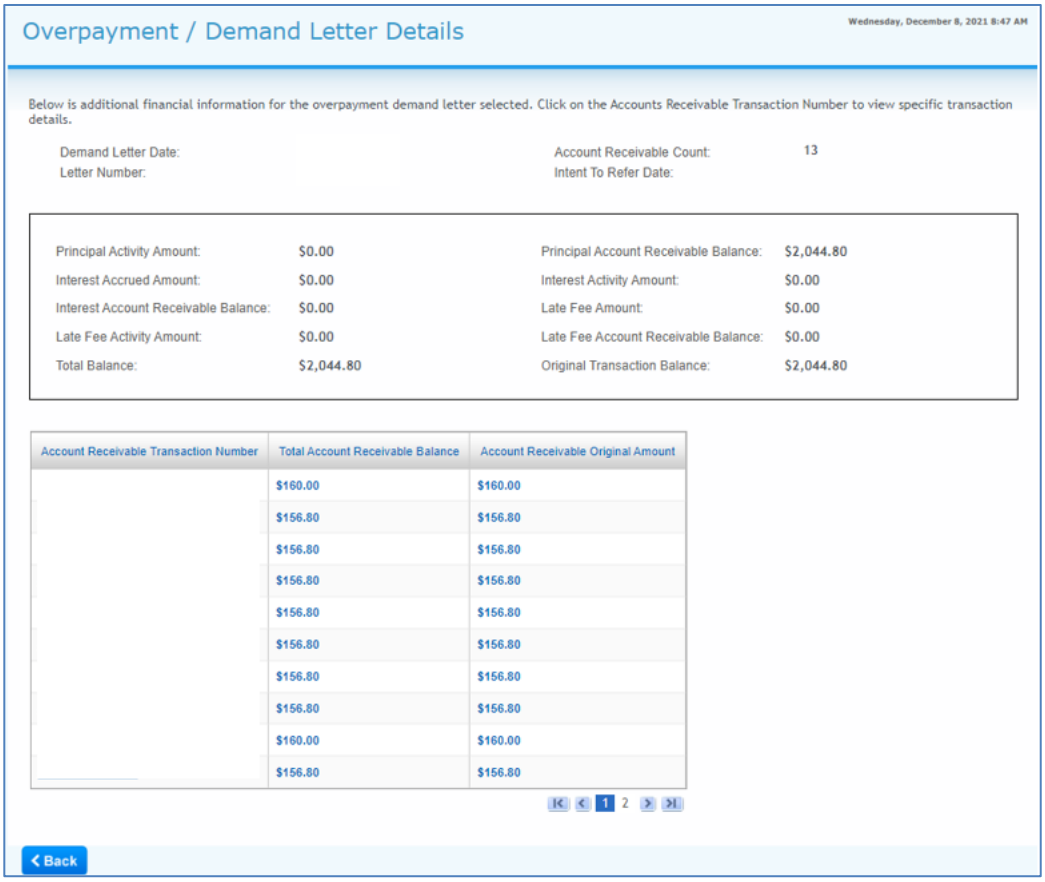

Figure 47.3 – View Letter Details

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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.**

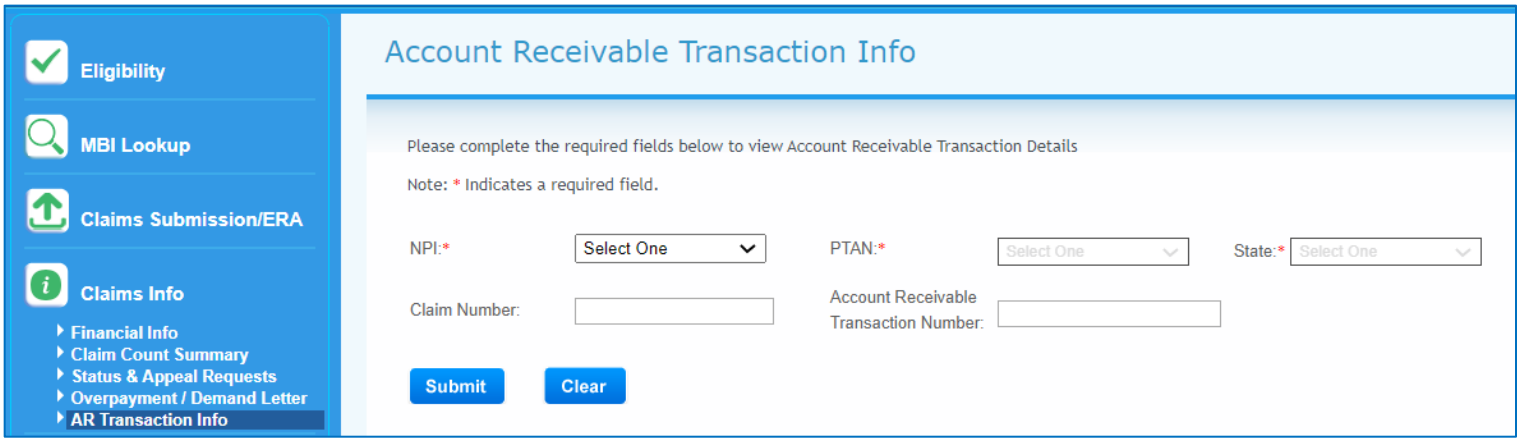

Figure 47.4 – AR Transaction Info

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**.

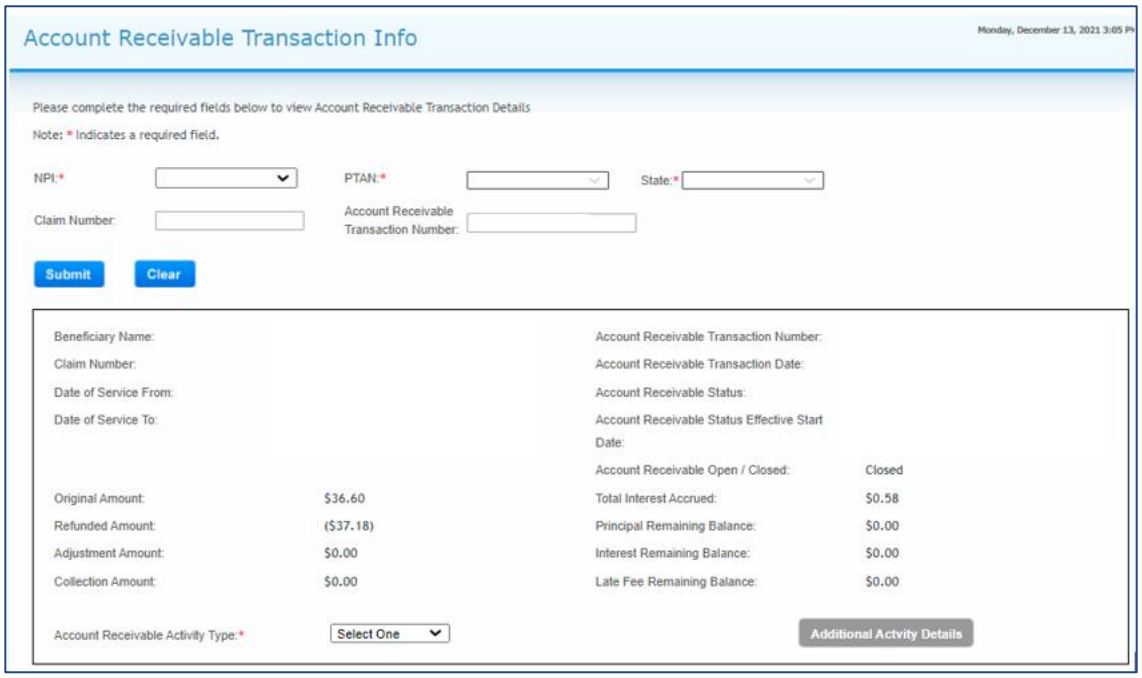

Figure 47.5 – AR Transaction Info Output

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.

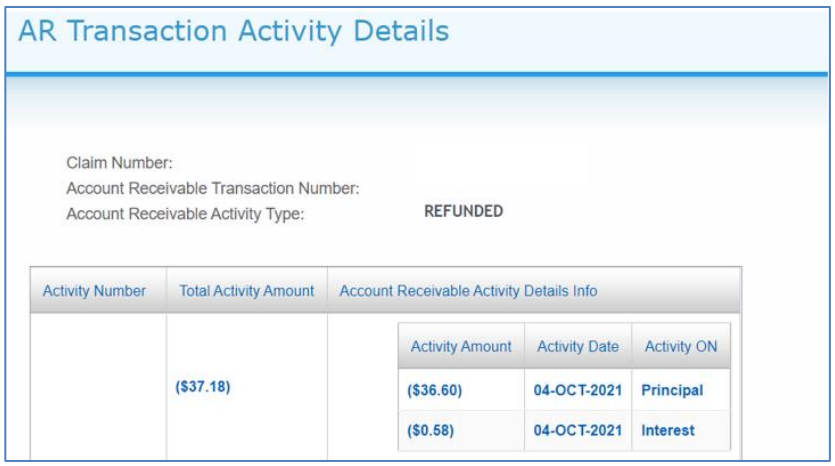

Figure 47.6 – AR Transaction Activity Details

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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.**

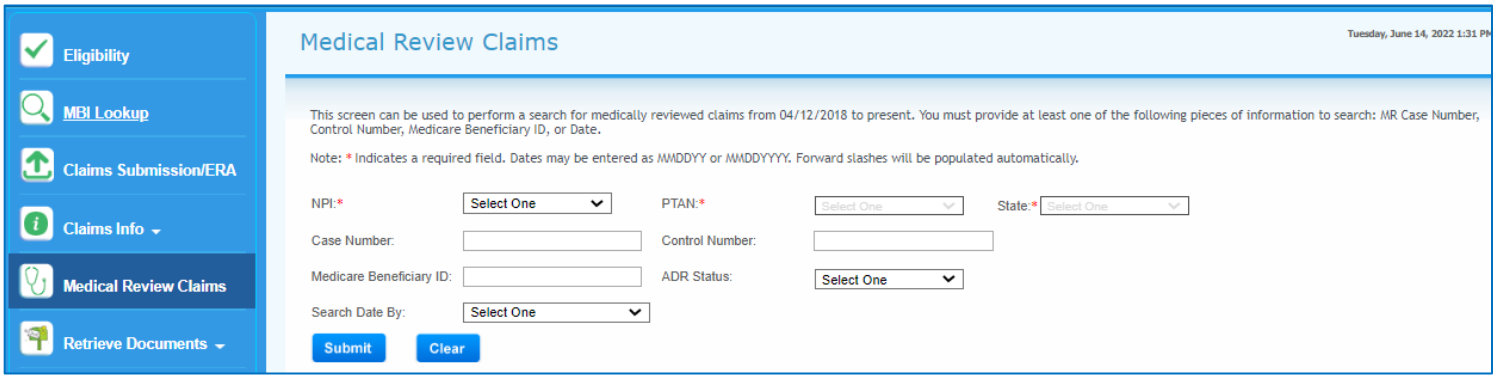

Figure 48 – Medical Review Claims

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.

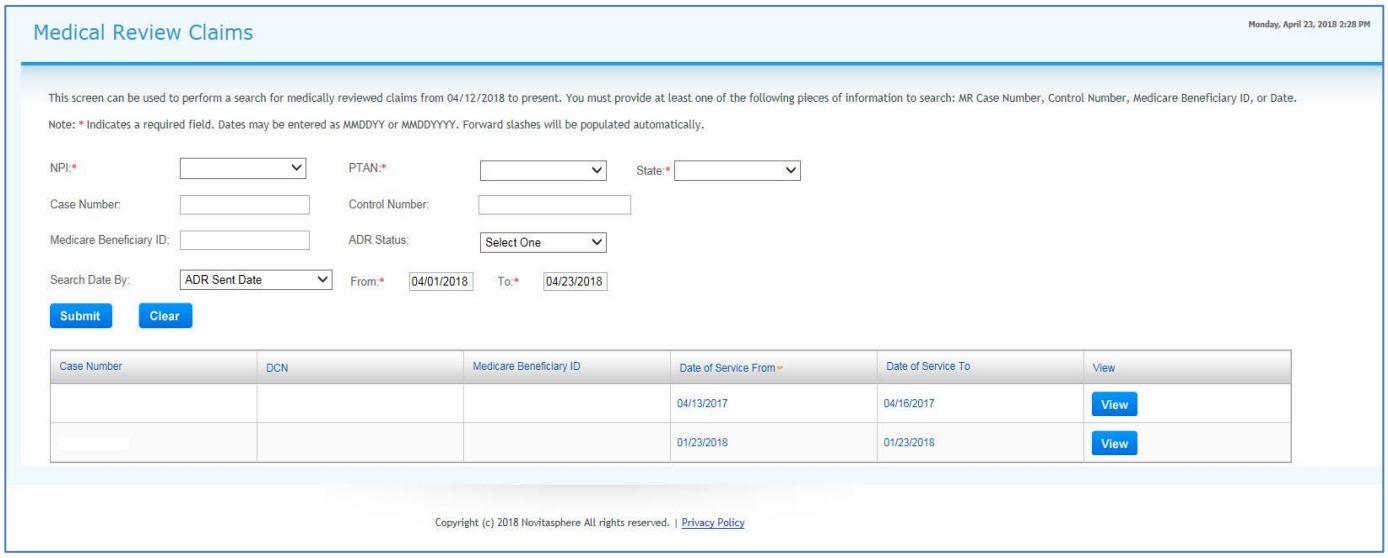

Figure 49 – Medical Review Claims Output

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.

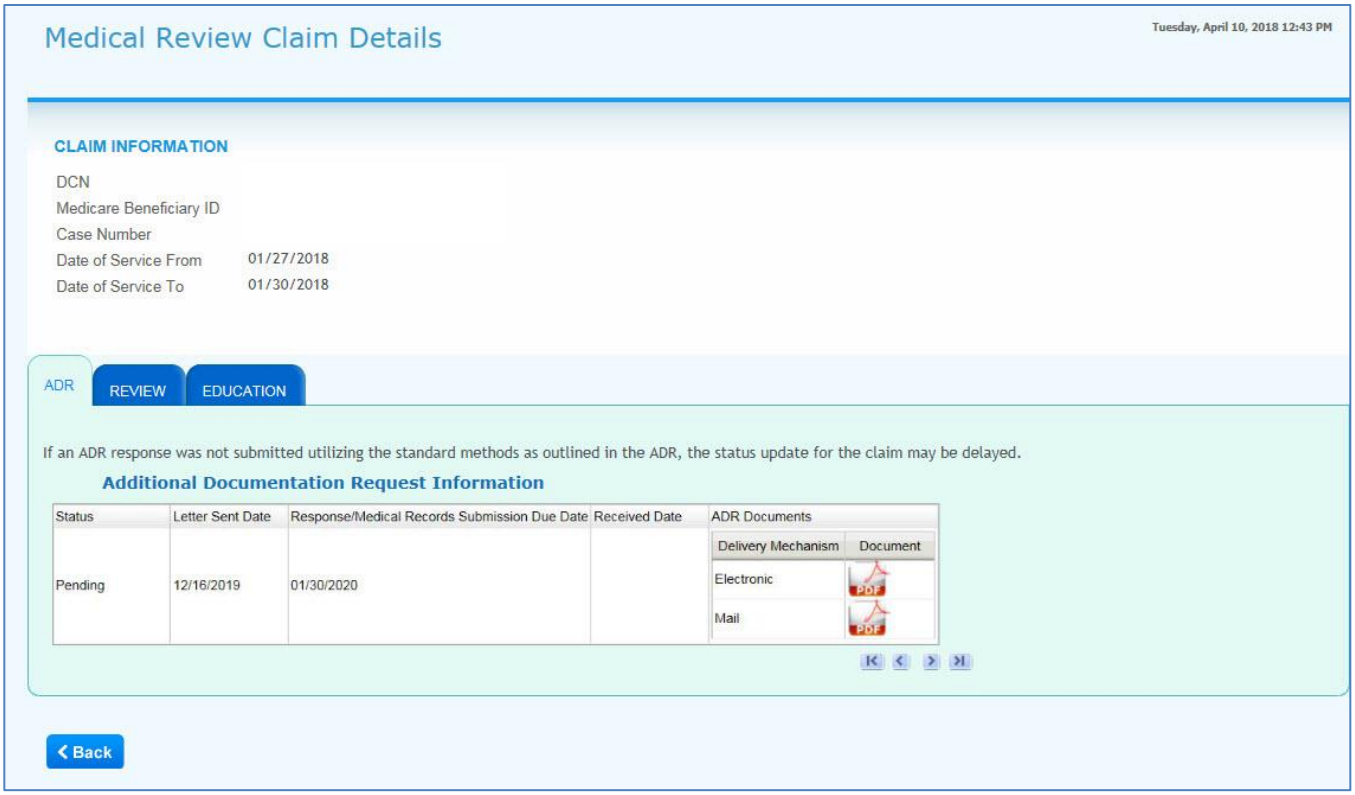

Figure 50 – Medical Review Claim Details – ADR Tab

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**.

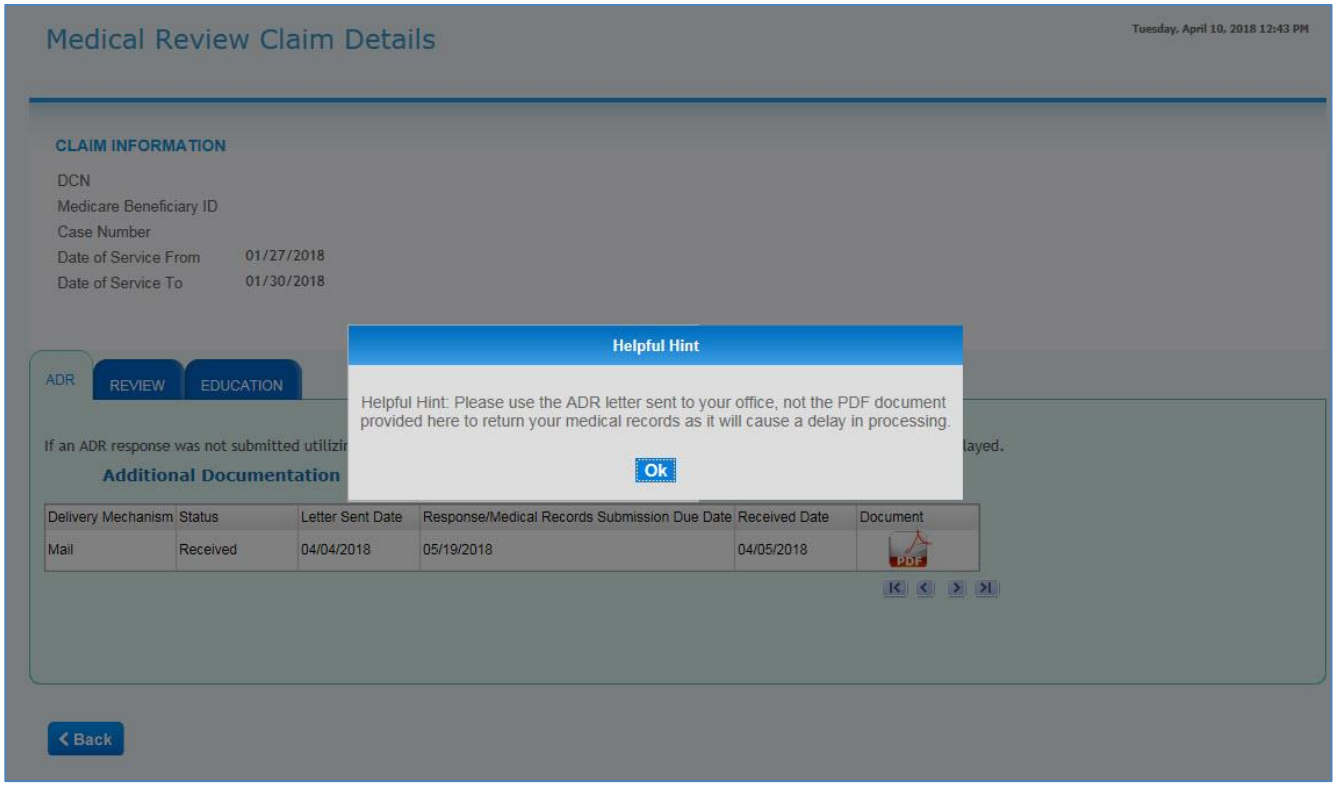

Figure 51 – Medical Review Claim Details – Helpful Hint

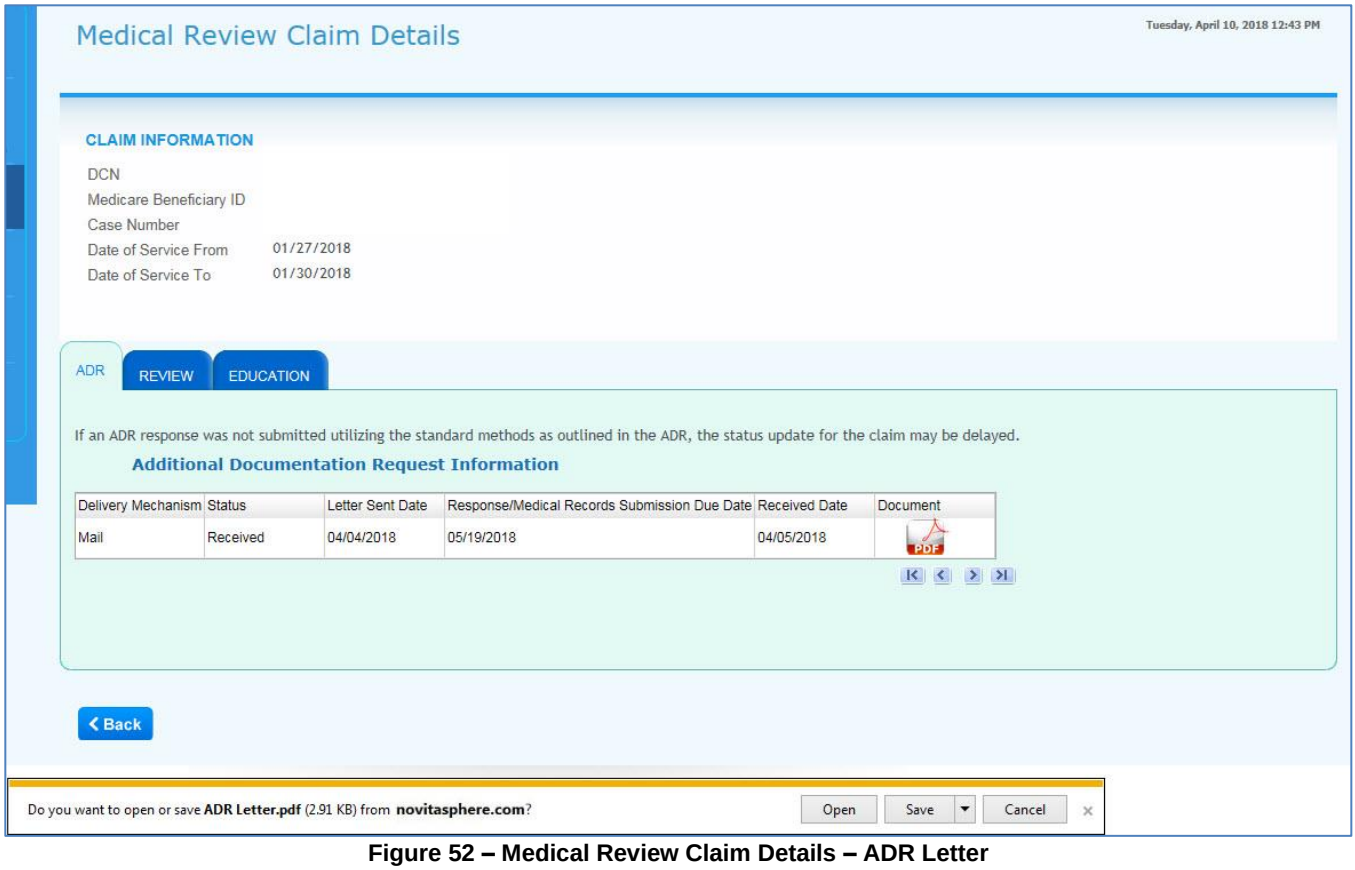

Figure 52 – Medical Review Claim Details – ADR Letter

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

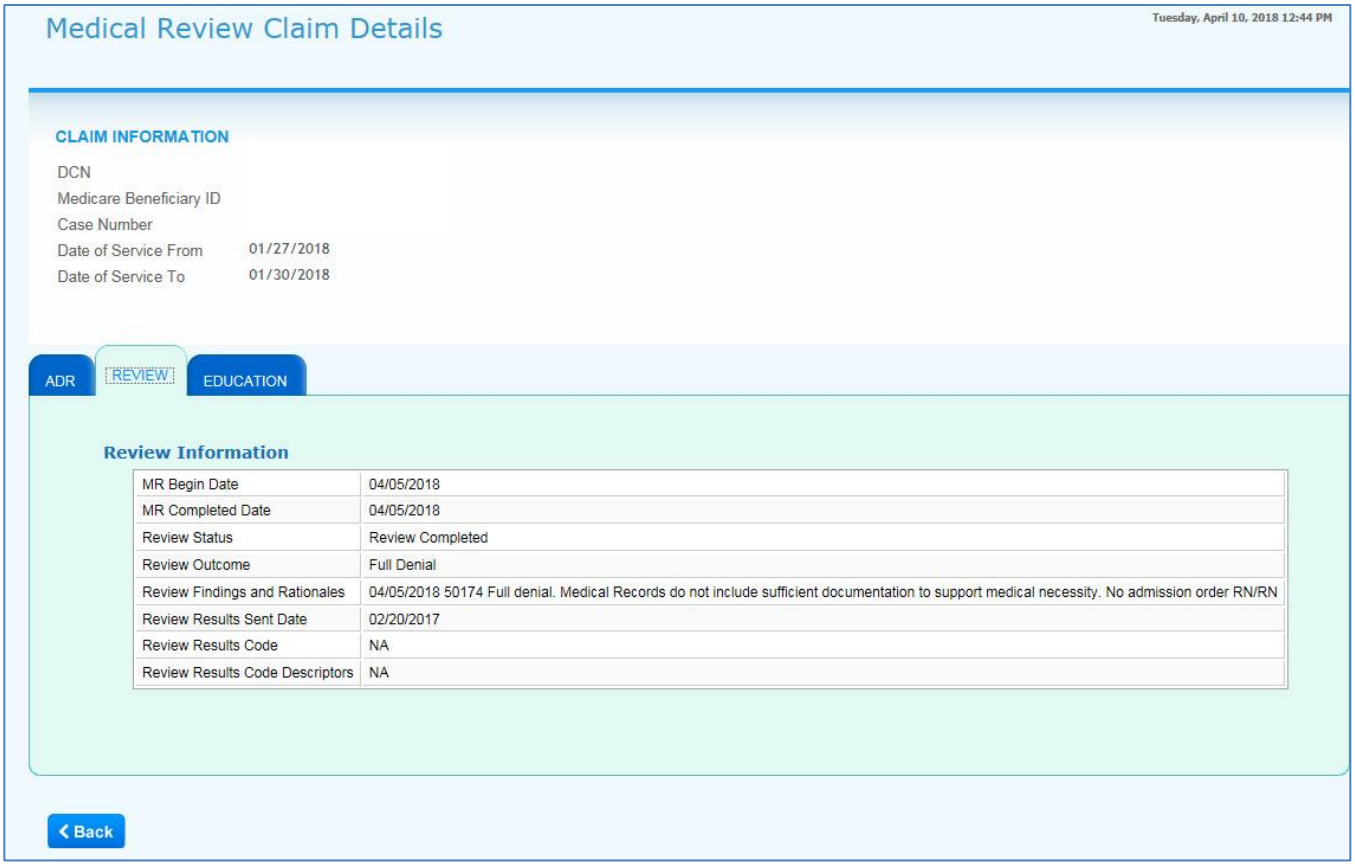

Figure 53 – Medical Review Claim Details – Review Tab

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.

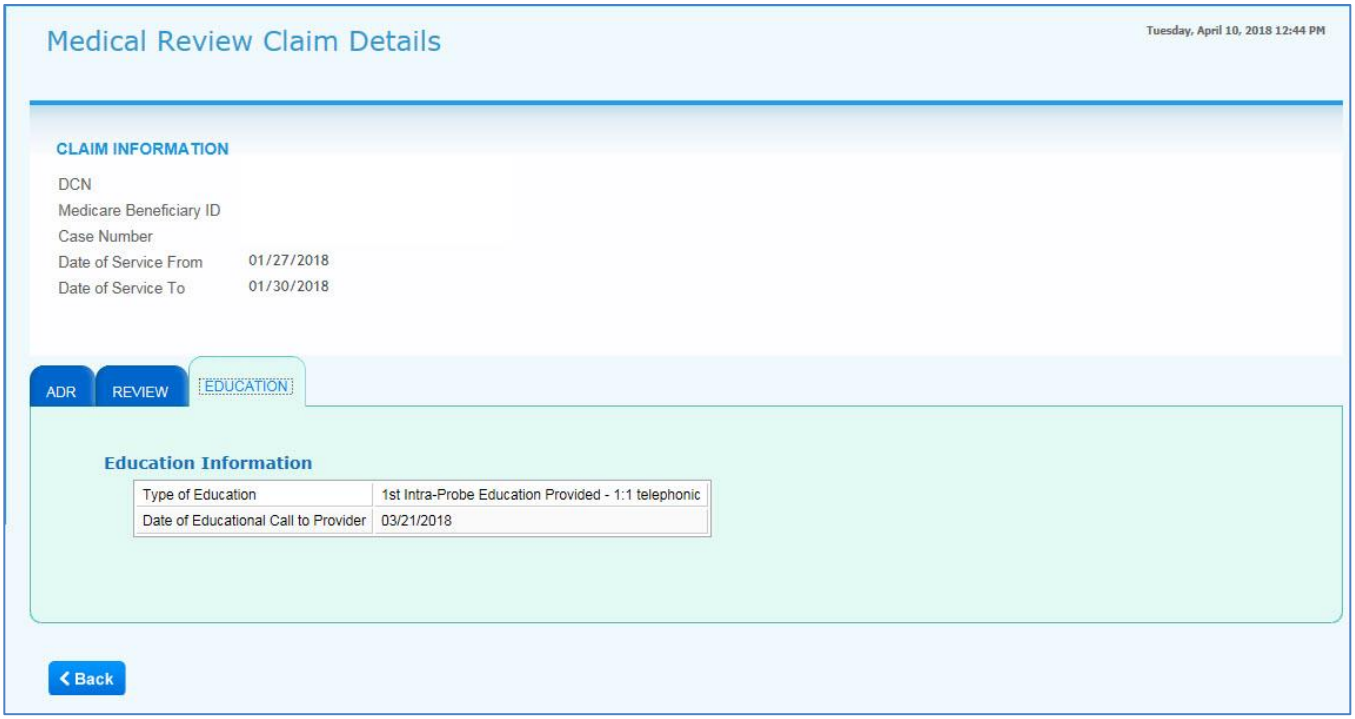

Figure 54 – Medical Review Claim Details – Education Tab

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**.

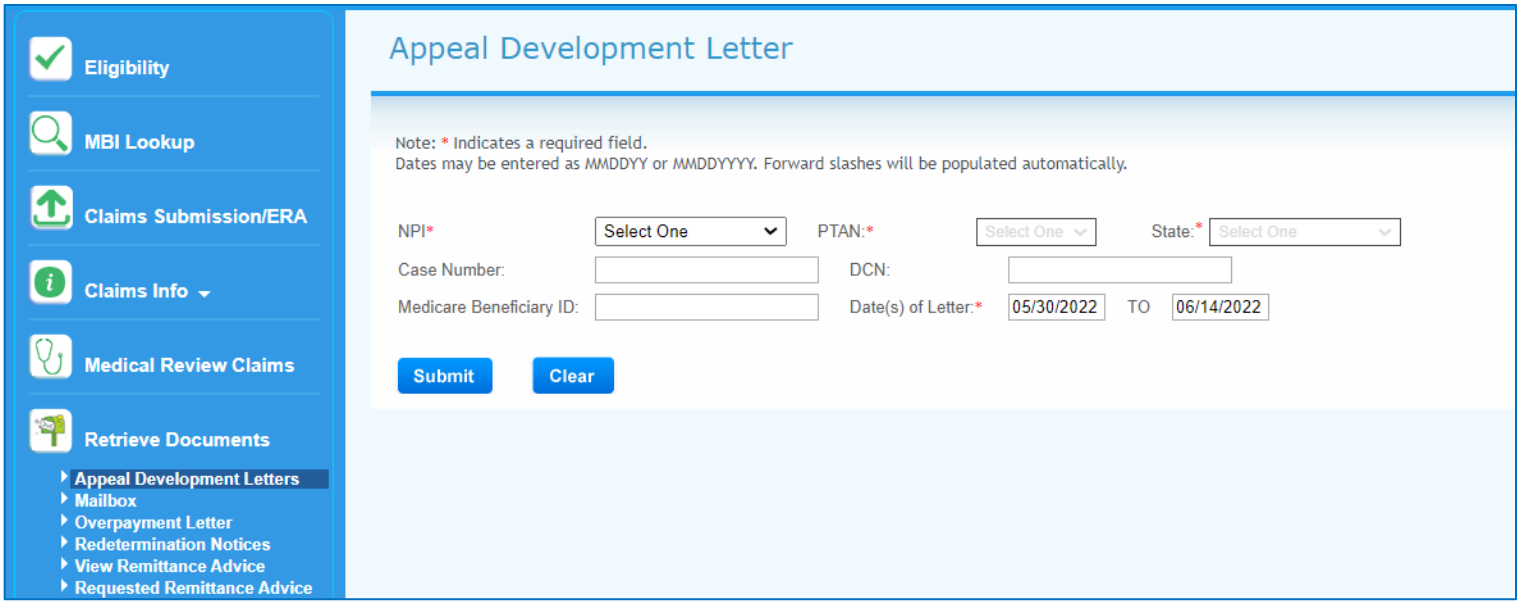

Figure 55 – Appeal Development Letter

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.

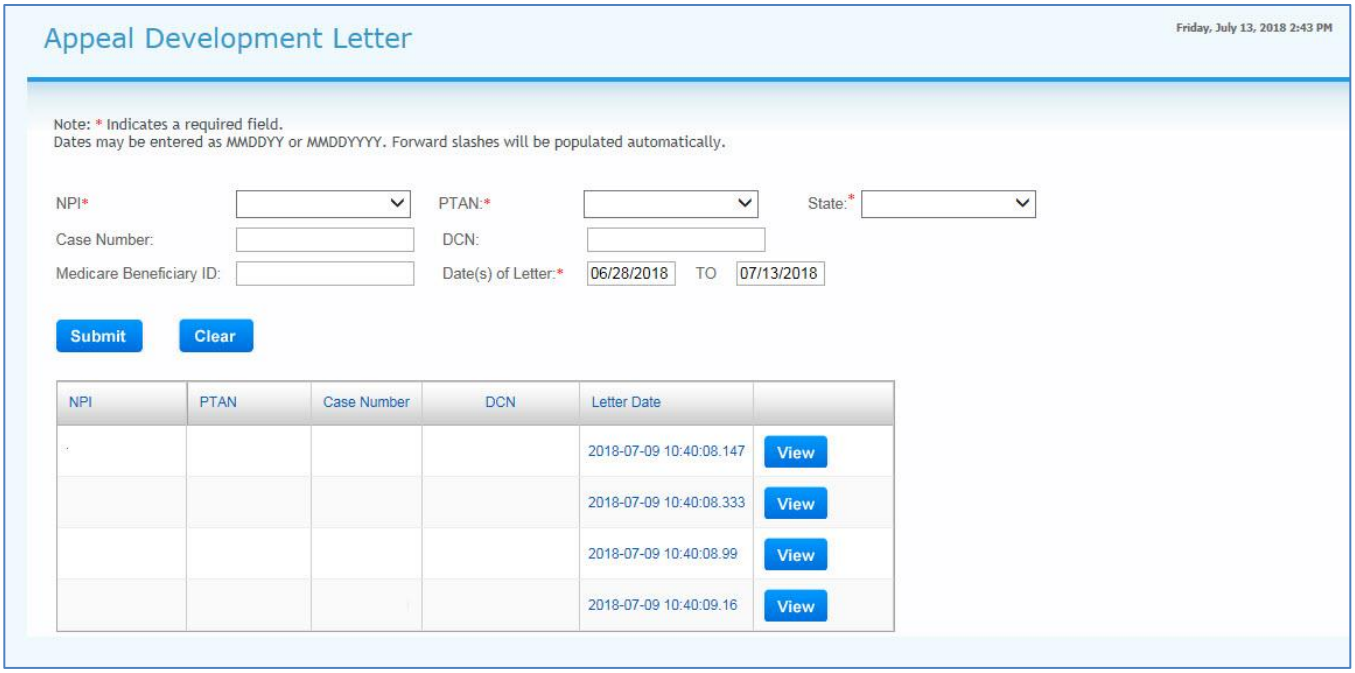

Figure 56 – Appeal Development Letter Results

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 show in **Figure 58 – Acknowledgement PDF**.

Thank you for your submission

Thank you for using Novitasphere to submit your Medical Review Record to Novitas Solutions Inc.The confirmation number of your Medical Review submission is:

You can track the status of your upload using the Secure Message Submission History screen. This screen only tracks the submittal of the record, not the progress of the review.

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**.

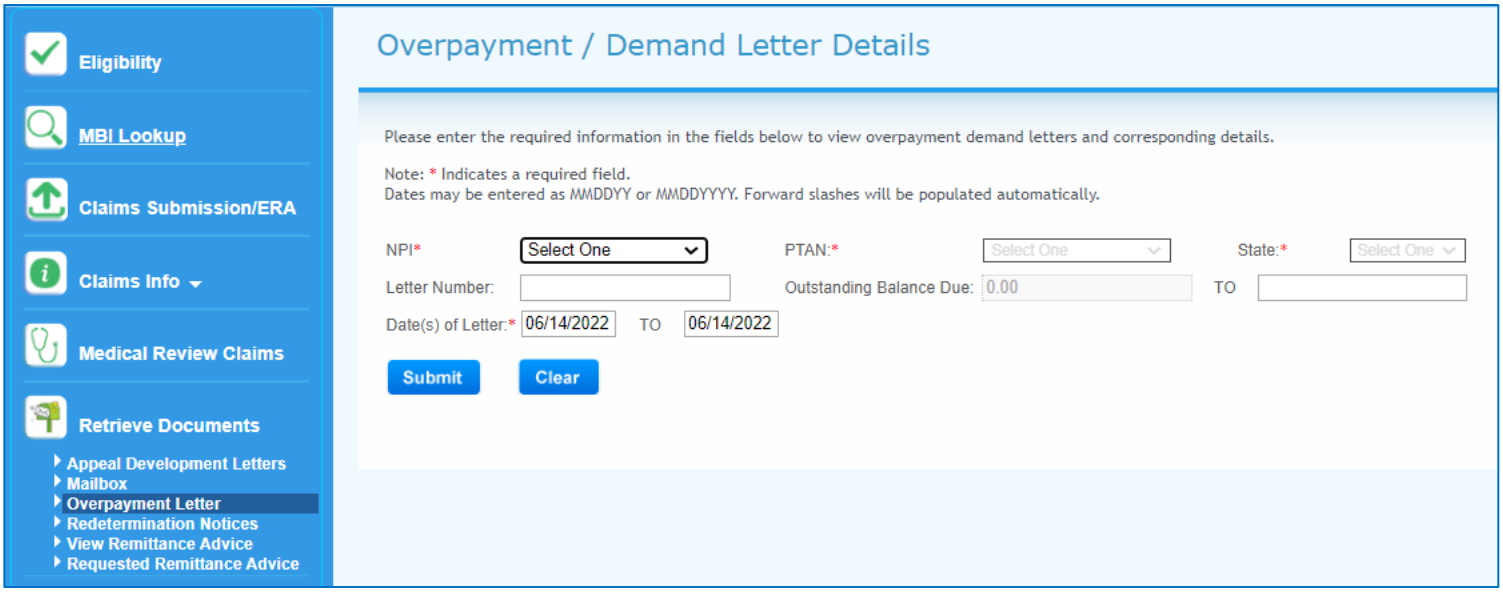

Figure 59 – Overpayment Letter

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.

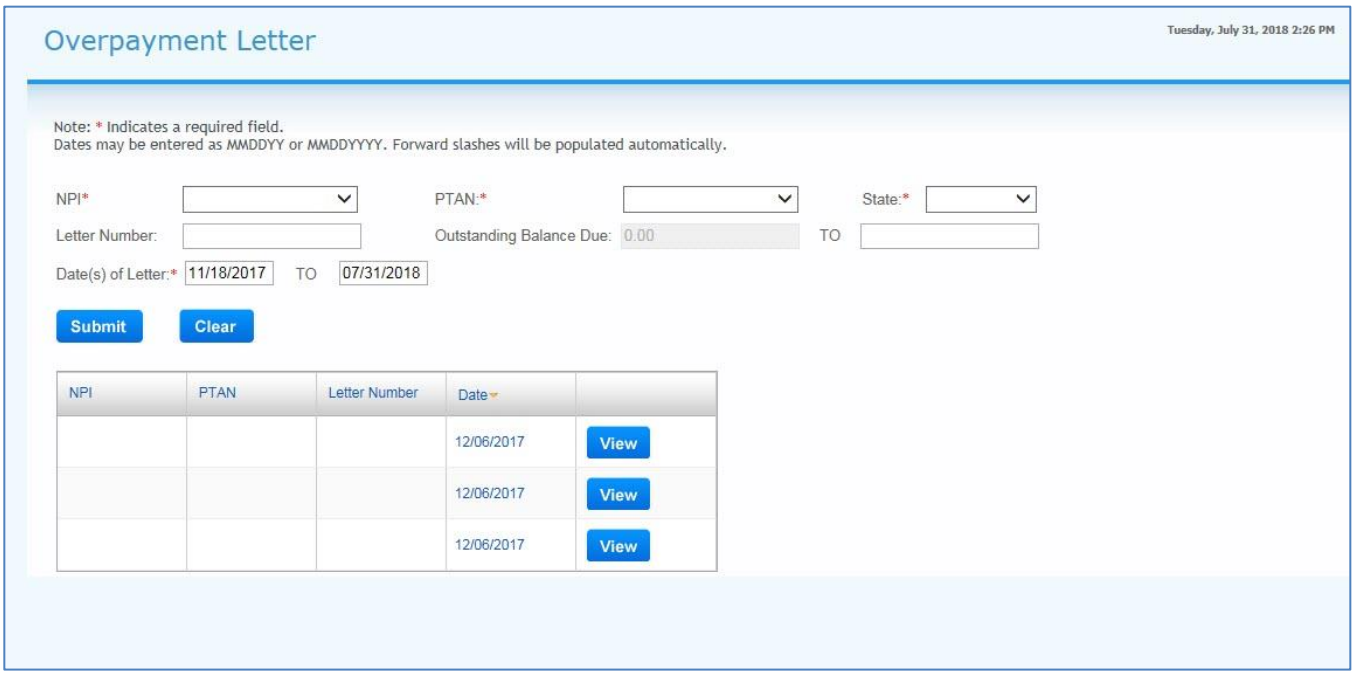

Figure 60 – Overpayment Letter Results

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**.

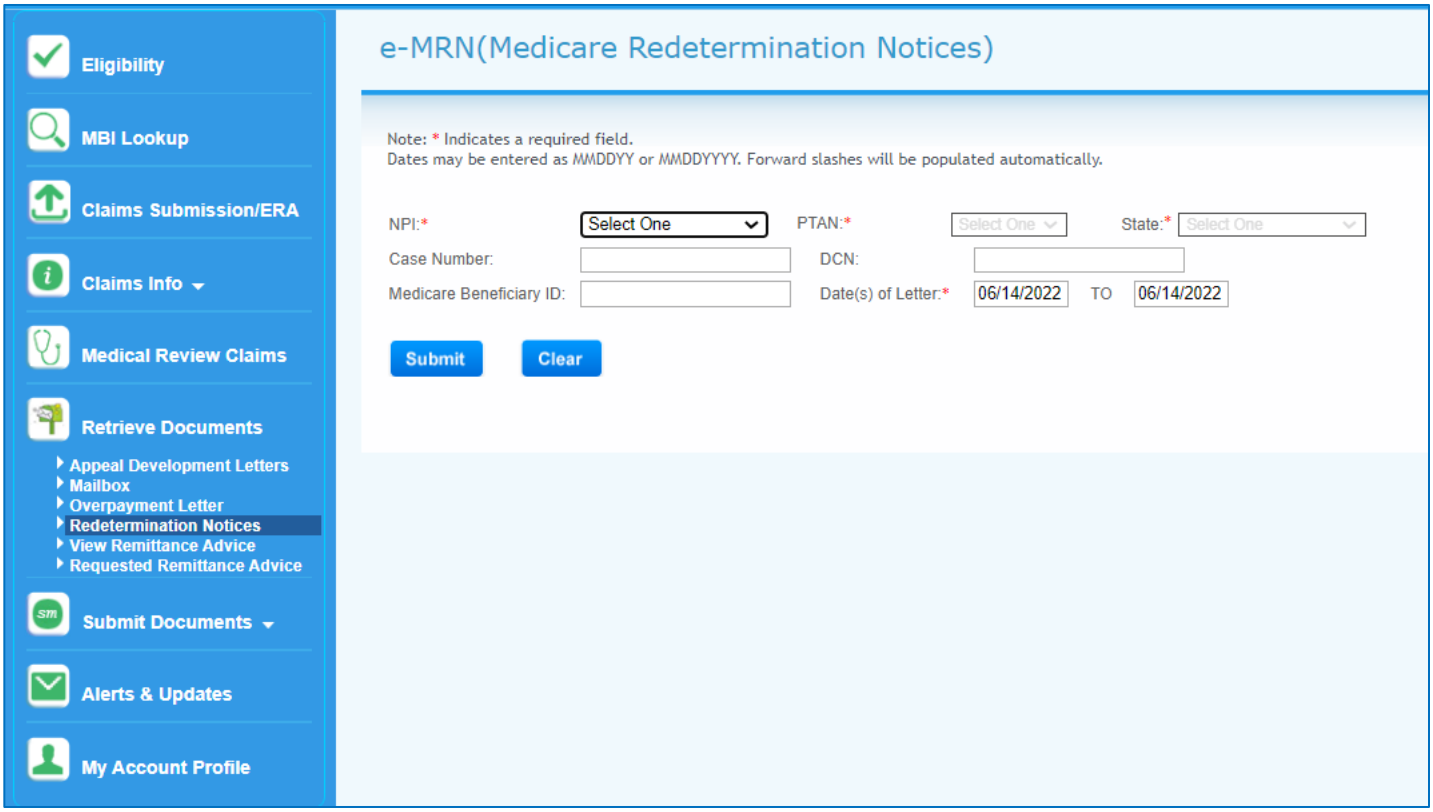

Figure 61 – e-MRN

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.

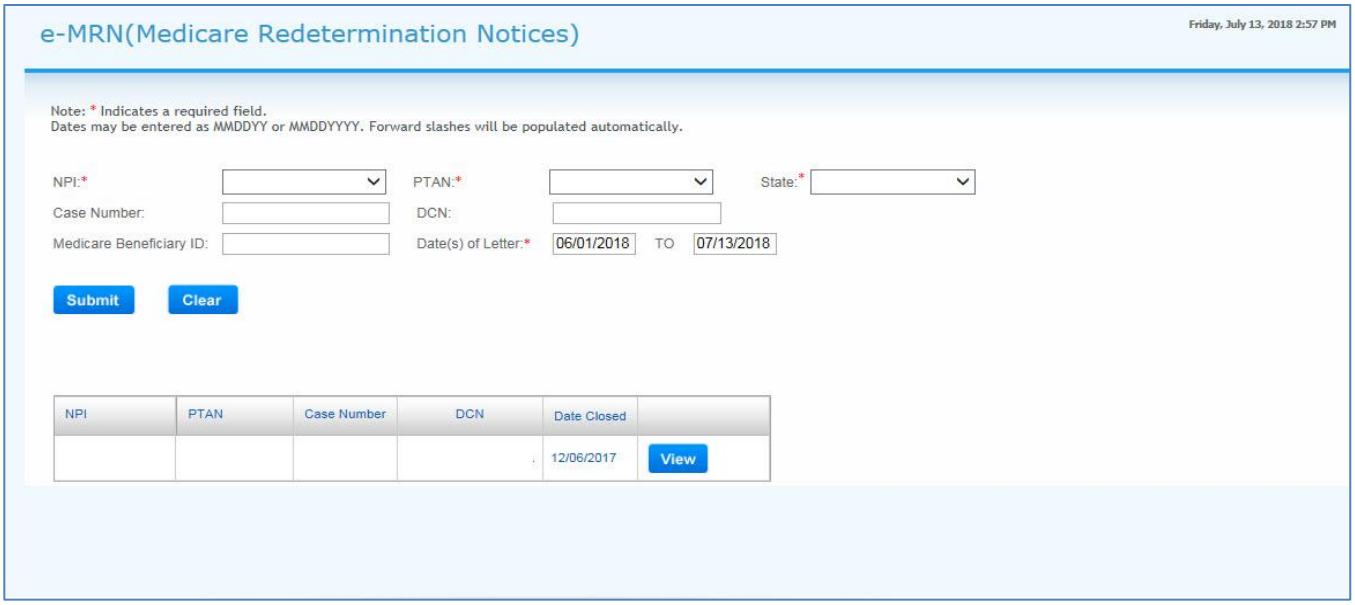

Figure 62 – e-MRN Results

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**.

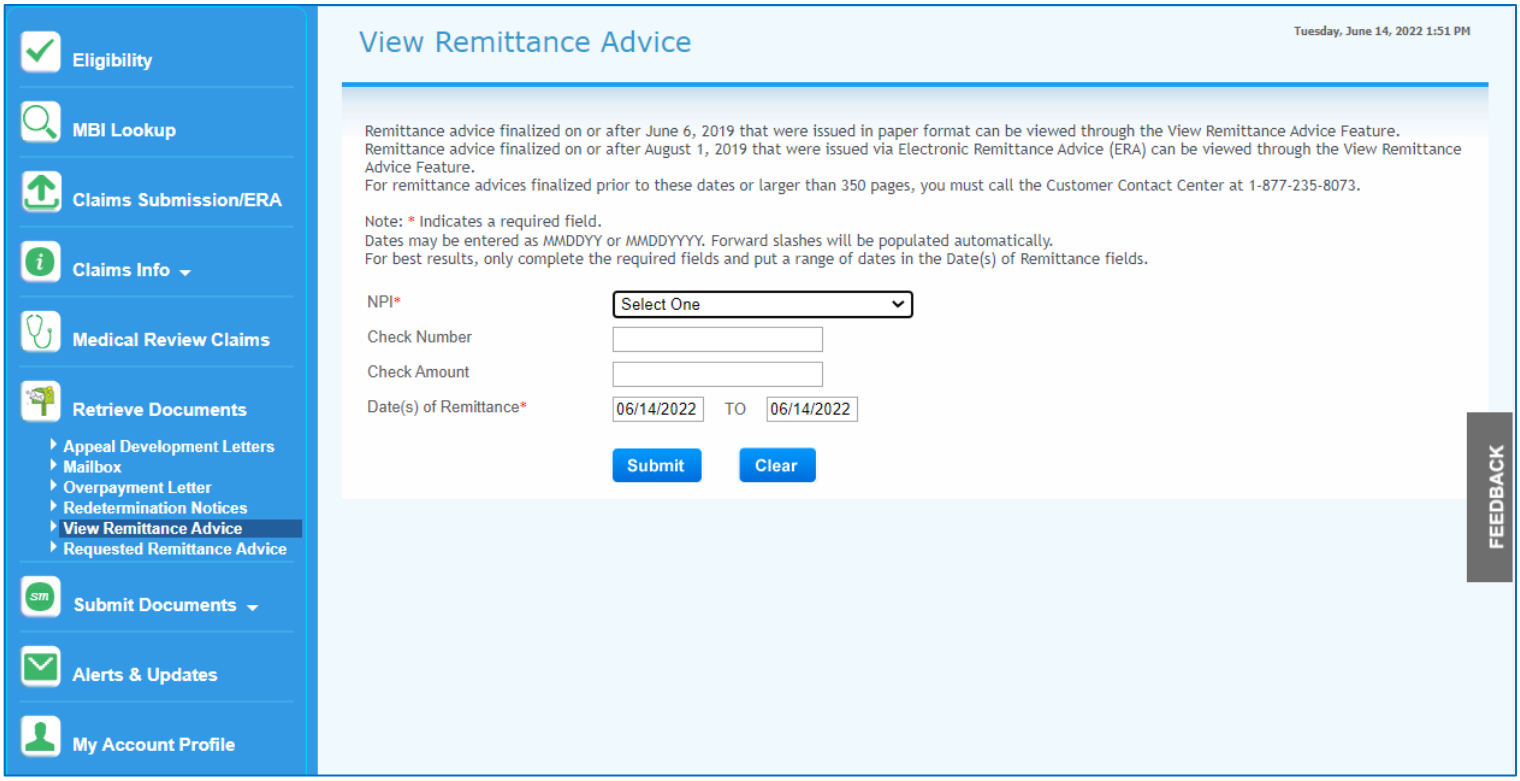

Figure 63 – View Remittance Advice Input

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**.

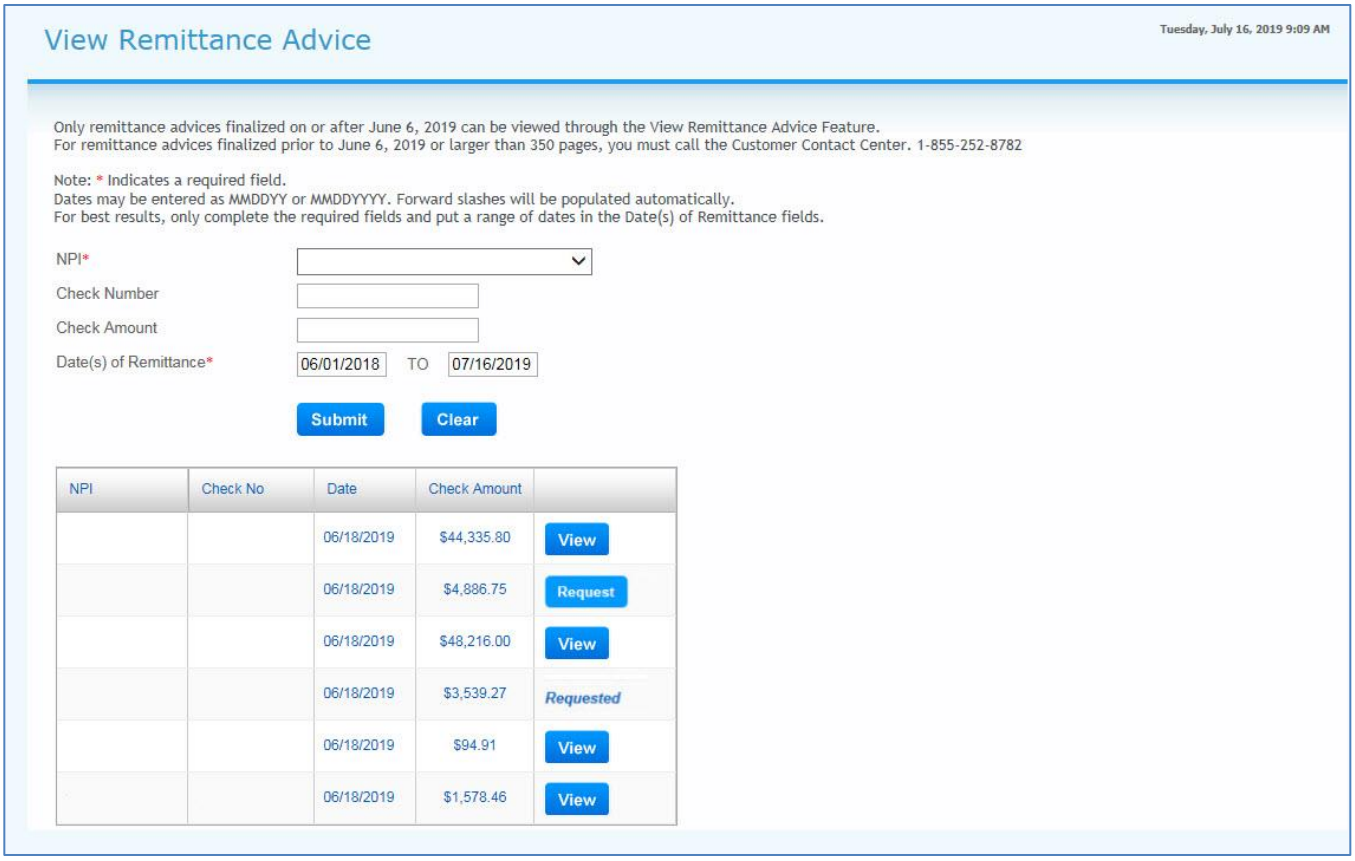

Figure 64 – View Remittance Advice Output

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.**

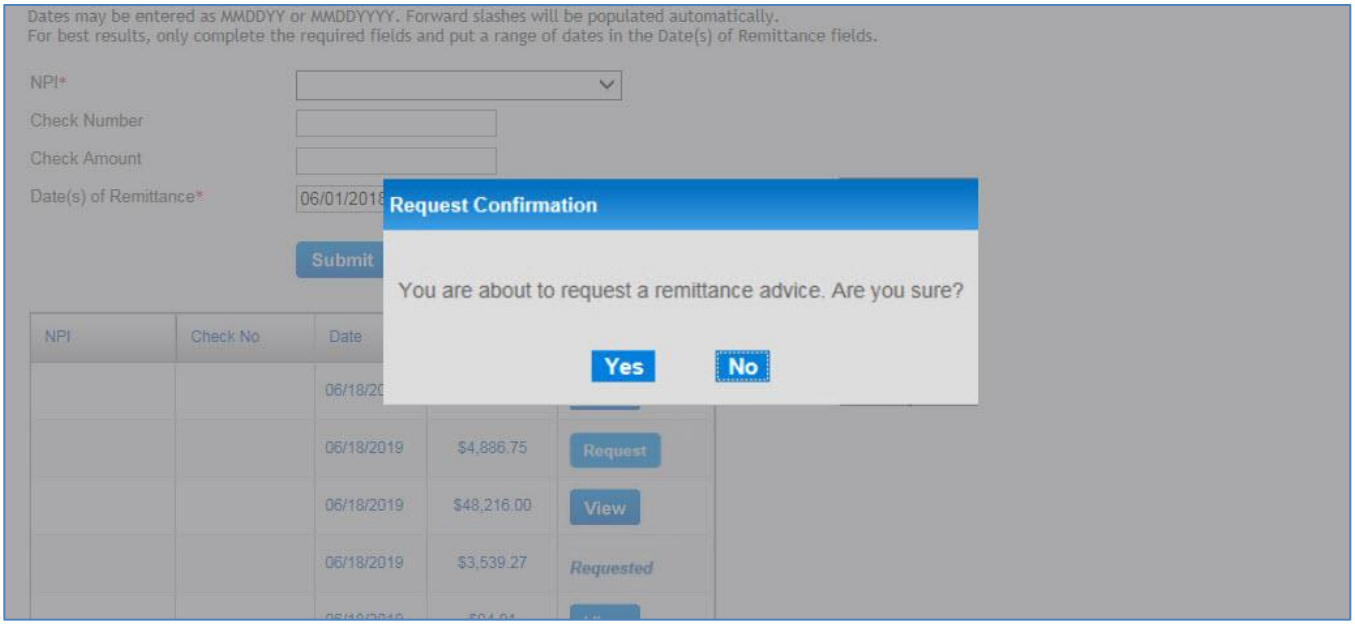

Figure 65 - Remittance Request Confirmation Message

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.**

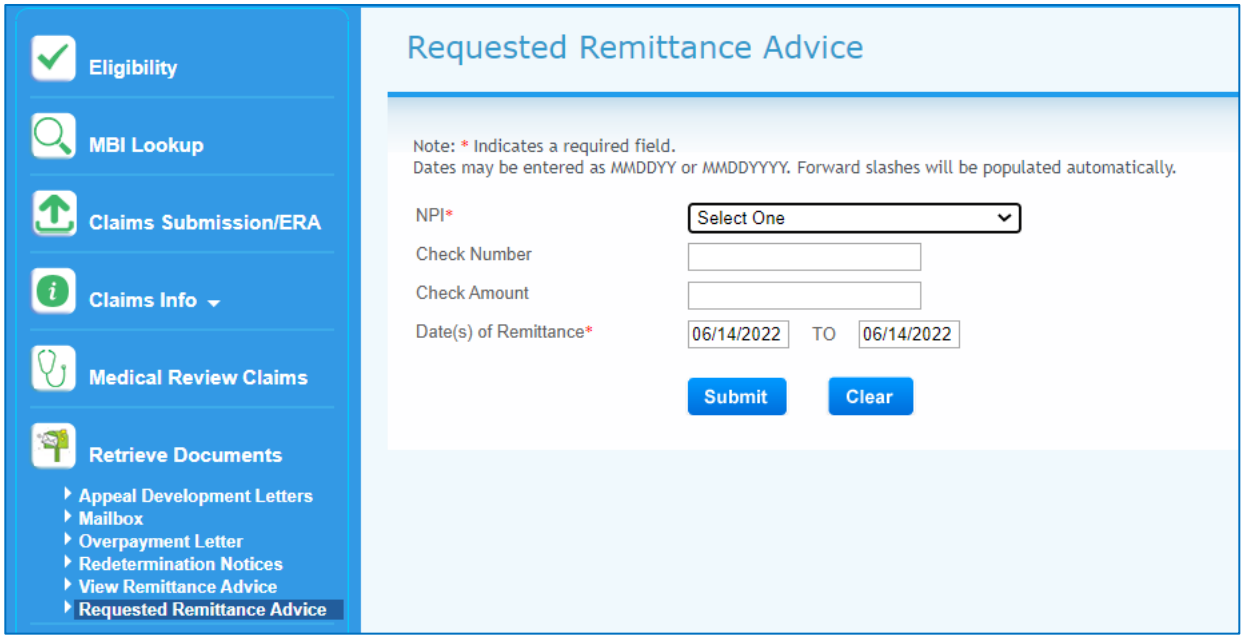

Figure 66 – Requested Remittance Advice Input

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.

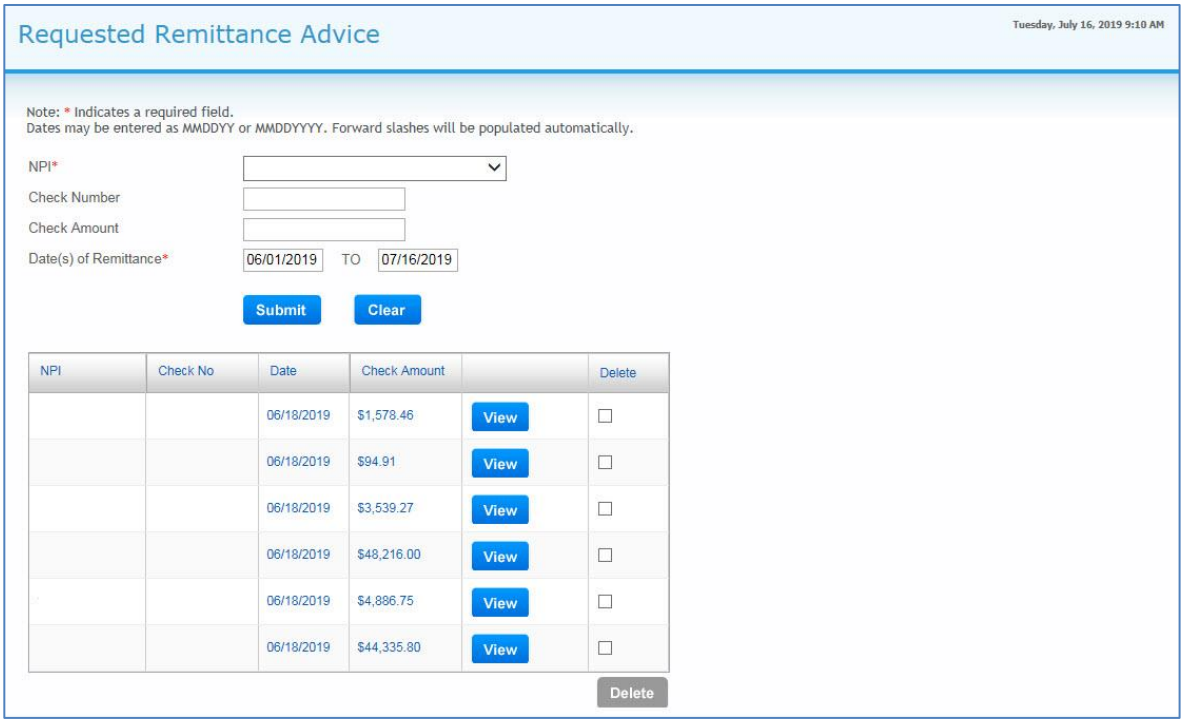

Figure 67 – Requested Remittance Advices

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**.

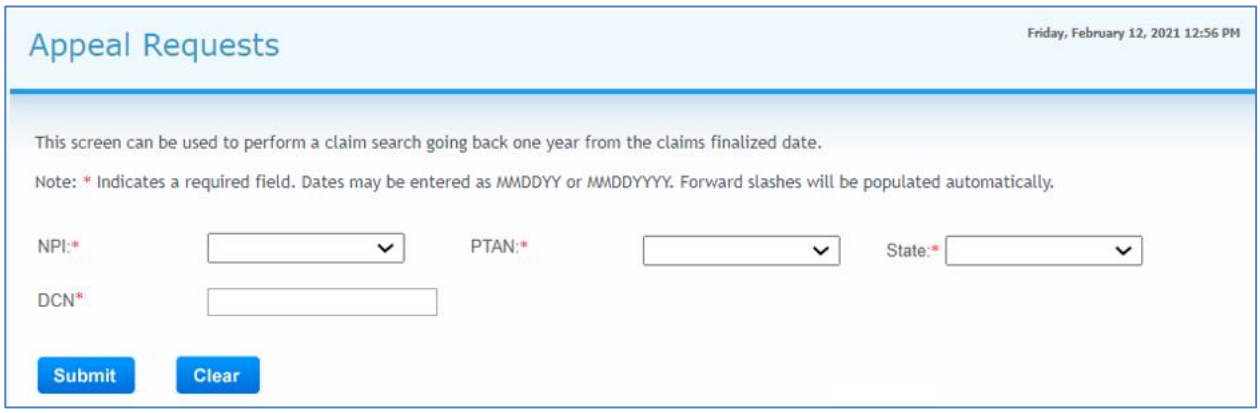

Figure 68 – Appeal Requests Input

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).

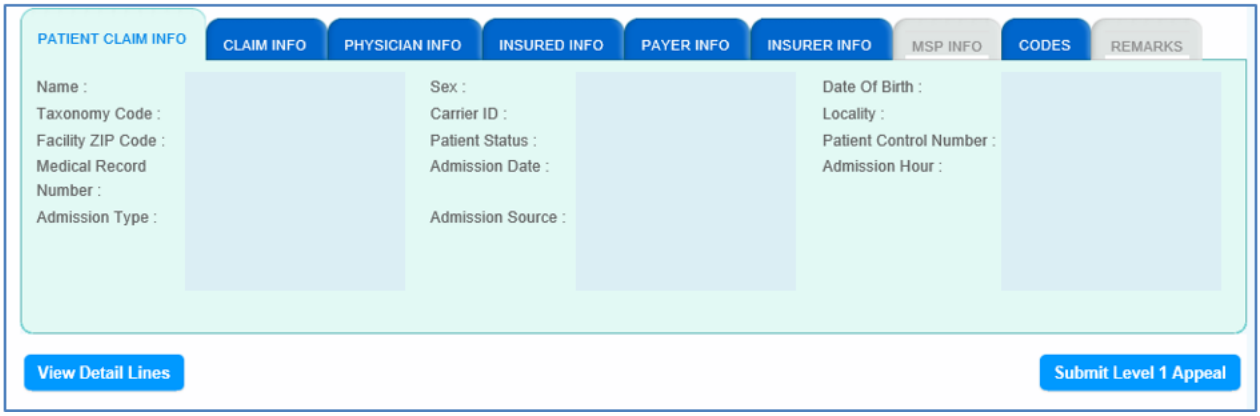

Figure 70 – Submit Level 1 Appeal

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.

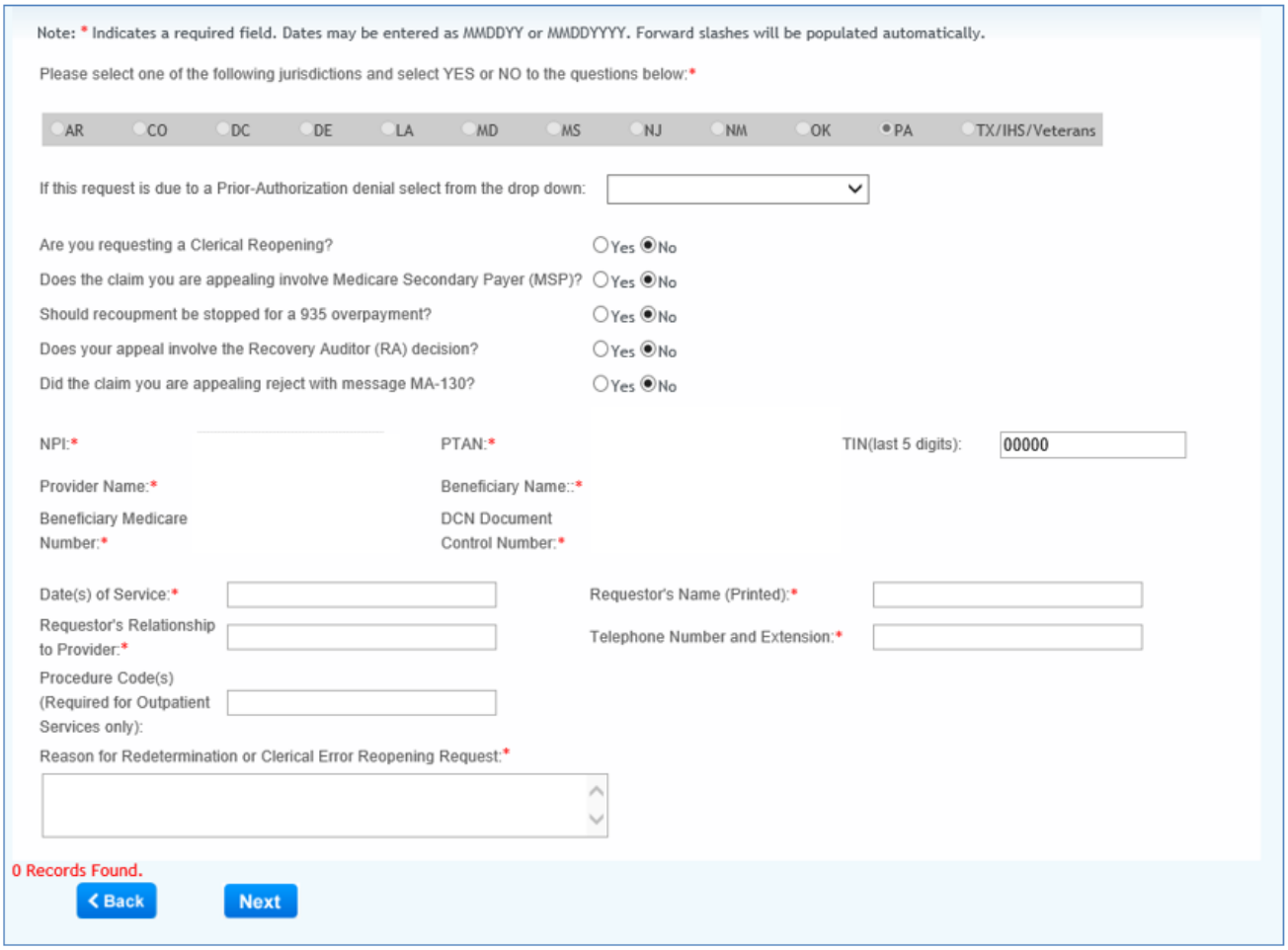

Figure 71 – Appeal Input

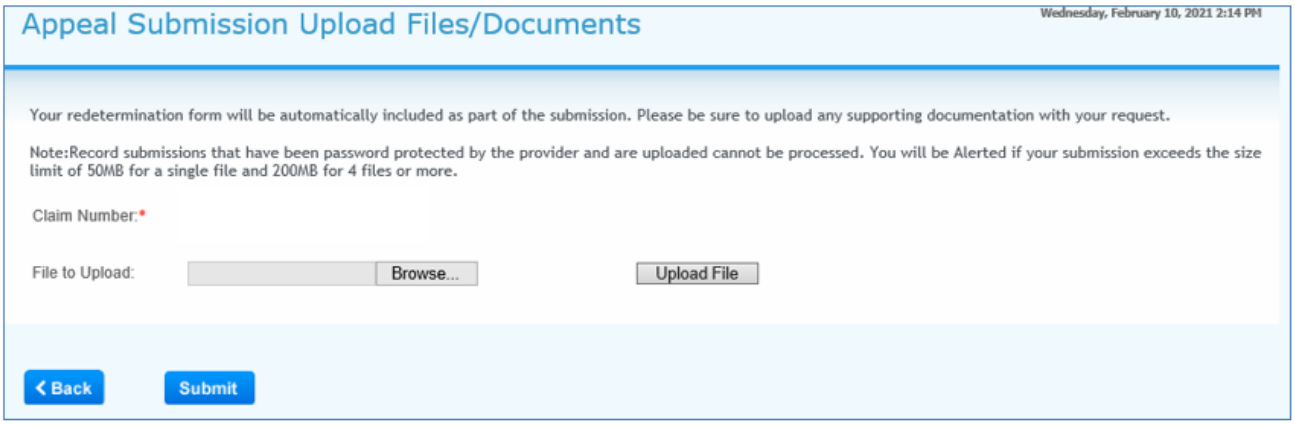

Figure 72 – Appeal Submission Upload Files/Documents

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.

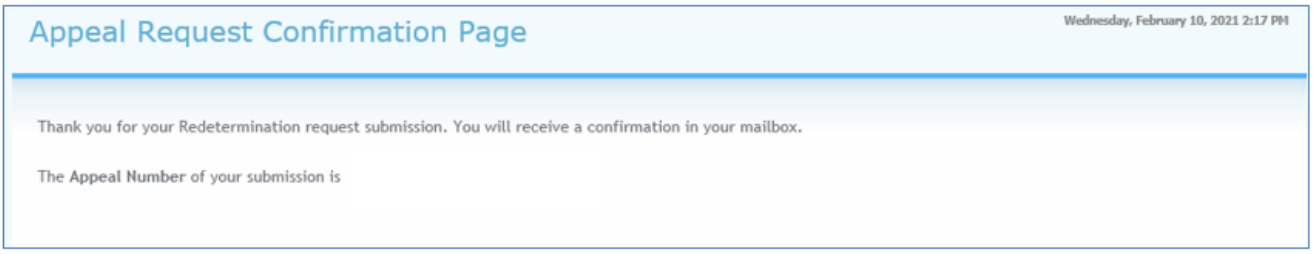

Figure 73 – Appeal Request Confirmation Page

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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.

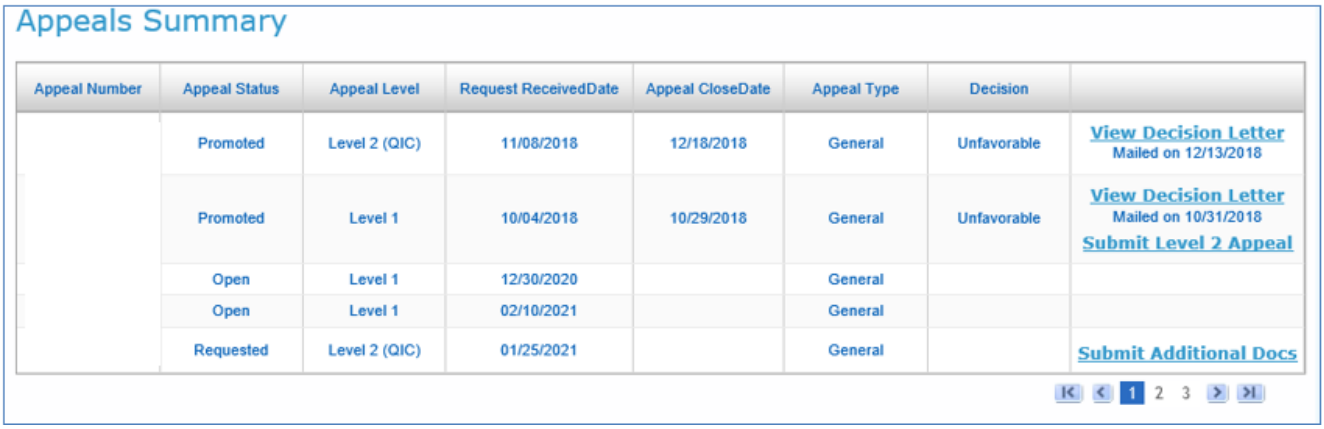

Figure 74 – Appeals Summary

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.

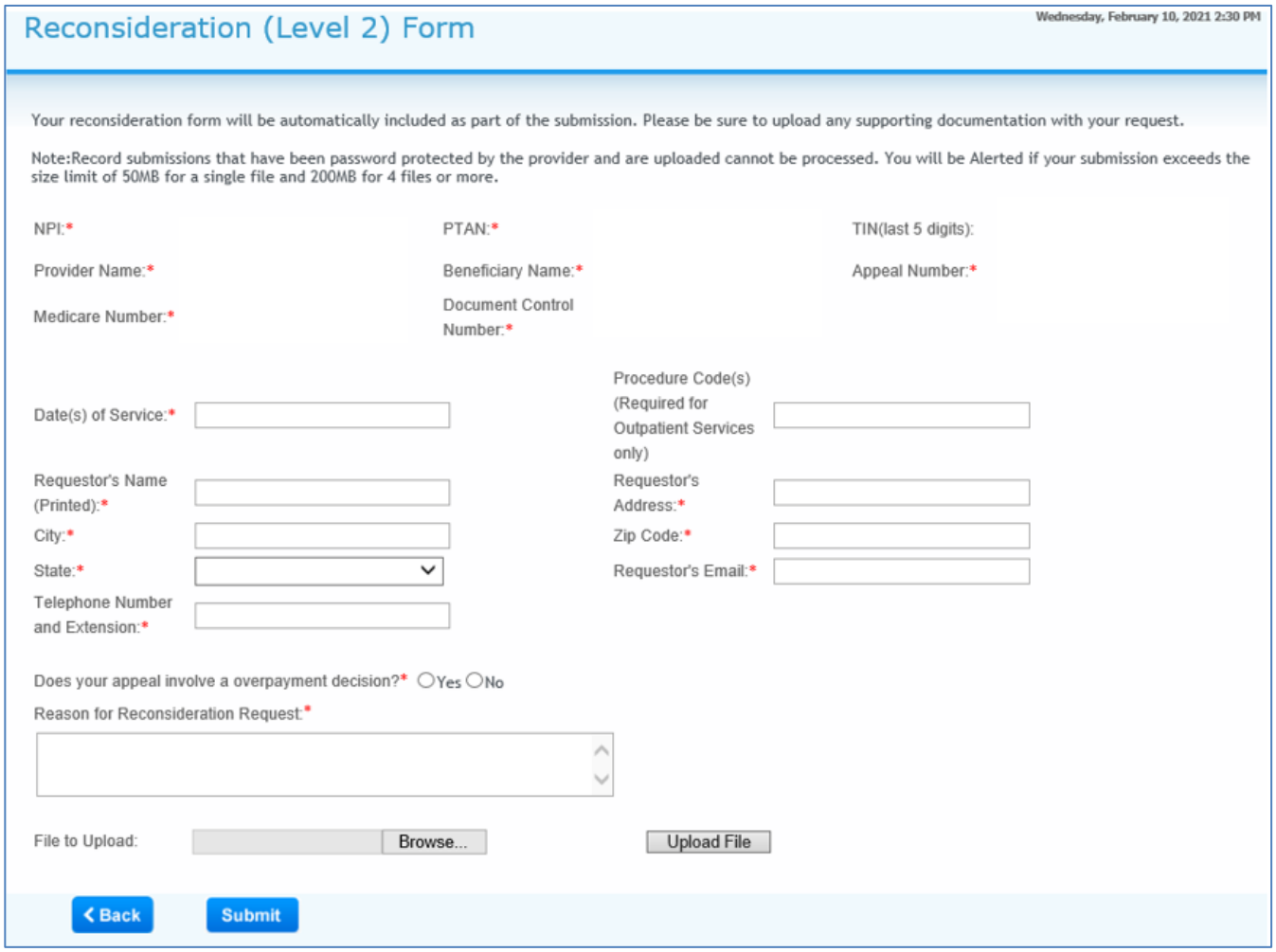

Figure 75 – Reconsideration (Level 2) Form

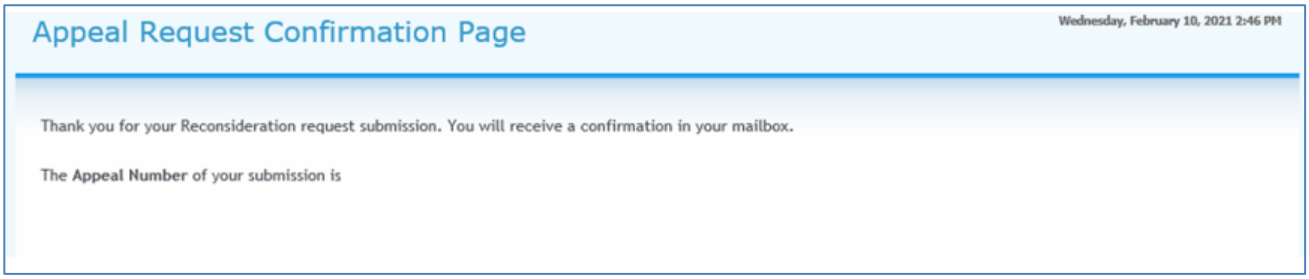

Figure 76 – Appeal Request Confirmation Page

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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**.

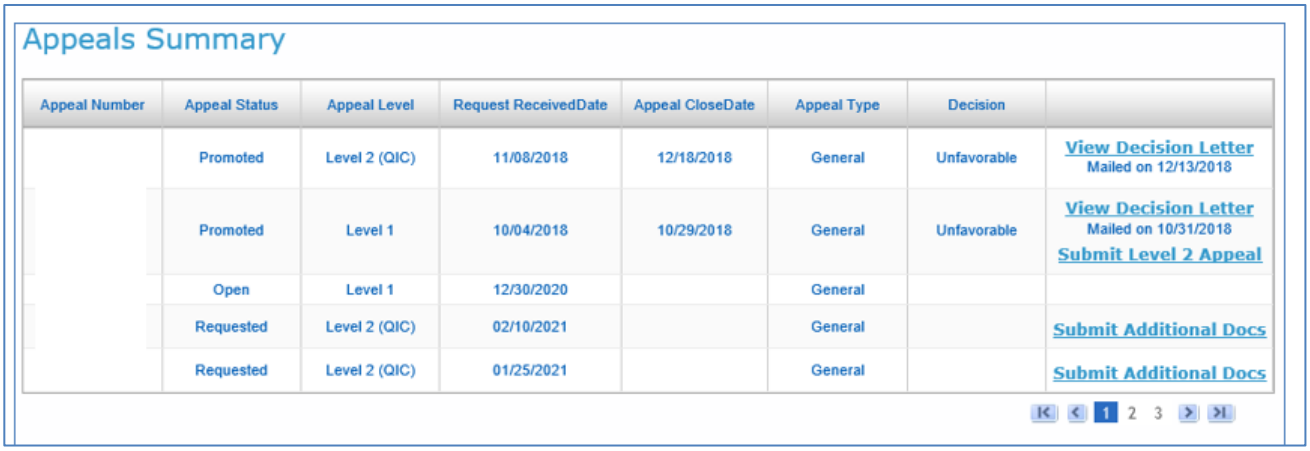

Figure 77 – Appeals Summary

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.

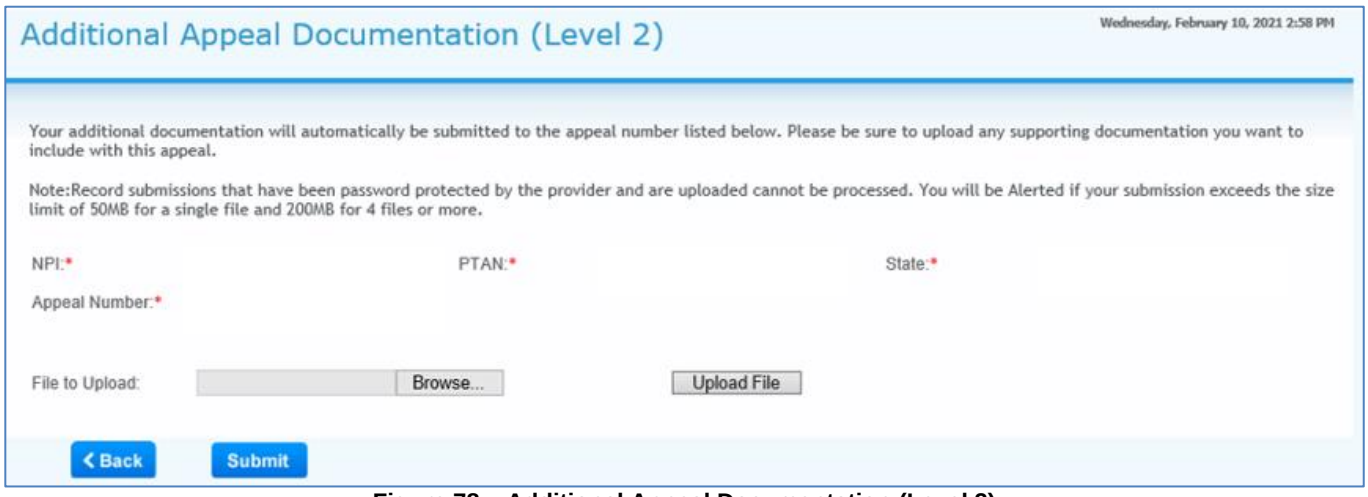

Figure 78 – Additional Appeal Documentation (Level 2)

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.**

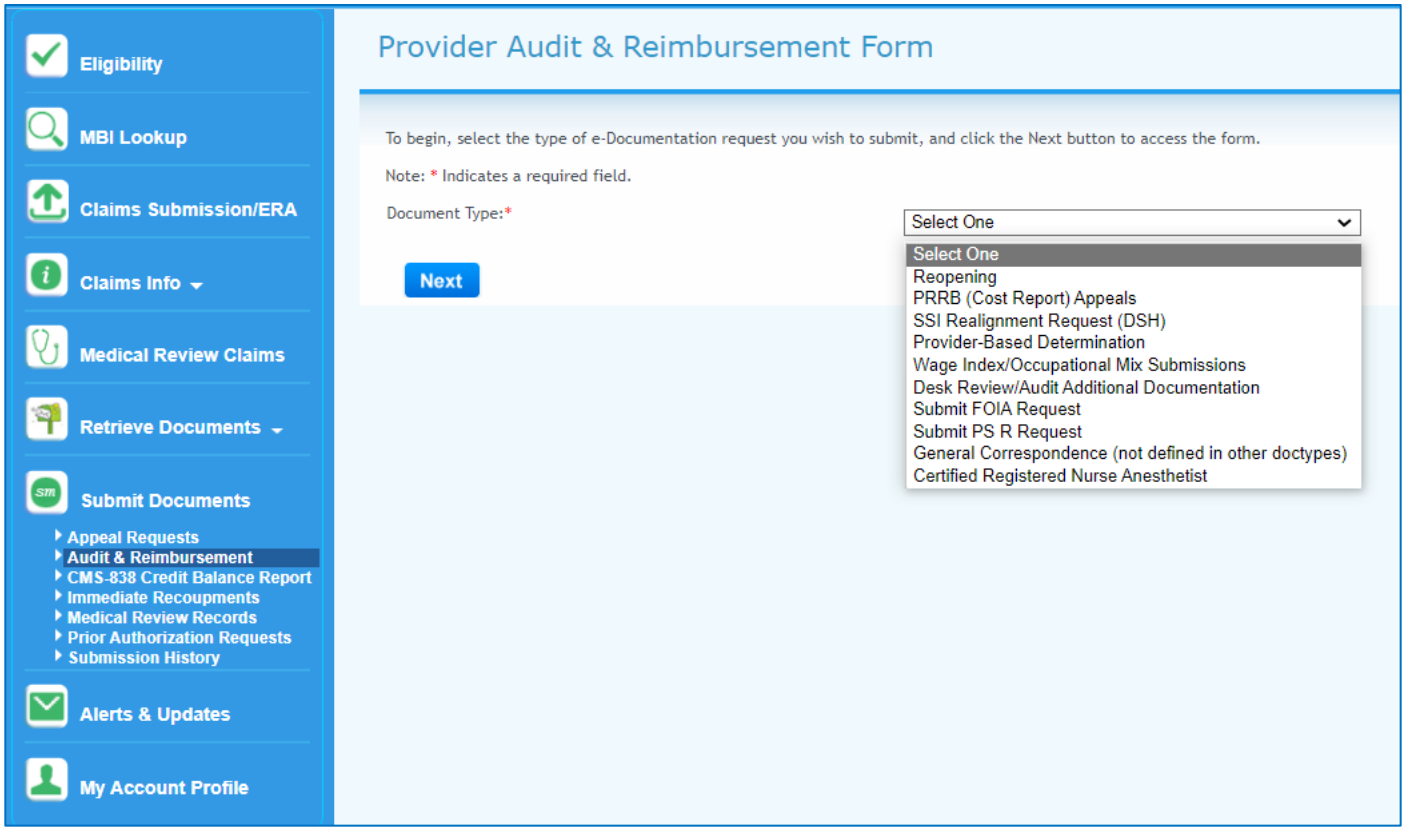

Figure 79 – Provider Audit and Reimbursement Form

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	Used to submit documentation for items not covered in the above-mentioned table selections. Such items include the following: • 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.

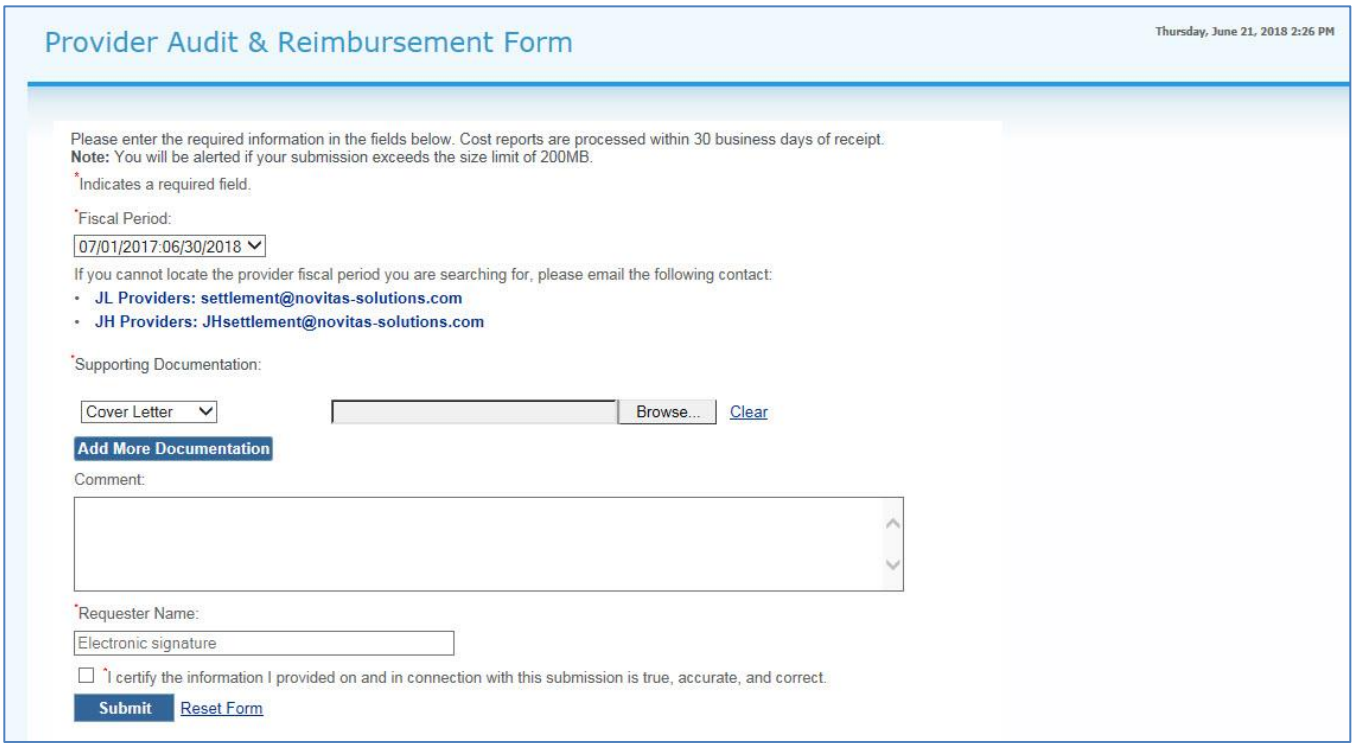

Figure 80 – Provider Audit & Reimbursement Form

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).

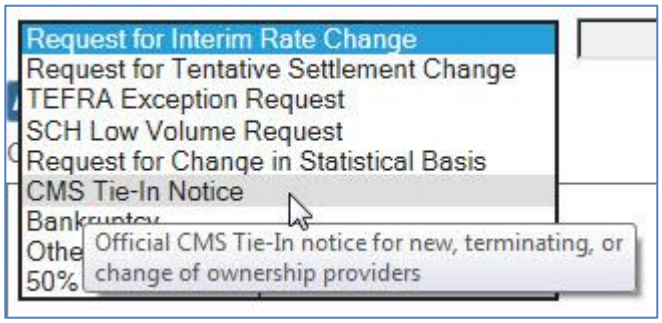

Figure 81 – Provider Audit and Reimbursement Documentation Sub Document Type Descriptions

- 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.**

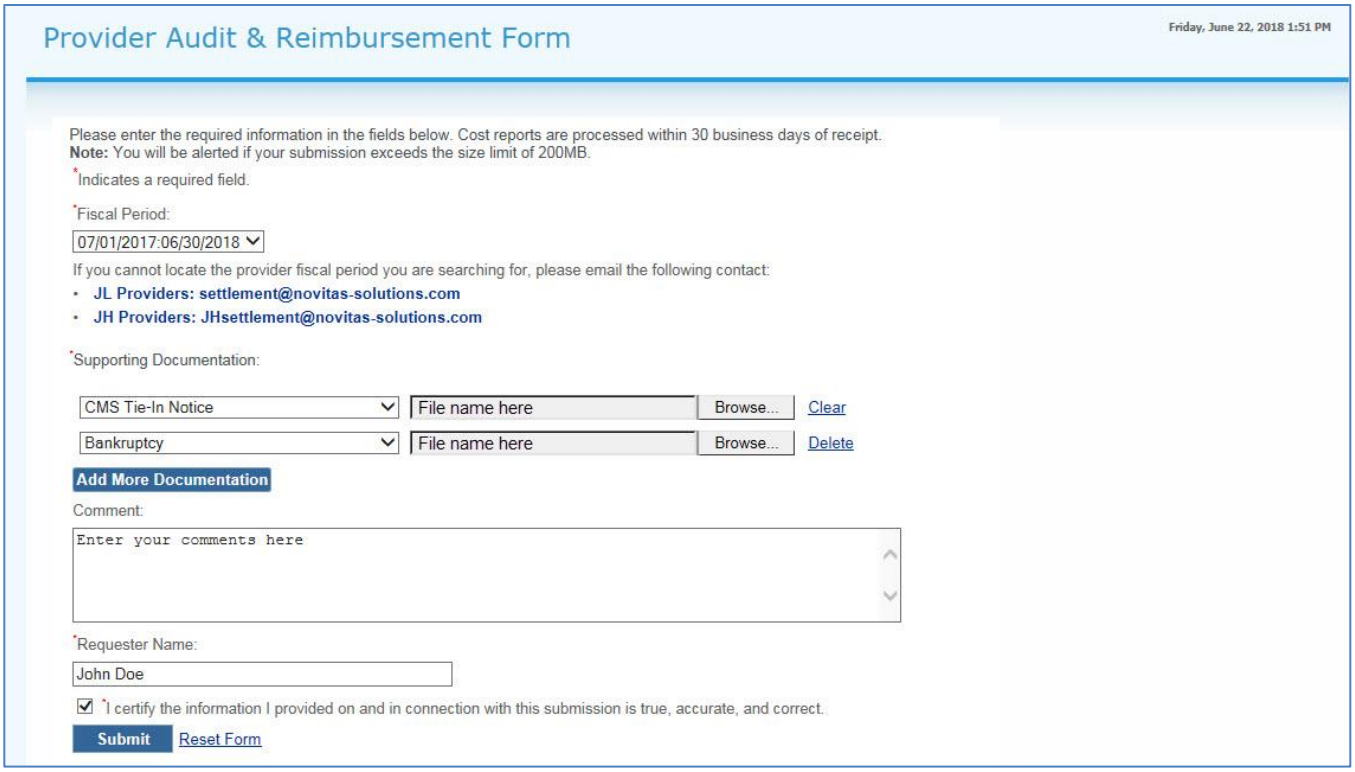

Figure 82 – Completed Provider Audit and Reimbursement Documentation Submission Form

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

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 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.**

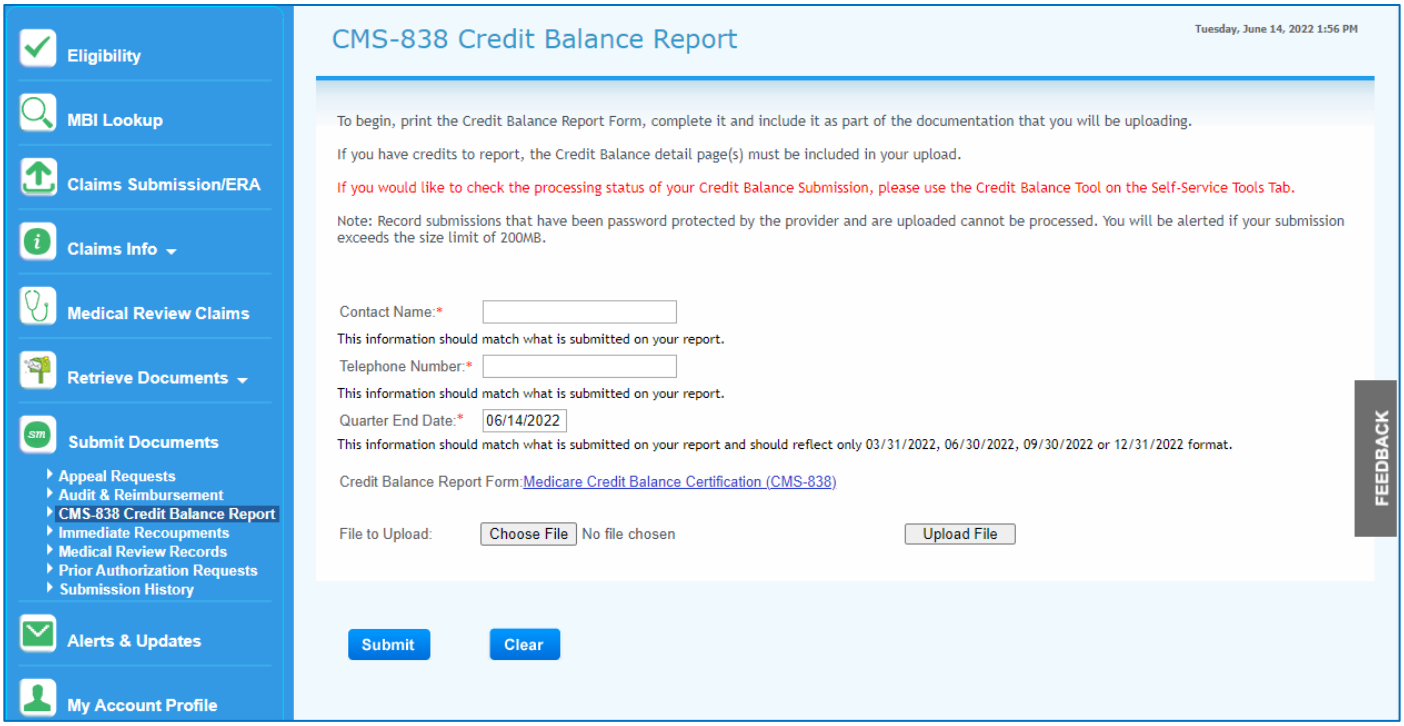

Figure 84 – Credit Balance Report

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.**

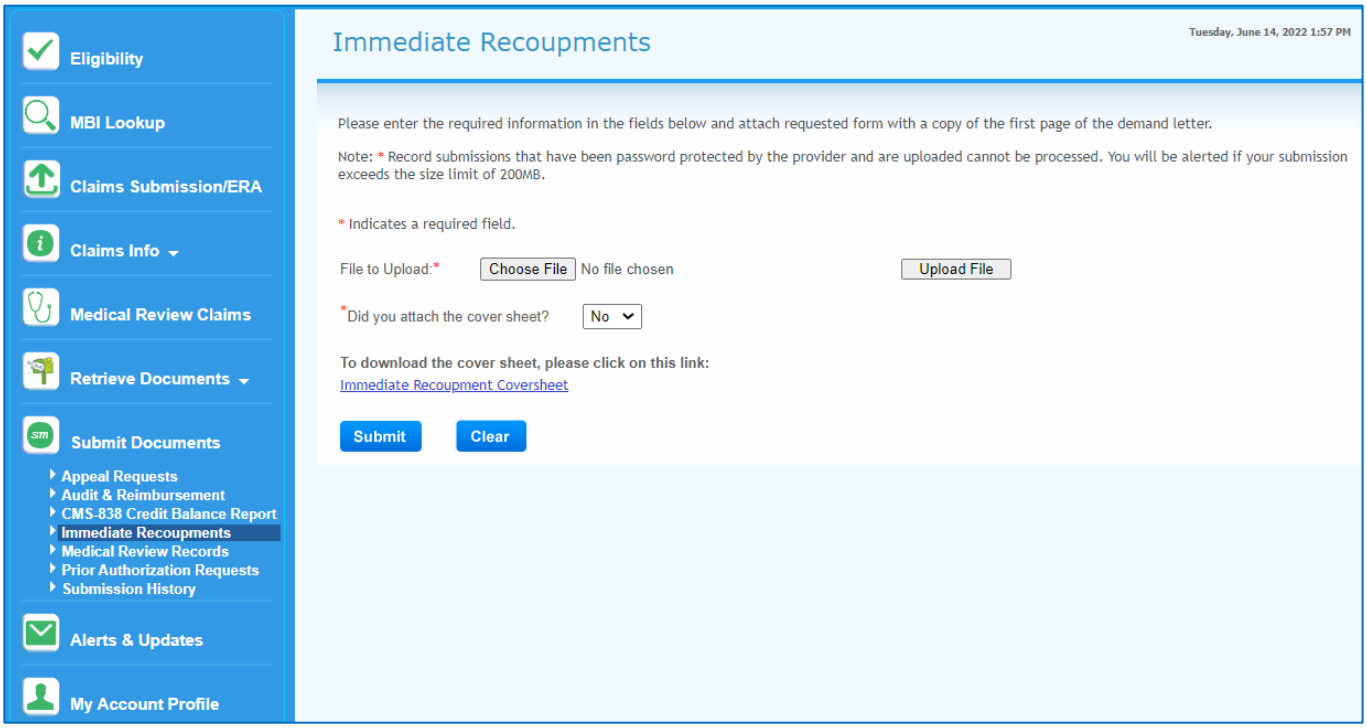

Figure 85 – Immediate Recoupments Input

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.**

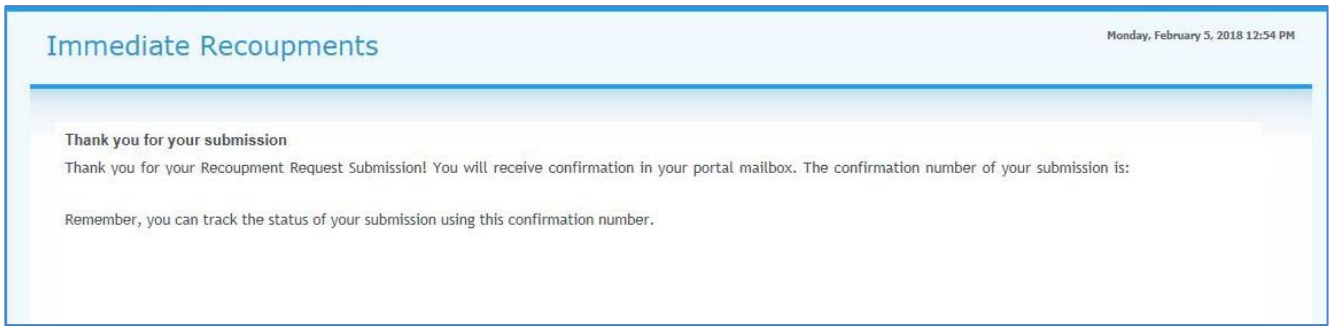

Figure 86 – Immediate Recoupments Confirmation

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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.**

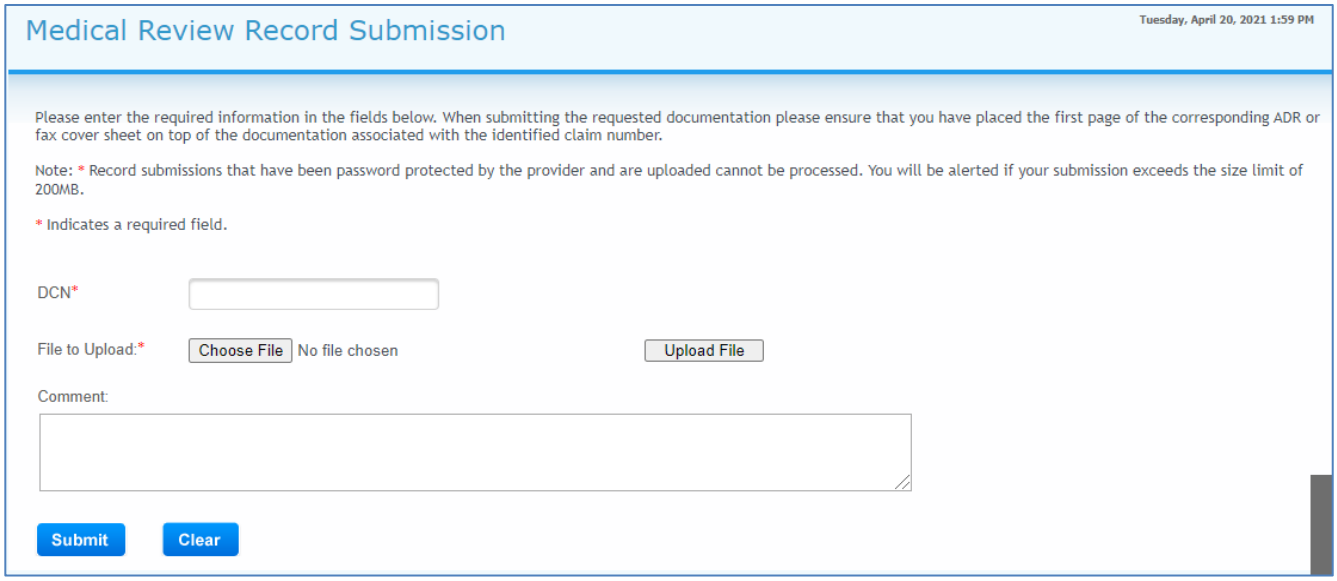

Figure 87 – Medical Review Record Submission

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.**

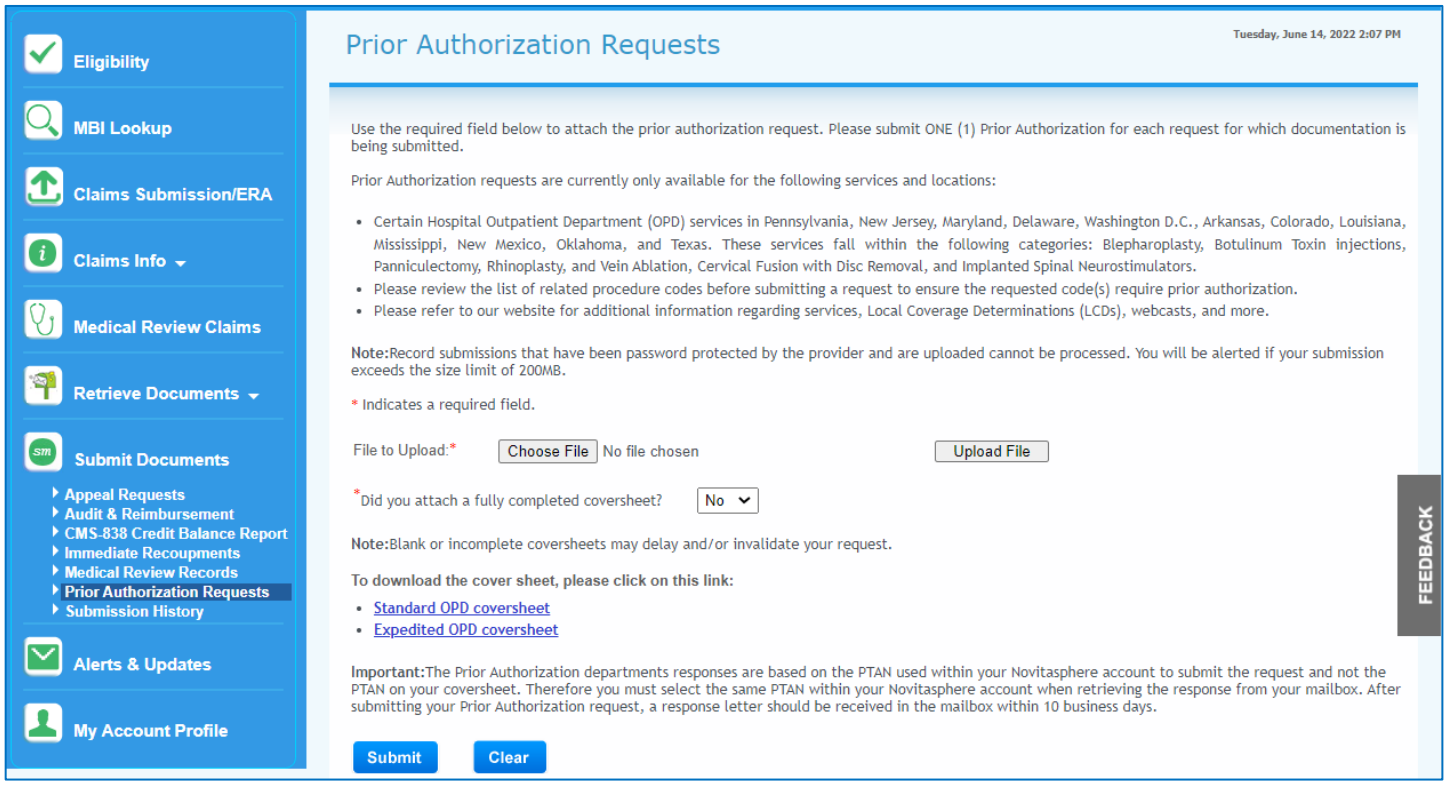

Figure 89 – Prior Authorization Request Submission

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

- *FILE TO UPDLOAD
  - 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 F**igure 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.

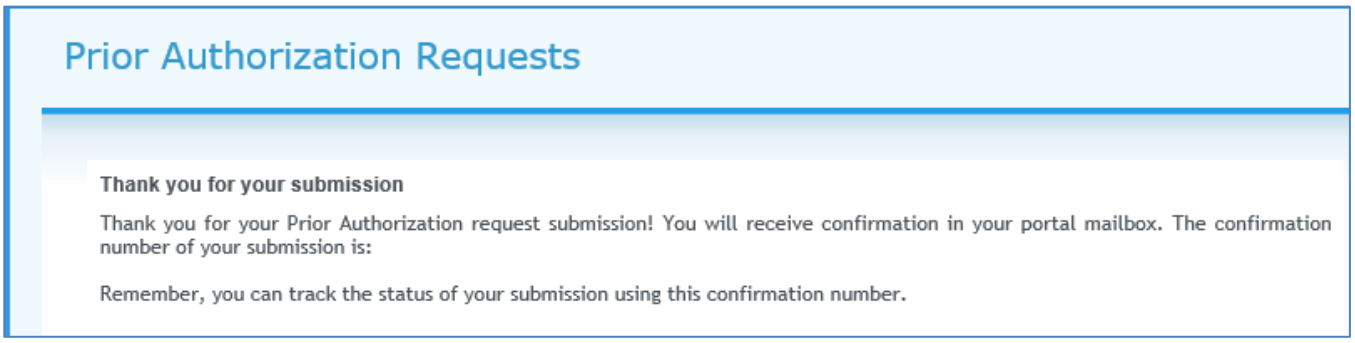

Figure 90 – Prior Authorization Request Submission Confirmation

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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.

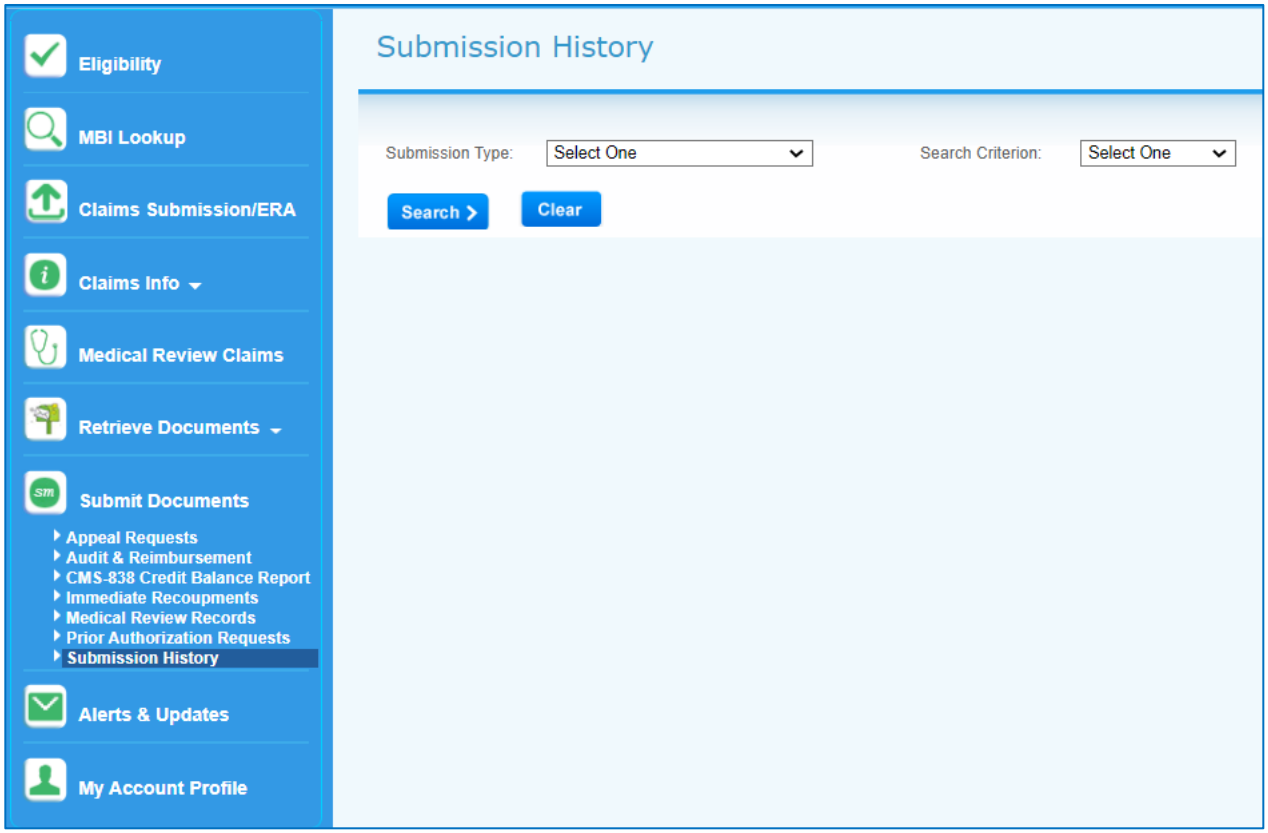

Figure 91 – Submission History – Search by Date Range

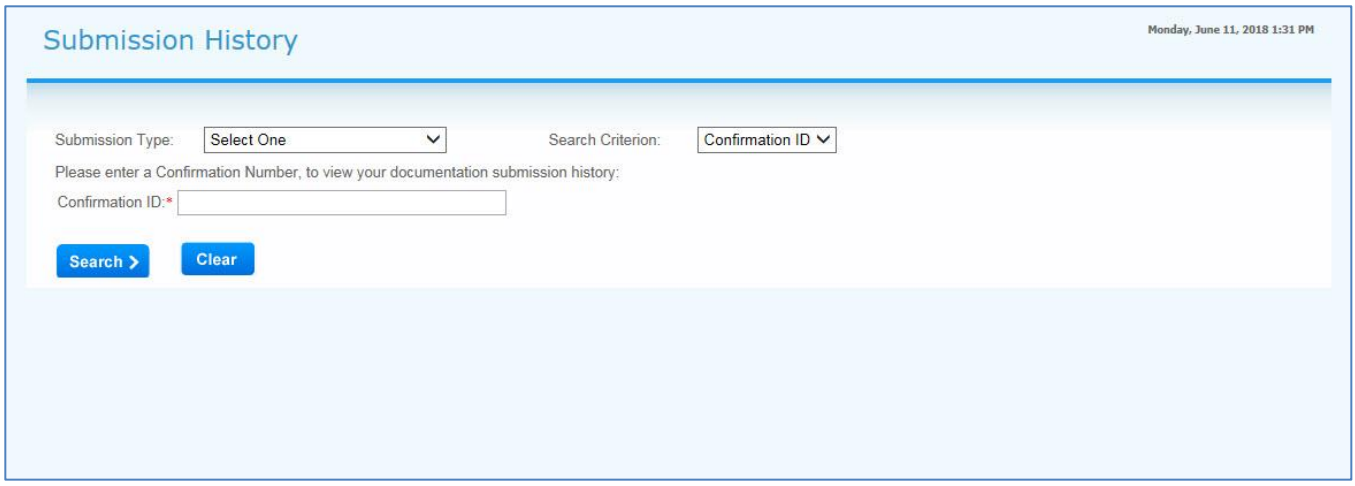

Figure 92 – Submission History – Search by Confirmation ID

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.”

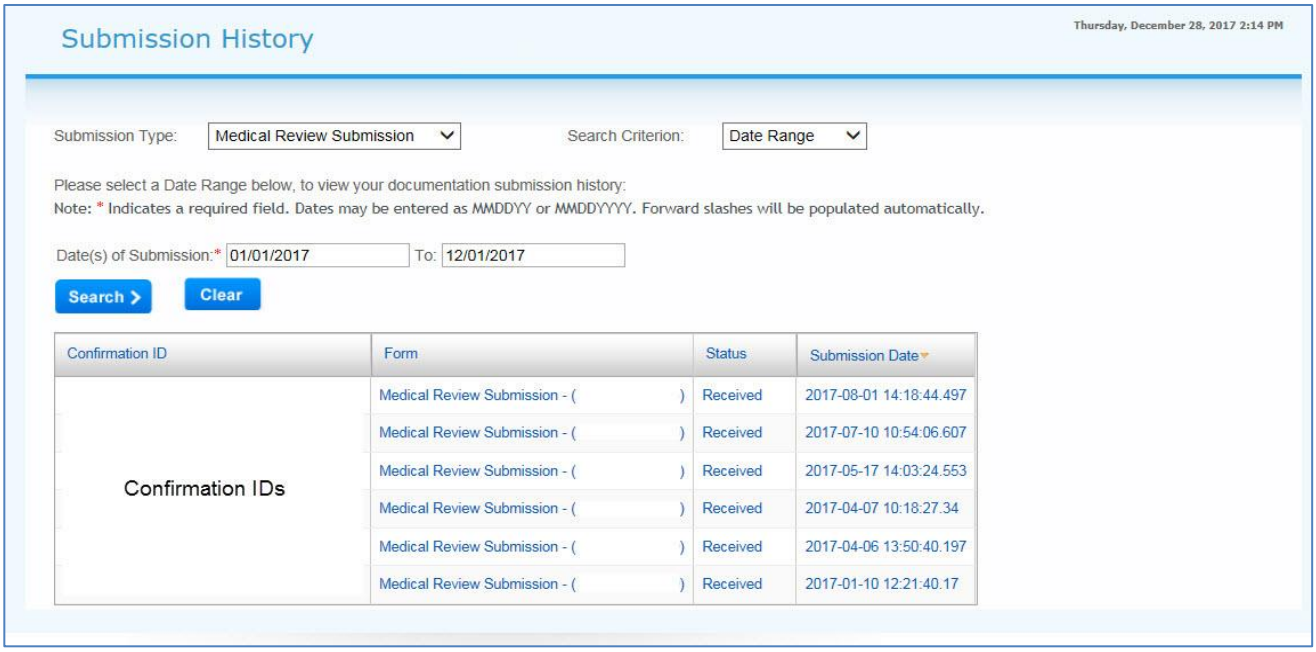

Figure 93 –Submission History –Submission Results

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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.

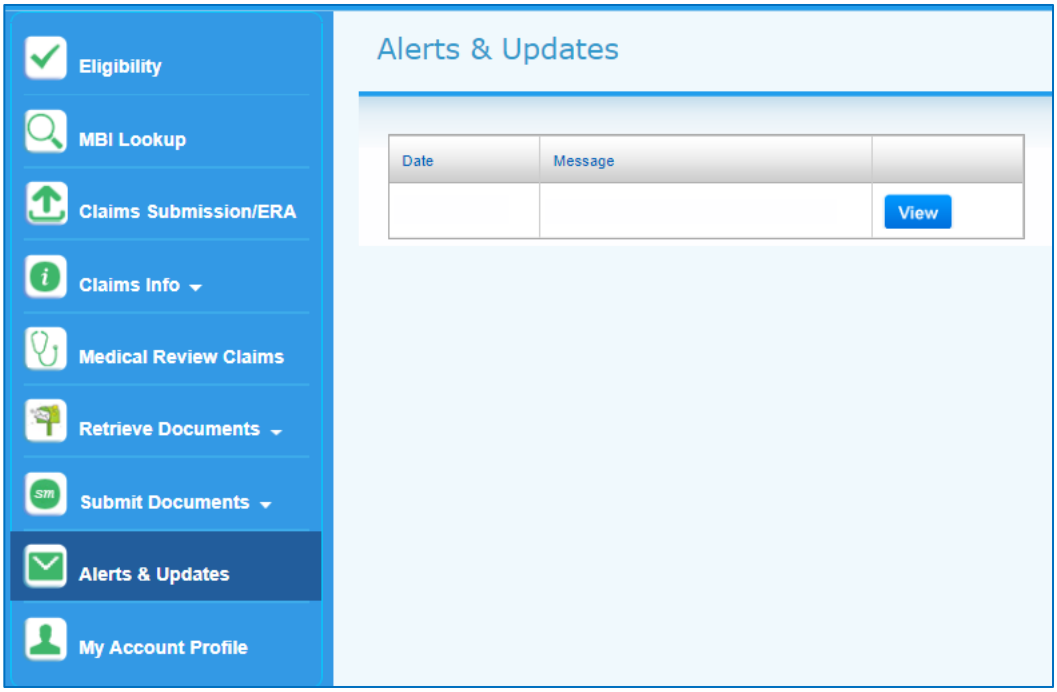

Figure 94 – Alerts & Updates

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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)

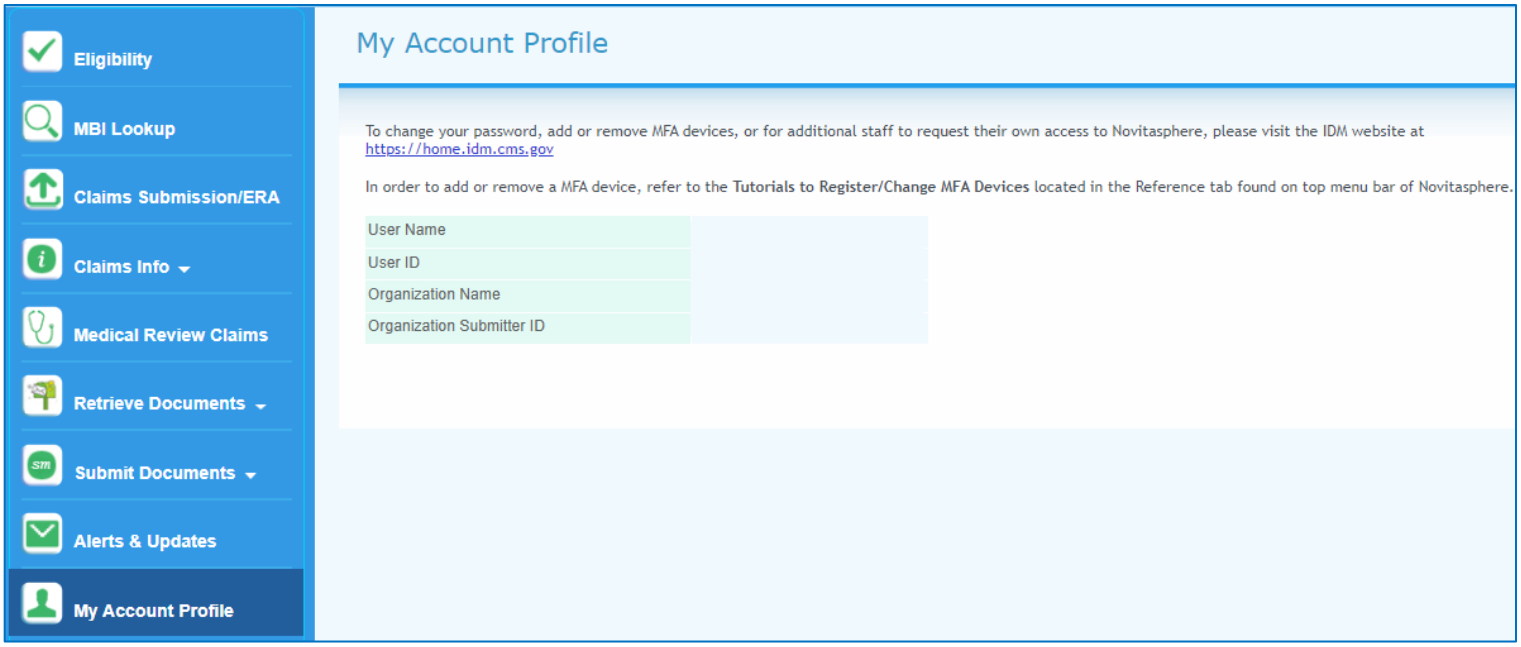

Figure 95 – My Account Profile

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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.**

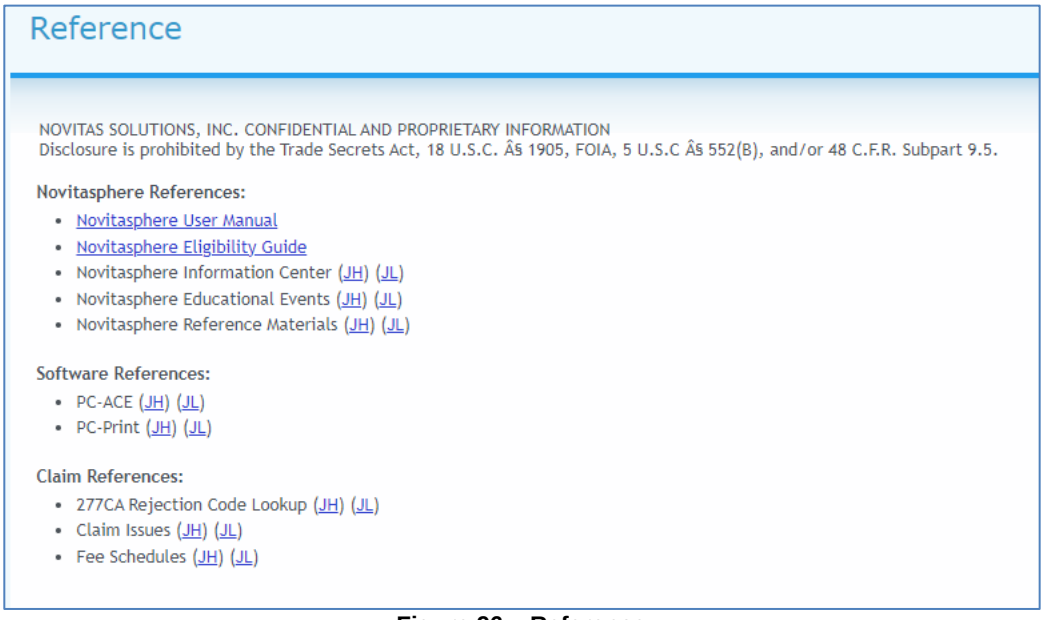

Figure 96 – Reference

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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.**

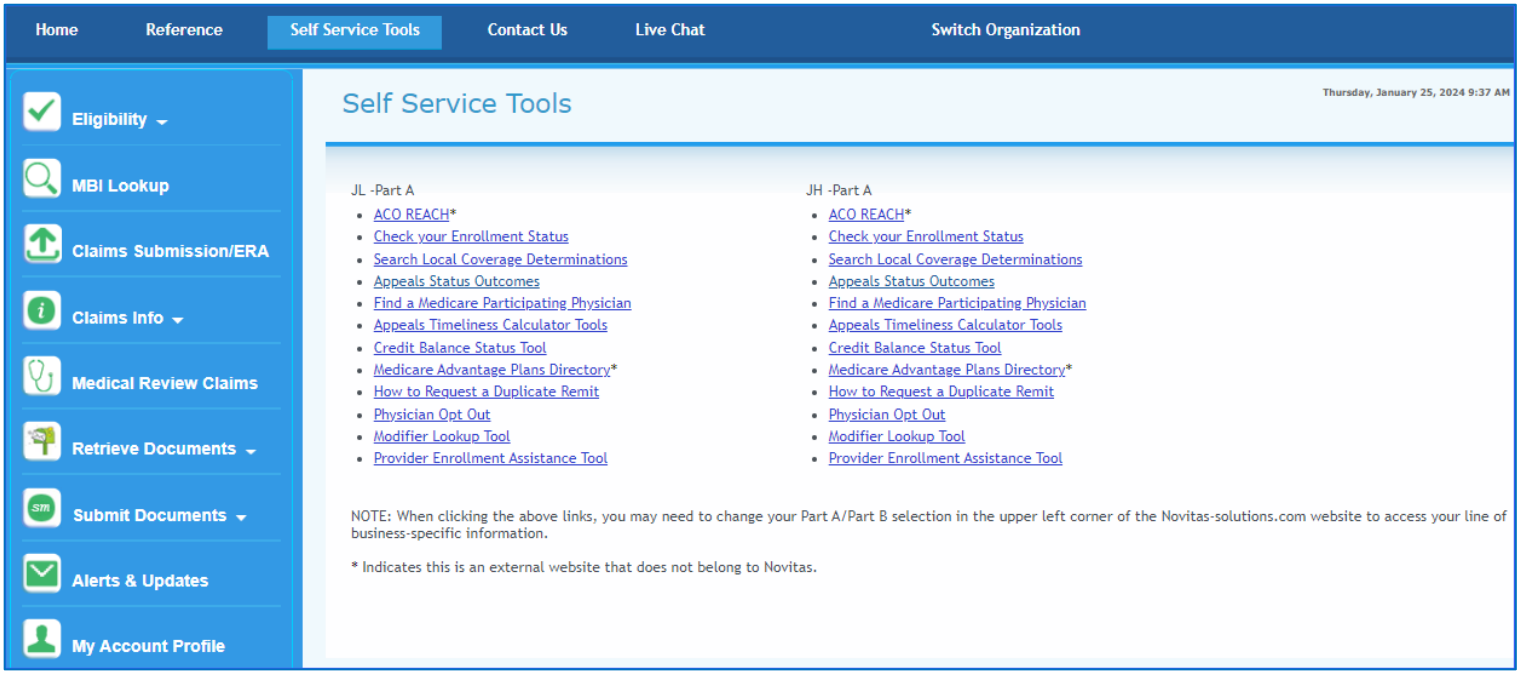

Figure 97 – Self Service Tools

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.**

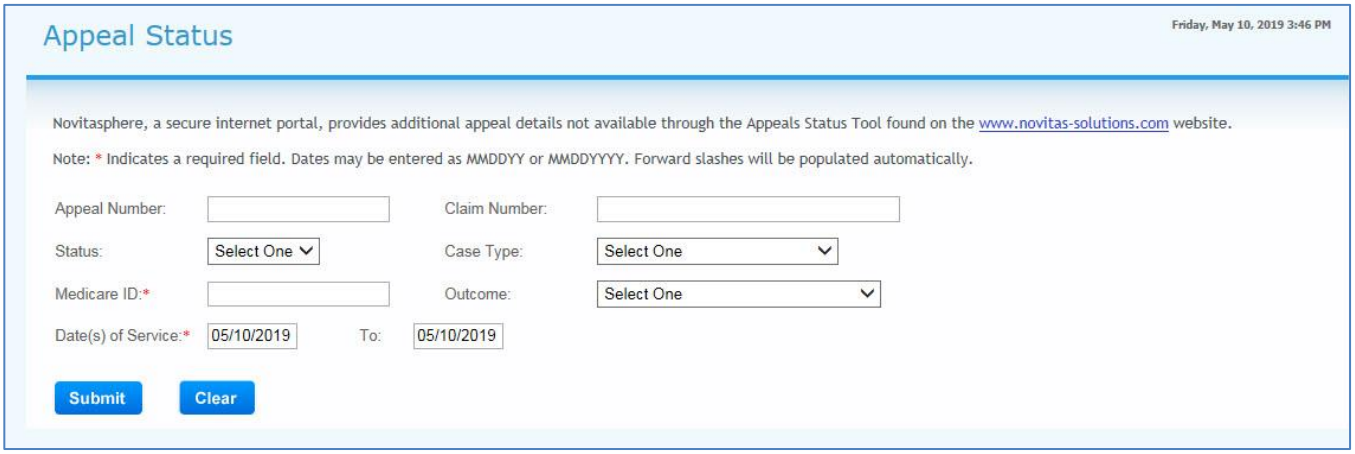

Figure 98 - Appeal Status

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.

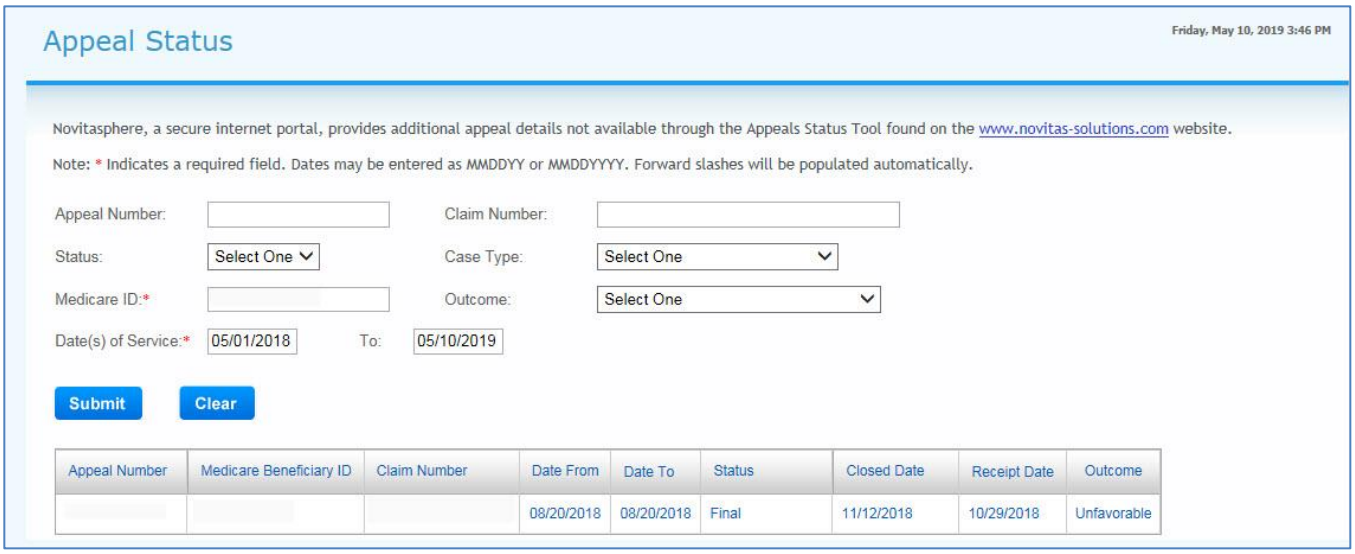

Figure 99 – Appeal Status Search Results

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.**

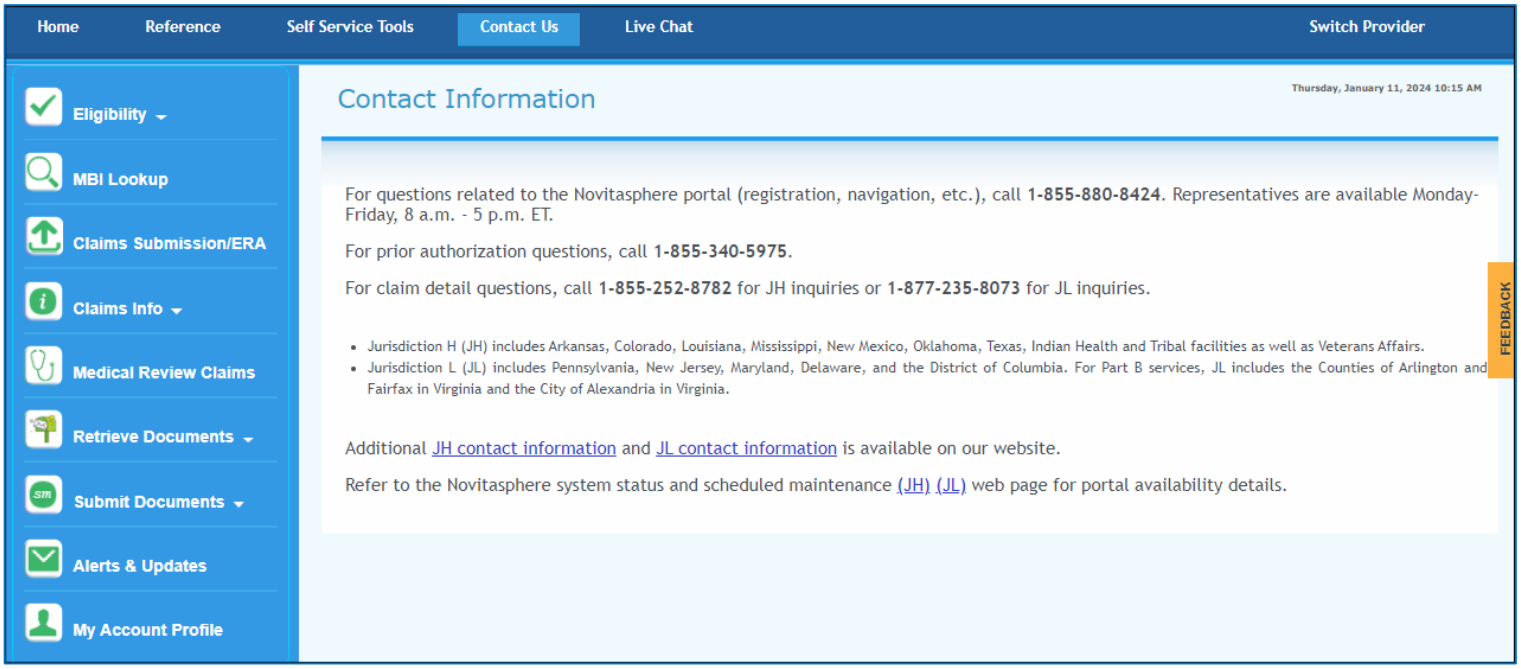

Figure 100 – Contact Us

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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.**

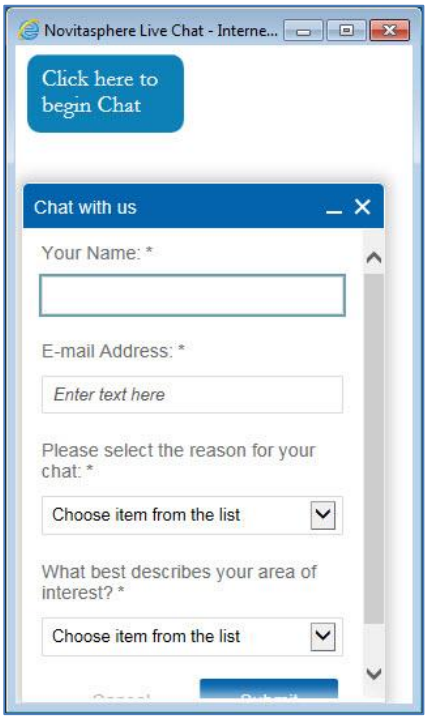

Figure 102 – Pre-chat Information

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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.