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Join Our Email List Today

- Stay current with Medicare by receiving emails twice a week
- Available email lists (not all-inclusive):
  - Jurisdiction H
  - Part B Electronic Billing
  - Novitasphere Portal
  - ABILITY| PC-ACE
  - Medicare Remit Easy Print (MREP) Users
- JH Providers join using:
Today’s Presentation

- Agenda:
  - 2019 Medicare Updates and Reminders
    - RHC Reminders
    - RHC Top Claim Submission Errors
  - New Medicare Card
  - Utilizing the Novitasphere Portal
  - Novitas Initiatives

- Objectives:
  - Identify and understand the current 2019 Medicare updates
  - Understand the New Medicare Card
  - Understand the benefits of the Novitasphere Portal
  - Identify and utilize the Novitas Initiatives
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<th>Definition</th>
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<td>AIR</td>
<td>All Inclusive Rate</td>
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<td>BHI</td>
<td>General Behavioral Health Integration</td>
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<td>CCM</td>
<td>Chronic Care Management</td>
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<td>CMS</td>
<td>Centers for Medicare &amp; Medicaid Services</td>
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<td>CNM</td>
<td>Certified Nurse-Midwife</td>
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<td>CoCM</td>
<td>Psychiatric Collaborative Care Model</td>
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<td>FAQ</td>
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<td>Healthcare Common Procedure Coding System</td>
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<td>IPPE</td>
<td>Initial Preventive Physical Exam</td>
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<td>NP</td>
<td>Nurse Practitioner</td>
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<tr>
<td>Acronym</td>
<td>Definition</td>
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<td>MBI</td>
<td>Medicare Beneficiary Identifier</td>
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<td>MLN</td>
<td>Medicare Learning Network</td>
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<td>PA</td>
<td>Physicians Assistant</td>
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<td>PPS</td>
<td>Prospective Payment System</td>
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<td>RA</td>
<td>Remittance Advice</td>
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<td>RHC</td>
<td>Rural Health Clinic</td>
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<td>RTP</td>
<td>Return to Provider</td>
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<tr>
<td>SSA</td>
<td>Social Security Administration</td>
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2019 Medicare Updates and Reminders
Update to the RHC PPS

- **MM10989:**
  - Effective: January 1, 2019
  - Implementation: January 7, 2019

- **Key Points:**
  - RHC PPS base payment rate is $84.70
    - 2019 base payment rate reflects a 1.5 percent increase
RHC Medicare Benefit Policy Manual Chapter 13 Updates

- **MM11019:**
  - Effective: January 1, 2019
  - Implementation: January 2, 2019

- **Key Points:**
  - Chapter 13 of the Medicare Benefit Policy Manual is being updated and revised for RHCs:
    - RHC PPS Update
    - Care Management in RHCs as finalized in the Calendar Year (CY) 2019 Physician Fee Schedule Final Rule
    - Virtual Communication Services
Update to Medicare Deductible, Coinsurance and Premium Rates for 2019

- **MM11025:**
  - Effective Date: January 1, 2019
  - Implementation Date: January 7, 2019

- **Key Points:**
  - 2019 Part B – Medical Insurance:
    - Deductible: $185.00 a year
    - Coinsurance: 20 percent

- **Additional Reference:**
  - [2019 Medicare Parts A & B Premiums and Deductibles Fact Sheet](#)
Care Coordination Services and Rural Health Center (RHCs)

- **MM10175**:  
  - Effective: January 1, 2018  
  - Implementation: January 2, 2018

- **Key Points:**
  - Payment for care coordination services in RHCs by establishing two new G codes for use by RHC:
    - General Care Management HCPCS G0511:  
      - This code can only be billed once per month per beneficiary, and could not be billed if other care management services are billed for the same time period
    - Psychiatric CoCM HCPCS G0512:  
      - This code can only be billed once per month per beneficiary, and could not be billed if other care management services are billed for the same time period
General Care Management Requirements (G0511)

- RHCs can bill new General Care Management when:
  - Practitioner furnishes a comprehensive E/M, AWV, or IPPE:
    ✓ Within one year of commencing care management services
  - Beneficiary Consent:
    ✓ Obtained during or after the initiating visit
    ✓ Prior to care coordination services by RHC practitioner or clinical staff:
      ➢ Written or verbal consent, must be documented in the medical record

- Eligible patients:
  - Option A:
    ✓ Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient and place the patient at significant risk of death
  - Option B:
    ✓ Any behavioral health or psychiatric condition treated by the RHC practitioner:
      ➢ Including substance use disorders:
        » Clinical judgment of the RHC practitioner, warrants BHI services
Eligibility requirements of Option A:

- Comprehensive care plan is established implemented revised or monitored
- Minimum of 20 minutes of care per month
- Beneficiary must be able to receive notification and provide consent
- Patients must be given a written or electronic care plan
- Access to care management services 24/7 that provides the beneficiary with a means to make timely contact with health care practitioners
- RHCs would continue to be required to meet the RHC Conditions of Participation and any additional RHC payment requirements

Continuity of care with a designated practitioner or member of the care team with whom the beneficiary is able to get successive routine appointments

- Coordinate with all health care providers:
  - Documentation of communication
Care plan must be a structured recording using EHR technology:

- Demographics
- Problems
- Medications/medication allergies
- Creation of a structured clinical summary record
- A full list of problems, medications and medication allergies in the EHR must inform the care plan, care coordination and ongoing clinical care
Eligibility requirements of Option B:

- Initial assessment or follow-up monitoring:
  - Use of applicable validated rating scales
- Behavioral health care planning:
  - Including revision for patients who are not progressing or whose status changes
- Facilitating and coordinating treatment:
  - Psychotherapy, Pharmacotherapy, Counseling and/or Psychiatric consultation
- Continuity of care with a member of the care team
Psychiatric CoCM (G0512)

- RHCs can bill Psychiatric CoCM when:
  - Practitioner furnishes a comprehensive E/M, AWV, or IPPE:
    - Within one year of billing the CCM
  - Beneficiary Consent:
    - Obtained during or after the initiating visit
    - Prior to care coordination services by RHC practitioner or clinical staff:
      - Written or verbal consent, must be documented in the medical record
  - First calendar month:
    - Minimum of 70 minutes:
      - Under direction of RHC practitioner
  - Subsequent calendar months:
    - Minimum of 60 minutes:
      - By RHC practitioner and/or Behavioral Heath Care Manager (under general supervision)

- Eligible patients:
  - Any behavioral health or psychiatric condition treated by the RHC practitioner:
    - Including substance use disorders
    - Clinical judgment of the RHC practitioner, warrants BHI services

- Continues to oversee ongoing oversight, management, collaboration and reassessment

- Required elements:
  - Psychiatric CoCM requires a team that includes the following:
    - RHC (physician, NP, PA, or CNM):
      - Directs the behavioral health care manager or clinical staff
    - Oversees the patients care:
      - Prescribing medications
      - Providing treatments for medical conditions
      - Referrals to specialty care when needed

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Psychiatric CoCM (G0512)
Behavioral Health Care Manager and Psychiatric Consultant

- Behavioral Health Care Manager
- Acting in consultation with the psychiatric consultant
- Available to provide services face-to-face with the beneficiary
- Continuous relationship with the patient
- Collaborative, integrated relationship with the rest of the care team
- Available to contact the patient outside of regular RHC hours as necessary to conduct the behavioral health care manager’s duties
Communication Technology Based Services and Payment for RHCs

- **MM10843:**
  - Effective: January 1, 2019
  - Implementation: January 7, 2019

- **Key Points:**
  - RHCs can receive payment for Virtual Communication services when:
    - At least five minutes of communication technology based or remote evaluation services are furnished
      - RHC practitioner
    - Patient who has had an RHC billable visit within the previous year:
      - Medical discussion or remote evaluation is for a condition not related to an RHC service provided within the previous seven days
      - Medical discussion or remote evaluation does not lead to an RHC visit within the next 24 hours or at the soonest available appointment
Virtual Communication Billing

- Payment for virtual communication services in RHCs by establishing a new G code for use by RHCs:
  - Virtual Communication Services HCPCS G0071
- G0071 can be billed either alone or on the same claim as a billable visit:
  - Virtual communication services are not billable if an RHC visit was furnished within the previous seven days or the next 24 hours or soonest available appointment
- Coinsurance applies
- Face-to-face billing requirement waived
- For 2019, the payment amount for code G0071 will be $13.69
RHC Medicare Benefit Policy Manual Chapter 13 Updates

- **MM11019:**
  - Effective: January 1, 2019
  - Implementation: January 2, 2019

- **Key Points:**
  - Chapter 13 of the Medicare Benefit Policy Manual is being updated and revised for RHCs:
    - RHC PPS Update
    - Care Management in RHCs as finalized in the Calendar Year (CY) 2019 Physician Fee Schedule Final Rule
    - Virtual Communication Services
RHC Reminders
Required Billing Updates for RHC

- **MM9269:**
  - Effective April 1, 2016
  - Implementation April 4, 2016

- **Key Points:**
  - RHCs are required to report the appropriate HCPCS code for each service line along with the revenue code and other codes as required
  - Payment for RHCs will continue to be made under the AIR when all of the program requirements are met
RHC HPCS Reporting Requirements and Updates

- **Special Edition Article SE1611**
- **Key Points:**
  - When a preventative service is the primary service for the visit, RHC’s should report modifier CG on the revenue code 052x with the preventative health service.
  - Coinsurance and deductible are waived for the approved preventative health services.
  - Medicare will pay 100 percent of the AIR service.
Billing for Multiple Visits Same Day

- Multiple encounters on the same day constitute a single RHC visit, except for the following:
  - The patient suffers an illness or injury that requires additional diagnosis or treatment on the same day:
    ✓ The subsequent medical service should be billed using a valid HCPCS code, revenue code 052X, and modifier 59:
      ➢ Modifier 59 signifies that the conditions being treated are unrelated and services are provided at separate times of the day
  - The patient has a medical visit and a mental health visit on the same day
  - The patient has an IPPE and a separate medical and/or mental health visit on the same day:
    ✓ IPPE is a once in a lifetime benefit and should be billed using HCPCS code G0402 and revenue code 052X.
RHC Top Claim Submission Errors
## Top Claim Submission Errors

<table>
<thead>
<tr>
<th>JH Reason Codes</th>
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</thead>
<tbody>
<tr>
<td>38200</td>
</tr>
<tr>
<td>U5233</td>
</tr>
<tr>
<td>C7010</td>
</tr>
<tr>
<td>32402</td>
</tr>
<tr>
<td>38031</td>
</tr>
<tr>
<td>W7091</td>
</tr>
<tr>
<td>U5061</td>
</tr>
</tbody>
</table>
Reason Code 38200/38031

- **Duplicate rejection:**
  - The newly submitted claim is a duplicate to a previously submitted outpatient claim

- **Research:**
  - Verify claims history to determine if another claim was submitted for this date of service:

- **Reason code action:**
  - If the posted claim is incorrect:
    - ✓ Submit an adjustment correcting the information
Reason Code U5233

- RTP error:
  - No Medicare payment can be made because the statement covered period falls within or overlaps an enrollment period in a risk HMO

- Research:
  - Verify the statement covered period
  - Verify the patients eligibility

- Reason code action:
  - Bill the claim to the beneficiaries HMO on file
Reason Code C7010

- RTP error:
  - The edited outpatient claim has a from/through date that overlap a hospice election period

- Research:
  - Verify the statement covered period:
    - Hospice election period verified through Novitasphere, Fiscal Intermediary Shared System (FISS), HETS or Interactive Voice Response (IVR)

- Reason code action:
  - Related to the terminal illness:
    - Bill the Hospice
  - Unrelated to the terminal illness:
    - Resubmit the claim to Medicare with the appropriate condition code 07
Reason Code 32402

- RTP error:
  - Invalid revenue code for a HCPCS code reported or HCPCS is not valid for the date on which services were provided

- Research:
  - Verify the revenue code billed
  - Verify the HCPCS code billed
  - Verify the “from” and “through” dates

- Reason code action:
  - Once revenue, HCPCS and/or from and through dates verified and corrected F9 claim for processing
Reason Code W7091

- RTP error:
  - Non RHC services

- Research:

- Reason code action:
  - Bill Part B CMS 1500 claim form
Reason Code U5061

- **Rejection:**
  - Invalid Health Insurance Claim number, not found in the Common Working File crosswalk

- **Research:**
  - Verify with the beneficiary for their valid Medicare number:
    - Verify the Medicare number using, Novitasphere, Fiscal Intermediary Shared System (FISS), HIPPA Eligibility Transaction System (HETS) or Interactive Voice Response (IVR)

- **Reason code action:**
  - Resubmit claim with corrected Medicare number
New Medicare Card
New Medicare Card

- Background:
  - Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires CMS to remove Social Security Numbers (SSNs) from all Medicare cards by April 2019
  - Medicare Beneficiary Identifier (MBI) will replace the SSN-based Health Insurance Claim Number on the new Medicare cards

- Purpose:
  - Fight identity theft
  - Protect private healthcare
  - Protect financial information
Notice Logo on New Cards

- New Medicare card:
  - Health and Human Services (HHS) logo
  - Railroad Retirement Board logo
  - No gender or signature line
  - Part A and Part B effective dates are unchanged
# New Medicare Card: All Mailing Waves Complete

## Wave

<table>
<thead>
<tr>
<th>Wave</th>
<th>States Included</th>
<th>Cards Mailing</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia</td>
<td>Beginning May 2018 COMPLETE</td>
</tr>
<tr>
<td>2.</td>
<td>Alaska, American Samoa, California, Guam, Hawaii, Northern Mariana Islands, Oregon</td>
<td>Beginning May 2018 COMPLETE</td>
</tr>
<tr>
<td>3.</td>
<td>Arkansas, Illinois, Indiana, Iowa, Kansas, Minnesota, Nebraska, North Dakota, Oklahoma, South Dakota, Wisconsin</td>
<td>Beginning June 2018 COMPLETE</td>
</tr>
<tr>
<td>5.</td>
<td>Alabama, Florida, Georgia, North Carolina, South Carolina</td>
<td>Beginning August 2018 COMPLETE</td>
</tr>
<tr>
<td>7.</td>
<td>Kentucky, Louisiana, Michigan, Mississippi, Missouri, Ohio, Puerto Rico, Tennessee, Virgin Islands</td>
<td>Beginning October 2018 COMPLETE</td>
</tr>
</tbody>
</table>
Inform Medicare Patients

- New Medicare cards have been sent to Beneficiary’s mailing address on file with Social Security
- Beneficiaries should destroy the traditional Medicare card
- Keep the new MBI confidential
- Issuance of the new number will not change Medicare benefits:
  - The effective date for Medicare Part A and Part B will remain the same on the new card
- Medicare & You Handbook includes information on new card
MBI is coming! Are you ready?

- Effective January 1, 2020, claims submitted to Medicare will require the beneficiary’s MBI number
- Is your office or facility prepared for the MBI transition?
- Use MBI now for all Medicare transactions
- 3 ways to get the MBI:
  - Ask your patient for their card
  - Use your Medicare Administrative Contractor’s look up tool:
    - Sign up for the Portal to use the tool
  - Check the remittance advice:
    - MBI is returned on the remittance advice if a valid and active Health Insurance Claim Number is submitted
- Get Your New Medicare Card
- Beneficiaries who did not receive their card can:
  - Sign into MyMedicare.gov:
  - Call 1-800-MEDICARE (1-800-633-4227) for assistance
  - TTY users can call 1-877-486-2048
MBI Lookup

- Select the MBI Lookup from the left navigation bar
MBI Lookup Results

This tool is to be used only when a Medicare patient doesn't or can't give you his/her Medicare Beneficiary Identifier (MBI). The patient's first name, last name, date of birth, and social security number are required to get a unique match. The MBI is confidential so you'll have to protect it as Personally Identifiable Information and use it only for Medicare-related business.

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

First Name* Jane
Last Name* Doe
Date of Birth (MM/DD/YYYY)* 01/01/1937
SSN* 111-22-3333
NPI* 123789456

Submit  Clear

MBI Lookup Information

<table>
<thead>
<tr>
<th>Subscriber First Name</th>
<th>Jane</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subscriber Last Name</td>
<td>Doe</td>
</tr>
<tr>
<td>Subscriber MBI Number</td>
<td>1EG4-TE5-MK72</td>
</tr>
</tbody>
</table>
Beginning October 1, 2018 through transition period:

- MID field will reflect the Medicare identification submitted
- MBI field will reflect the MBI when a valid and active Medicare number is submitted

FISS Standard Paper Remittance Advice Example

Beginning October 1, 2018, through the transition period:

- The **MID field** (line 32) will show the Medicare ID submitted on the claim
- The **MBI field** (line 66) will show the Medicare Beneficiary Identifier (MBI) when a provider submits a valid and active HICN
Beginning October 1, 2018, through transition period:
- MID field will reflect the Medicare identification submitted
- MBI field will reflect the MBI when a valid and active Medicare number is submitted
MBI Transition Period

- **Transition Period Ends December 31, 2019:**
  - To ensure your Medicare patients continue to have access to care, you can use either the former Medicare number or the new MBI for all Medicare transactions through December 31, 2019.
  - Beginning January 1, 2020, you must use the MBI on all Medicare transactions.

- **Few Exceptions:**
  - **Appeals** - You can use either the Medicare number or the MBI for claims appeals and related forms.
  - **Audits** – You can use either the HICN or the MBI for audit purposes.
  - **Claim status query** - You can use either the Medicare number or the MBI to check the status of a claim if the earliest date of service on the claim is before January 1, 2020.

  ✔ If you're checking the status of a claim with a date of service on or after January 1, 2020, you have to use the MBI.
88 Percent of Claims Submitted With MBI

- Week ending September 6th, providers submitted 88% of fee-for-service claims with the MBI:
  - 88% Institutional
  - 88% Professional
- Use MBI now for all Medicare transactions
- **Three ways to get the MBI:**
  - Ask your patient for their card:
    - If your Medicare patient says they did not get a card, instruct him or her to call 1-800-MEDICARE (1-800-633-4227), to help them request a new card
  - **Novitasphere Portal:**
    - Novitasphere is a FREE, secure internet portal for providers, billing services, and clearinghouses
    - Portal offers an MBI Lookup feature allowing access to the patient’s MBI number
  - Check the remittance advice:
    - We return the MBI on the remittance advice for every claim with a valid and active Health Insurance Claim Number
Novitasphere Portal
What is Novitasphere?

- Free, secure web-based portal which allows enrolled users access to a number of time-saving features
- Available providers, billing services and clearinghouses Dedicated Help Desk- 1-855-880-8424
- For demonstrations and more information JH
Part A Navigation Bar

Eligibility:
- Deductible
- Medicare Secondary Payer
- Medicare Advantage Plan
- Hospice/Home Health
- Preventive Services
- Inpatient
- QMB - Qualified Medicare Beneficiary

Retrieve Documents:
- Appeal Development Letters
- Mailbox
- Overpayment Letter
- Redetermination Notices

Claim Submission/ERA:
- File Submission
- File Status and Reports

Medical Review:
- Additional Documentation Requests
- Claim Review
- Education

Submit Documents:
- Appeal Requests
- Audit and Reimbursement
- CMS-838 Credit Balance Report
- Immediate Recoupments
- Medical Review Records
- Prior Authorization Requests
- Submission History

INNOVATION IN ACTION
Part B Navigation Bar

Eligibility:
- Deductible
- Medicare Secondary Payer
- Medicare Advantage Plan
- Hospice/Home Health
- Preventive Services
- Inpatient
- QMB - Qualified Medicare Beneficiary

Claim Submission/ERA:
- File Submission
- File Status and Reports

Claims Info:
- Summary
- Status

Appeal Requests:
- Redeterminations and Clerical Error
- Reopening Requests

Medical Review Claims:
- Additional Documentation
  - Request status and copies
  - Education

Submit Documents:
- General Information Requests
- Immediate Recoupments
- Medical Review Records
- Prior Authorization Requests
- Submission History

Retrieve Documents:
- Appeal Development Letters
- CBR Reports
- Claim Correction Confirmation
- MailBox
- Overpayment Letter
- Redetermination Notice
- View Remittance Advice
- Requested Remittance Advice

Billed In Error
Claim Correction
Alerts & Updates
My Account Profile
Eligibility Information

- Eligibility
  - Part A and B Eligibility Effective and Termination Dates
  - End Stage Renal Disease (ESRD) dates and information

- Deductible
  - Part B Total Deductible Remaining for Calendar year
  - Occupational, Physical and Speech Therapy amounts applied to the capitation limits
  - Rehabilitation Session counts

- Medicare Advantage Plan (MAP)
  - Contract Name, Number, Address and Telephone Number
  - Plan number and Plan name
  - Type of Medicare Advantage Plan
  - The Bill Option code of the Plan type
  - Effective and Termination Dates

- Medicare Secondary Payer (MSP)
  - The reason Medicare is secondary
  - Effective and Termination Dates
  - MSP Diagnosis code
  - Name of Insurance Company and Address

- Hospice/Home Health
  - Certification codes and dates
  - Home Health Episode Start and End Dates
  - Home Health Episode termination date
  - Provider NPI Number of the Home Health Facility

- Preventive Services
  - Number of Smoking Sessions remaining
  - Medicare Diabetes Prevention Program (MDPP) usage
  - Preventive Service Procedure Code
  - Preventive Technical and Professional Dates
  - Deductible Applied for the Calendar Year
  - Deductible Remaining for the Calendar Year
  - Coinsurance Remaining for the Calendar Year

- Inpatient
  - Date of earliest and latest billing activity for the spell of illness
  - Hospital Information
  - Skilled Nursing Facility Information

- QMB
  - QMB Effective and Termination Dates
  - QMB Deductible and Coinsurance Remaining
  - QMB Inpatient Spell, Hospital Information and SNF Information
Eligibility Details

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

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

First Name* ___________________________ Last Name* ___________________________
Suffix: ___________________________ Medicare Beneficiary ID* ___________________________
Date of Birth (MM/DD/YYYY) ___________________________
Date(s) of Service* 06/08/2018 TO 06/08/2018
NPI* ___________________________
Types of Data: All

Submit  Clear
Eligibility Results

### Inquiry Information

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<th>Inquiry Information</th>
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<tbody>
<tr>
<td>Subscriber First Name</td>
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<td>Subscriber Last Name</td>
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<tr>
<td>Subscriber Date of Birth</td>
</tr>
<tr>
<td>Subscriber Medicare #</td>
</tr>
<tr>
<td>Date of Service/Date of Service Range</td>
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### Eligibility Tab

#### Active Eligibility Periods

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<tr>
<th>Part</th>
<th>Effective Date</th>
<th>Termination Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Part A</td>
<td>12/1/2012</td>
<td></td>
</tr>
<tr>
<td>Part B</td>
<td>12/1/2012</td>
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</table>

#### Inactive Eligibility Periods

<table>
<thead>
<tr>
<th>Effective Date</th>
<th>Termination Date</th>
</tr>
</thead>
</table>

#### End Stage Renal Disease (ESRD)

<table>
<thead>
<tr>
<th>Effective Date</th>
<th>Termination Date</th>
<th>Benefit Description Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>6/1/2011</td>
<td>1/5/2013</td>
<td>Renal Supplies in the Home</td>
</tr>
</tbody>
</table>
Novitas Initiatives
Website Satisfaction Surveys

Rate Your Website Experience

You've been selected to participate in a customer satisfaction survey to help us improve your website experience.

The survey will take 2-3 minutes, and will appear at the conclusion of your visit.

This survey is conducted by an independent company ForeSee, on behalf of the site you are visiting.

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  - Issued every Tuesday and Friday
  - CMS MLN Connects issued Thursdays
- Subscribing is quick and easy:
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Summary

- Provided the latest news, updates, reminders and top claim submission errors
- Demonstrated the user-friendly functionality of the Novitasphere Portal
- Reviewed helpful Medicare reminders and education resources
Thank You

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