



Eligibility Verification Overview

The eligibility verification process provides for either the manual entry or electronic retrieval of insurance eligibility and benefits verification information; the storage of this information within the application; and the tracking, reporting, and display of this and related information. Conceptually the eligibility verification process works very similar to the Charge Entry (CE), Claim Process (CP), and Claim Response Process (CRP) for claim filing and management.

With this release the APM Core provides on-line, real-time, eligibility verification through Ingenix ENS and Availity processing centers (Please refer to their respective payer list for support payers). This is accomplished using the 270/271 transaction sets and is done over the Internet. From the perspective of the end-user APM supports both real-time and batch mode methodologies. In point of fact it is all real-time; what appears to be batch processing is simply the compilation at one-time of a series verification requests which are then executed in real-time. As we have worked with verification over the past year we have found, to our surprise, that real-time is the predominate mode of communication.

What follows is an introduction to the eligibility process:

Claim Processing Center (CPC) form setup

- Determine which of the currently supported processing center(s) will be utilized for eligibility verification. This decision will normally be driven by the payers from which your end-user will want to get verification – Ingenix ENS currently offers a broader scope of payers but has fees associated with the service; Availity offers some payers not available from Ingenix ENS (BCBS of Texas, etc.) and is free. Both processing centers can be utilized; the center of choice is assigned at the Insurance Company (IC) level.
- If Ingenix ENS is going to be used as a processing center a record will need to be created for this processing center. To do this go to the Claim Processing Centers (CPC) form; create a new record with the ID equal “ENS” and the Name equal any value of your choosing (it will be overwritten during the DbSync); run DbSync; return to the ENS processing center record and complete the appropriate fields. The account user name and password should be entered in the CPC record. Nothing is required to be entered in the “connection host name” field. This field should only be populated if you wish to override the url used to post 837s and 271s.
- If Availity is going to be used as a processing center, and you are not already sending claims to them, a record will need to be created for them. To do this go to the Claim Processing Centers (CPC) form; create a new record with the ID equal



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“AVA” and the Name equal any value of your choosing (it will be overwritten during the DbSync); run DbSync; return to the AVA processing center record and complete the appropriate fields.

- Contact the processing center(s) you will be using to insure you are setup as a vendor for the processing of eligibility verification requests. If you are already sending claims you will still need to contact them for eligibility. As an HTA member you should not need to undergo any form of testing; each center has agreed to blanket certification for HTA.

Company (CO) and Eligibility Settings (ELS) form setup

There are a number of “fine points” associated with eligibility verification processing, particularly if you wish to utilize the Appointment Scheduler (AS) to drive the issuance of the request. These settings are available through either the Company (CO) or the Eligibility Settings (ELS) forms. The Eligibility Settings (ELS) form is new with the introduction of eligibility verification. Please note it is NOT necessary to complete any of these settings or to utilize the Appointment Scheduler (AS) form to perform eligibility verification, this simply provides a much more automated way to accomplish the task and help insure no one is missed.

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The screenshot shows the [ELS] Eligibility Settings window with the following configuration options and callouts:

- 1** Enable Eligibility Icon and Tooltip Display:
- 2** Require Secondary/Other Elig Check:
- 3** Create for Appointments: CPC Supported Eligibility Only
- 4** Days Before Appt: 7
- 5** Re-use IVE days: [empty]
- 6** Exclude Inactive Covg:
- 7** Coverage Case Default Provider: C [empty] MD
- 8** Background Process Settings:
 - Create Elig Batches:
 - Transmit Elig Batches:
 - Schedule as Process:
 - Base on Schedule: ELIG-F Eligibility Hourly Requests
- 9** Run Now button

Resource Selection Filters:

Provider	Exclude	Bill Prov
A Al [empty] s PA	<input type="checkbox"/>	<input checked="" type="checkbox"/>
C C [empty] n MD	<input type="checkbox"/>	<input type="checkbox"/>

Resource	Exclude
CPI CPI	<input type="checkbox"/>
1 Default for Echo	<input type="checkbox"/>
ECHO Echo	<input type="checkbox"/>
MED Medtronic	<input type="checkbox"/>

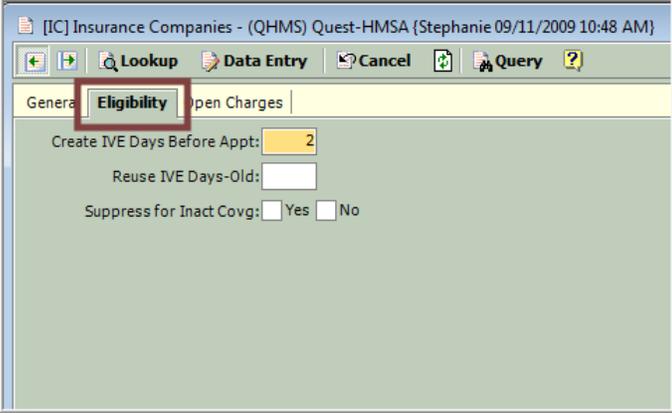
Facility	Exclude
DO Doctor's Office	<input type="checkbox"/>
BI Doctor's Office - Big Island	<input type="checkbox"/>
KI Doctor's Office - Kauai	<input type="checkbox"/>

Appointment Type	Exclude
BIO Bioimpedence	<input type="checkbox"/>
BP Blood Pressure	<input type="checkbox"/>
CL Carelink	<input type="checkbox"/>
ECH Echo	<input type="checkbox"/>

- 1 Enable Eligibility Icon and Tooltip Display:** This will display the eligibility icons on the appointment scheduler and display the eligibility status on the tooltip. (Automatically defaulted during the update.)
- 2 Require Secondary/Other Elig Check:** If the user views the scheduler in 'Automatic (Summary) Mode', checking this box will display a warning if any insurance is not checked. For example, if primary is active but secondary or tertiary has not been checked. If it is not checked then in a situation where the primary has been checked and is ok, but the secondary has not been checked, then a green (non-warning) icon will appear in "Automatic" or "Summary Mode."

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- 3 Days Before Appt:** This setting determines how far in advance of an appointment an IVE record is created and sent for automatic verification. This value can be overridden at the Insurance Company level (see screen shot to the right)



The screenshot shows a software window titled "[IC] Insurance Companies - (QHMS) Quest-HMSA (Stephanie 09/11/2009 10:48 AM)". The window has a menu bar with "Lookup", "Data Entry", "Cancel", and "Query". Below the menu bar are tabs for "General", "Eligibility", and "Open Charges". The "Eligibility" tab is active and contains the following fields:

- "Create IVE Days Before Appt:" with a text box containing the number "2".
- "Reuse IVE Days-Old:" with an empty text box.
- "Suppress for Inact Covg:" with two radio buttons labeled "Yes" and "No". The "No" radio button is selected.

- 4 Re-Use IVE Days:** During automated IVE creation only (through the scheduler), if patient's eligibility has been checked and is due to return for another appointment within the days specified here, then the IVE is copied and will display on the appointment scheduler. It is a **COPY** and **NOT** a re-verification of eligibility.
- 5 Exclude Inactive Covg:** If the Coverage Case in the appointment has been terminated then an IVE is not created. A warning Icon will appear.
- 6 Resource Selection Filters:** The tables in this section will list all Providers, Resources, Facility and Appointment Types. In the Provider grid, if the Billing Provider box is checked, then the billing provider, rather than this provider will be used to check eligibility (locums for example). Checking the "Exclude" box suppresses the creation of IVEs in these instances.
- 7 Coverage Case Default Provider:** When checking for eligibility, the 270 specification requires that a provider be specified. The provider on the appointment is used by default. If there isn't a provider on the appointment, or that provider isn't set up for eligibility, then the IVE will be created using the billing provider in the Coverage/Case associated with the appointment. If there is no billing provider in the Coverage/Case (or there isn't a Coverage/Case) then the provider specified in this field is used.
- 8 Background Process Settings:** Used for batch processing. By checking these boxes, we can setup the 270 and 271 to go out and check for responses at specific times. This is based on the Processes that are already setup in Akamai. Our standard is to set this up as 'Eligibility Request Hourly'.
- 9 Run Now:** Will force the [ER] (Eligibility Request Batch Processing) to run instead of waiting for the Process Schedule to take place.

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Service Type Ordering: When a 271 (eligibility response) is returned by an insurance plan, by default it displays tabs in the order they are returned by the Payer. The following settings offer the ability to modify this order. If the 271, has additional information to return, other than what is specified, it will add it to the end of this order.

Certain specialty-based service types are available, but please keep in mind that not all payers provide detailed benefit information for all service types. If you find service types appropriate for your particular specialty, go ahead and enter it into the table.

Service Type
30-Health Benefit Plan Coverage
98-Professional (Physician) Visit - Office
99-Professional (Physician) Visit - Inpatient
96-Professional (Physician)
1-Medical Care
2-Surgical
48-Hospital - Inpatient
*

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Insurance Company (IC) form setup

The screenshot shows the MedTrak Practice Manager interface for setting up an Insurance Company (IC) form. The 'General' tab is selected, and the 'Eligibility' sub-tab is active. The form is for Aetna Insurance. Two red boxes highlight specific areas: the 'E/E Verification' checkbox and the 'Payer Ids' grid. The 'Payer Ids' grid contains the following data:

Payer Ids	Processing Ctr	Submission Id	Remittance Id	Elig
AVA	Availity	60054		

Below the grid is a table for 'Claim Type Schedules':

Claim Type	Fee Schedule Type	Claim Coding Type	P/Clim Form	NDC Req	Box 243	A/Time	A/Min 24G	Adj Req	Write-Off Setting
MG	Medicap	MC Medicare	H E						

There are two fields that need to be completed on the Insurance Company (IC) form as part of the activation of eligibility verification. These fields are highlighted in red above. For each insurance company that will be active for verification one needs to select the processing center to be utilized as shown in field “E/E Verification”. For the selected processing center the “Payer Ids” grid, “Eligibility” column will need to be completed with the appropriate processing center payer id.

Completion of the “Eligibility” tab on the Insurance Company (IC) form has been previously discussed.

Insurance Verification Entry (IVE)

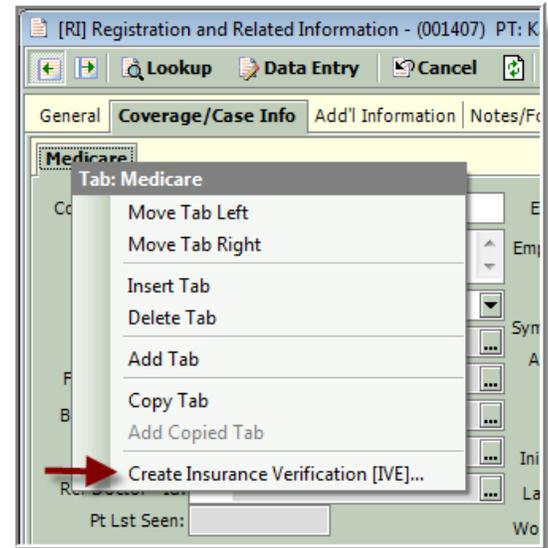
An insurance verification record is created, updated, and reviewed through the Insurance Verification Entry (IVE) form. Think of this as the eligibility verification equivalent of a Charge (CE) record. The IVE record has two major portions, the request for information portion and the results portion. The “request for information” portion details the type of insurance eligibility information being requested; the “results” portion contains the information furnished in response to the request.

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IVE records can be created manually by going to the IVE form, creating a new record (per standard APM protocol), and completing the appropriate parameter data, or in more automated fashion using one of several options

One can, from the Registration and Related Information (RI) form, right clicking on a Coverage/Case tab and use the “Create an Insurance Verification Entry (IVE)” option to immediately create an IVE record. This is shown in the screen shot to the right. Selection of this option will open the Insurance Verification Entry (IVE) form pre-populated with appropriate information from the insurance information tab selected.

Similarly the pop-up menu (right mouse click) associated with an appointment has an option to “Create Ins. Verification Entry”. In this case selection of this option will open the Insurance Verification Entry (IVE) form pre-populated with appropriate information from the appointment that had focus when the pop-up menu was selected.



Lastly, a “batch” of Insurance Verification records can be created automatically via the Appointment Scheduler (AS). The automatic creation process is controlled by the settings previously described in the “Company (CO) and Eligibility Settings (ELS) form setup” section above.

Once an IVE record is created, either manually or automatically, it can be “sent” to the applicable insurance company for a response. These requests can be “sent” either manually, via phone, fax, etc., or electronically via a processing center as a ANSI compliant 270 transaction. Similarly, responses can be returned either manually or electronically, or some combination of both. While the “request for information” portion of the IVE record is singular (only one set of parameters), the “results” portion is tabular and thus provides for the storage of multiple “results” over time.

IVE records that are created for electronic submission can be processed in a one of two ways. The request can be sent immediately by clicking the “Check Now” button available at the bottom of the Insurance Verification Entry (IVE) form as shown below. Clicking on this button will start a “real-time” eligibility check. Electronic eligibility checks are driven by the “Process” checkbox as highlighted in yellow below. Checking this box will “activate” a verification request for the associated insurance company assuming that company supports electronic verification.

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Verification ID: 9 Status: Unverified

Benefit Date: 09/08/2009

Patient: 013050 Lau, [Redacted] Coverage Case: MEDI/HMSA

Provider: 0 Cl [Redacted] MD

Facility: DO Doctor's Ofc Place of Service:

Insurance Details:

Insurance Company	Claim Type	Subscriber/Insured	R1tn	Member No	Grp Number	Prior Auth No	Referral No	Process?
MEDI Medicare	Medicare	013050 [Redacted]	S	575- [Redacted] A				<input checked="" type="checkbox"/>
HMSA HMSA	HMSA	047180 [Redacted]	SP	H00000([Redacted] 32	563			<input checked="" type="checkbox"/>

Service Type Inquiries:

Service Type	Coverage Level	Insurance Type
*		

Diagnosis / Procedure Inquiries:

Diagnosis Codes	Procedure Codes	Add'l Mod	Dx Line No.	Start Date	End Date
*	*				

Comments:

Check Now! Documents Other Actions Error Check Save Save-Next:

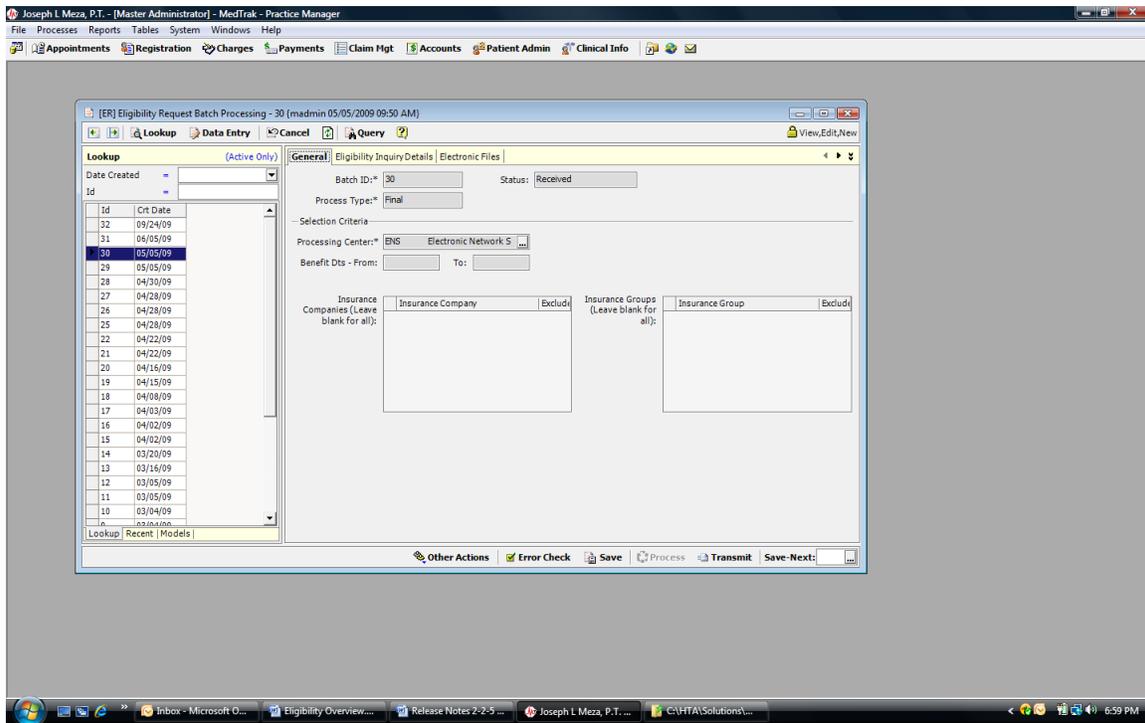
Within a relatively short period of time, approximately 10 to 20 seconds, eligibility information will appear on the Results tab of the IVE record. As you can see in the sample below, eligibility has been confirmed and the Benefit Details tab even shows that no deductible is remaining. In addition to viewing these records on the screen content can be printed by using the “Documents” button.

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The screenshot displays the 'Insurance Verification Entry - 9' window. The 'General Results' section shows '9/8/09 - 271 Response' with 'Insurance Detail: 1 - Medicare', 'Response Date: 09/08/2009', and 'Type: 271 Response'. The 'Plan Description' is 'Individual / Medicare Part B' and 'Coverage Active' is checked. The 'Member Information' section shows 'Subscriber' with 'Name: LAU', 'Relationship: Subscriber', 'Member ID: 575', 'DOB: 02/11/1955', and 'Gender: M'. The 'Benefit Details' section shows a table with columns: 'Covg Qualifier', 'Description', 'Plan Description', '\$ / %', 'Time Per Qual', 'Qty Qual', 'Qty', 'Auth/fi In Plan', 'Proc Code', and 'Diag Codes'. The 'Deductible' row is highlighted, with '0' in the 'Qty' column. The 'Free-Form Messages' section shows a table with columns: 'Qualifier', 'ID Number', 'Description', 'Start Date', and 'End Date', with a row for 'Benefit' from '1/1/09' to '12/31/09'.

The other option is batch based. Just as electronic claims are batched together for transmission to a processing center using the Claim Processing (CP) form, insurance verification requests (IVEs) are batched for transmission to a processing center using the Eligibility Request Batch Processing (ER) form. The Eligibility Request Batch Processing (ER), as with Claims Processing (CP), is performed at the user's discretion. The process involves three steps: First, the selection of all "active" IVE records that meet the Eligibility Request Batch Processing (ER) filter criteria; Second, the preparation of the 270 transactions; Third, the transmission of the transactions to the processing center.

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As indicated in the “Company (CO) and Eligibility Settings (ELS) form setup” above these steps can be configured to run in background as an automated process.

As with electronic claims, once a request for insurance verification (270) has been sent, a response is needed to complete the work flow. This is handled through the Eligibility Response Tracking (ERB) form; the insurance verification equivalent of the Claim Response Process (CRP) for electronic claims. It checks for, retrieves, and applies to the insurance verification record (IVE) electronic insurance company responses received from the processing center. Various status indicators are updated based on the content of the responses. A unique aspect of the ERB process for both the Ingenix ENS and Availity processing centers is, in the norm, there is no need for the user to utilize this form; the downloading of responses is automatic. This is because the 270/271 transactions for these centers are processed in real-time so there are no “batches” to pick up from the centers. There is also a report format for printing the contents of a batch which is available from the "Preview" button on the ERB form.

Appointment Scheduler (AS)

As indicated earlier, the Appointment Scheduler can work closely with the insurance verification process. Not only can it be utilized to manage the “batching” of the verification request, it can display various icons and information for both manually enter

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and electronically received insurance verification results. Because the display of information via “icons” on the Appointment Scheduler for eligibility verification is intermixed with the display of information via “icons” for the appointment reminders the discussion that follows must touch on both.

There are different “modes” of viewing icons in the Appointment Scheduler. The icons that are shown to the left of each patient’s name in the appointment grid vary depending on the mode selected. Like all configuration options in the Appointment Scheduler (AS), these settings are at the individual (user) level.

Also, keep in mind that detailed information about the status of each appointment (including eligibility and reminder status) is available by hovering over the appointment and viewing the “tool tip”.

The different icon modes are:

- Automatic (summary mode)
- Eligibility Status Icons
- Reminder Mode
- Turn Off Icons

(Reminder Mode icon options will only appear if this option has been chosen by the practice.)

Switching between modes is done by clicking on the down arrow next to the Icon selection button at the top of the appointment schedule (shown below).



If a practice is not using the appointment reminders, then the appointment schedule will default to Eligibility Mode. If the practice is doing both eligibility checking and using the appointment reminders then it will default to Automatic Mode.

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Eligibility Mode.

The icons which depict different eligibility statuses are as follows:

	All insurances have been checked and verified that coverage is active.
	Primary insurance has been verified as active, but secondary (or other) insurance has not been checked (no IVE created).
	Primary insurance has not been checked (no IVE created) but secondary insurance has been verified that coverage is active.
	Typically this will display if the appointment is outside of the Coverage Case effective and termination dates.
	One or more insurance verification checks have resulted in a response indicating <u>inactive</u> coverage.
	One or more insurances has rejected the insurance verification check. This does not mean that coverage is inactive, but that the payer has failed to recognize the request.
	An insurance verification request has been created, but a response has not yet been received by the payer.

Appointment Reminder Mode

Appointment Reminders can phone, email and text message patients to remind them about appointments. Offices have the option to allow patients to confirm or cancel appointments either through the reminder call or email.

The icons which depict different reminder statuses have recently been updated to provide further information. They are:

	Reminder message has been delivered and patient has confirmed the appointment.
	Phone was answered, reminder message has been delivered.
	Answering machine picked up the call. Reminder message has been delivered.
	Reminder message delivered, patient has cancelled appointment through the reminder system.
	Phone disconnected. Unable to deliver reminder.
	Unable to deliver reminder (for example no phone number on appointment or patient record)

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Automatic (also referred to as “Summary” Mode)

Automatic mode provides quick information on whether problems may exist with a given appointment or not. It “summarizes” information if both the eligibility and reminder features are being used. In summary mode, there are only three states; Green (ok), Yellow (problem) Red (unable to get results).

Here are the icons and explanations of each status.

	Information has been received. Nothing adverse to report.
	Information has been received, there is a problem with the appointment and results should be viewed. For example, eligibility may not be current, or a patient phone may be disconnected.
	Appointment has been canceled.

Insurance Verification Management (IVM)

The Insurance Verification Management (IVM) form provides a tool for managing the insurance verification records (IVE). This tool allows the user to filter the insurance verification records based on various criteria, view/update the resultant records on screen, and/or print a report of the resultant records. In addition, applicable insurance verification records (IVE) can be seen on the Registration and Related Information (RI) form, Insurance Eligibility Verifications tab. This tab displays all insurance verification records (IVE) for the selected patient.