ABILITY | CHOICE™

All Payer Eligibility

User Guide

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myABILITY™ Overview

At ABILITY®, our mission is to provide innovative products and services that reduce the administrative complexities of healthcare. The myABILITY platform provides you with streamlined, easy-to-use access and navigation to all your ABILITY solutions. As the name implies, myABILITY gives you the ability to select and configure network services specific to your business requirements.

Whether you are a biller, administrator, or supervisor; provide patient access and scheduling; or carry out other billing-related functions, myABILITY makes your job easier!

The myABILITY platform provides unified access to ABILITY innovative services including:

- ABILITY | EASE™
- ABILITY | COMPLETE™
- ABILITY | *IVANS* NOW™ (DDE/FISS)
- ABILITY | CHOICE™ Eligibility (HETS and All Payer)
- ABILITY | CHOICE™ Medicare Claims

About this guide

This guide provides you information for your ABILITY | CHOICE™ All Payer Eligibility product. Sections Include:

- Make an Eligibility Request
- Eligibility Response
- Request History
- Add or Edit NPI
- Configure Payers

Make an Eligibility Request

This page lets you request the eligibility for patients from all payers.

Step 1: Select an NPI

Select an NPI (National Provider Identifier) from the list provided by clicking **SELECT** next to that Provider's name and NPI number. To add a new NPI or edit an existing NPI, click **Add or Edit NPI Credentials**. You are able to select NPIs for which you have been configured. Contact your System Administrator if you do not see an NPI you need access to.

Step 2: Select Payer(s)

Enter a payer name to search for that payer or select an existing payer from the list provided. Click **Next**.

Top Payers

You may see a Top Payers lists above the All Payers list. Top Payers are those most commonly requested for that NPI. You may see up to 15 top payers displayed above other payers in the Top Payers list. You can quickly choose one of the top payers when creating an eligibility request. If you have not previously made eligibility requests, no Top Payers appear. Once requests have been made with that NPI, the Top Payer dynamically fills.

Make a Request for a Non-Configured Payer

If you want to select a payer that is not configured, you will see an icon indicating that the payer requires additional attention and you will not see a select option for that payer. Alert your system administrator if you need a payer configured for your NPI.

If you have Service Configuration permissions, you will see a link to configure this payer. Some payers require additional information to make an eligibility request. For more information on configuring payers, see **Configure Payers**.

Default Service Type Codes on a Medicare Request

All Service Type Codes supported by Medicare (except A7) are sent on Medicare requests. If you are a provider of mental health or psychiatric services, you can click **EDIT** in the Options column and select the **Designate this NPI as a Mental Health or Psychiatric services provider** checkbox to designate that you need to view A7 STC information. This is a setting that is configured by NPI and monitored by CMS. You can configure your NPI if you have Service Configuration permission from the **Add or Edit NPI** page.

Selecting Service Type Codes on a Non-Medicare Request

Service Type Code 30 is sent as the default for all non-Medicare payers that support STC 30. For payers that support multiple Service Type Codes, an Edit link for the codes you need to send displays on the eligibility request form.

Save Service Type Code Selections by Payer

You can save Service Type Code selections by payer. This allows you to send customized eligibility requests and saves you time when making additional requests with that payer.

Step 3: Enter Patient and Request Information

Depending on the payer selected, you have a choice of search options available to you. Select a search option based on the information you have available for the patient.

NOTE: Dependent search options appear only if they are available for that payer selected.

Click **Submit** to submit the Eligibility Request.

Pending Status

Pending Status displays if a payer is not responding to an eligibility request that was sent.

Although most of the time a result is displayed within 75 seconds, a request can take up to 15 minutes to receive a response from the payer. You will receive a failed request status if no response is received or if a non-271 response is received.

After 15 seconds, you will receive a message that this request is taking longer than expected and was sent to the Request History page. You can continue to wait for the response or make a new request.

Eligibility Response

The ABILITY | CHOICE™ All Payer Eligibility Response page appears after you enter an eligibility request. The following options are available to you on this page:

- **New Request** - create a new eligibility request by clicking **New Request**.
- **View Raw X12 File** - View the raw 271 EDI Eligibility Response. The raw 271 is viewed by clicking **View Raw 271** located at the top of the eligibility response. You can save the 271 to a file or cut and paste the content out of the window that appears.
- **PDF** - You can save the contents of the Eligibility Response page by selecting this from the top of the eligibility response. This selection creates a PDF of the Eligibility Response page that you can save or print.

NOTE: An eligibility response that takes longer than 15 seconds will display a pop-up box that lets you either continue to wait for the response or create a new request. If you decide to wait, the pop-up box continues to reappear every 15 seconds.

If an eligibility response is not received in 75 seconds, in most cases a Failed Request state is returned. This could be due to an unresponsive payer or difficulty in sending the request. A Failed Request message appears with additional information. If a request takes longer than 75 seconds, a non-X12 response was received from the payer and ABILITY will continue to reach out to the them.

The following filter options are available for the Inpatient/SNF/ESRD, Home Health & Hospice, Therapy Caps, Service Types, and Preventative panels described in this topic.

- **Show All** - display all sections associated with this panel
- **Hide All** - do not display any sections associated with this topic
- **Edit Display** - open a dialog box from which you can select the sections to display

Save Responses for Payers as Favorite View

By clicking the **Save View as Favorite** link, you can save the filtered view as your favorite. By clicking **Restore Favorite View**, you are able to restore this favorite view. Favorite views are set up by user and payer combination.

- **Save View as Favorite** - You can save your favorite view. This includes any filtered Inpatient, Home Health Hospice, or Therapy Caps Benefit Summaries, STCs, or Preventative Services that you have selected.
- **Restore Favorite View** - This is the default filtering on future eligibility requests. After seeing eligibility benefit details for a particular Subscriber, this selection also restores your favorite view.

Filter Medicare Responses

All default Medicare Service Type Codes are sent on Medicare requests and can be filtered on the response page. Additional summaries will appear on Medicare responses.

A Medicare eligibility response returns a page to you with the following panels:

- Your Request
- Patient Information Discrepancies
- Status Alerts
- Eligibility Summary (Medicare)
- Inpatient/SNF/ESRD
- Home Health & Hospice
- Therapy Caps
- Services Types
- Preventative

Filter Non-Medicare Responses

For non-Medicare responses, you are able to filter STCs on the request, view those STCs returned by that payer, and filter them on the Eligibility response page. You can use the STC filter to determine which STCs they want to see for that payer. See **Service Types** for more information.

A non-Medicare eligibility response returns a page to you with the following panels:

- Your Request
- Patient Information Discrepancies
- Patient Demographics
- Eligibility Summary (non-Medicare)
- Benefit Summary
- Services Types

Eligibility Response Panels

Your Request

The Your Request section displays the information you entered on the eligibility request page. If the payer returns any subscriber information different from the information you entered, the subscriber information the payer returned and displays in red.

Patient Information Discrepancies

If a payer returns patient information that was different from what you submitted, the Information returned to you on the Eligibility Response will be displayed in red. The system stores information sent back from the payer as the information on record for the patient.

Patient Demographics

The Patient Demographics section contains the subscriber's address, gender, and date of birth.

Status Alerts

The Status Alerts section displays to notify you the subscriber has a Medicare Part D, Medicare Advantage, Medicare Secondary Payer (MSP) or (Dual Eligibility) Medicaid Plan detected on the eligibility response returned from Medicare. The system returns plan information and effective dates. There can be multiple Status Alerts for each Status Alert type if multiples are detected on the eligibility response.

Eligibility Summary (Medicare)

The Eligibility Summary displays the overall Eligibility State. A user can see any plan information if it is provided by the payer. Dependent specific information displays with "Dep" and subscriber specific information displays with "Sub." preceding the field name.

The Eligibility Summary section displays effective dates for Medicare Parts A, B, and D. If the Subscriber is deceased, a Date of Death appears. Effective and Term Dates are returned for Medicare Parts A and B. Part D information, including deductible information, is shown if returned on the Medicare response. Inactive Coverage Periods are shown if returned on the Medicare response, including dates and any associated explanations for the inactive period.

Benefit Information

The Insurance Type and Coverage Level display on a response in the Benefit Information section. This section contains plan and benefit level information that is not attributed to a service type code on the eligibility response. If payer contact information appears on the 271, this section will display that information.

NOTE: The response page will display whatever value the payer sends back on the eligibility response for a given field name. These may or may not coincide with the field name descriptions.

Eligibility Summary (non-Medicare)

The Eligibility Summary displays the overall Eligibility State. A user can see any plan information if it is provided by the payer. This includes any REF segments (except for social security number) sent back on non-Medicare payer responses. Dependent specific information displays with "Dep" and subscriber specific information displays with "Sub." preceding the field name.

The Eligibility Summary section displays effective dates and eligibility state of the request.

View Eligibility State

An Eligibility State informs you if the patient has active or inactive insurance coverage or if the request failed, is missing information, or is in a pending status. Hovering over an icon causes a tooltip to appear that defines that icon.

The following Eligibility States appear next to the previous eligibility requests.

Active Coverage

Active coverage displays if a patient is currently covered by that payer. If a date range was provided in the request and contains both active and inactive periods, the current state or most recent state of Service Type Code 30 will determine the overall eligibility state. For non-Medicare payers that do not provide eligible/ineligible information for STC 30, active coverage displays only if there are no ineligible benefits present overall in the response.

Inactive Coverage

Inactive coverage displays if a patient does not currently have active coverage for Service Type Code 30 with the payer. If the current state of Service Type Code 30 was not provided by the payer, and a patient was ineligible for any benefits on the response, the eligibility state will appear as inactive coverage. These may require further review by you to determine if the patient is eligible for the specific date and service being provided.

Pending Status

Pending Status displays if a payer is not responding to an eligibility request that was sent. A request may take up to 15 minutes to receive a response from the payer. If no response is received or if a non-271 response is received, you receive a failed request status.

If a response is not generated within 30 seconds, a message appears notifying you that this request was sent as a pending request to the Request History page. In this case, you can display this response to see the eligibility results from the Request History tab.

Review: Other Plan Detected

Review: Other Plan Detected displays Status Alerts indicate that there was another insurance plan detected by the payer. For example, Medicare will send back Medicare Advantage Plan, Medicare Secondary Payer, Medicaid Plan, and Part D plan information. These generate a Status Alert eligibility state icon to notify you that the patient may have additional insurance coverage.

For non-Medicare payers, a “Review: Other Plan Detected” Eligibility State returns to you when an EB*R (Eligibility Benefit segment with R information code) is returned by the payer indicating there is another plan listed on the response. The other plan information displays on Status Alert boxes on this page.

Request Missing Information

Request Missing Information  displays if a payer returns a triple “AAA” error code indicating, for example, that patient details were missing on the eligibility request or that the NPI is not registered with that payer. The hover text specific for a request displays details, including any messages provided by the payer about what information (including registration information) was missing on the eligibility request.

Request Failed

Request Failed  displays when a payer could not be reached due to payer down or if a non-271 was received due to system errors. If the system is experiencing difficulty, the customer is directed to contact Customer Support.

Messages can also appear that give you additional information about failed requests. The following table gives examples of these messages.

Condition	Message
Response from payer not received after 75 seconds and timeout occurred	Payer is not responding to the eligibility request. If the problem persists please contact customer support
Problem connecting to our switch	There appears to be a problem sending the request. If the problem persists please contact customer support.
Empty Response from our switch	There appears to be a problem sending the request. If the problem persists please contact customer support.
Problem Parsing Switch response XML	There appears to be a problem reading the response received from the payer. If the problem persists please contact customer support.
Response is non x12 message (after 15 min retry period)	(non X12) Please contact customer support if this problem persists.
999 x12 response	(999) Please contact customer support if this problem persists.
997 x12 response	(997) Please contact customer support if this problem persists.
TA1 parse failure	There appears to be a problem reading the response received from the payer. If the problem persists please contact customer support.

Condition	Message
TA1 – A (Status pending – we should never see this)	Accepted
TA1 – E (Status pending – we should never see this)	Accepted With Errors
TA1 – R	Rejected + Add TA1 note codes
AAA 42(failed request state)	If we generate the 42, pass the error message along (example “payer not responding”, etc.).
AAA 80 (failed request state)	If AAA80, display “No Response received - Transaction Terminated. If the problem persists please contact customer support
Other AAA (missing info state)	A collection of all aaa summaries returned.
Inactive coverage state	Inactive Coverage
Status Alert State	Review: Other Plan Detected
Eligible State	Active Coverage
General Scheduler Exception	There appears to be a problem sending the request. If the problem persists please contact customer support.

Inpatient/SNF/ESRD

The Inpatient section displays on Medicare response pages and contains summaries for Inpatient Days Remaining, SNF (Skilled Nursing Facility) Days Remaining, and End Stage Renal Disease. Once Inpatient summaries have been selected and you click **Display**, the summaries show on the Eligibility Response page. You can save the view as your favorite so that these display each time on the eligibility response.

Home Health & Hospice

The Home Health Hospice Benefit filter displays on Medicare response pages and contains summaries for Home Health Certification, Home Health Care, and Hospice. Once Home Health Hospice summaries have been selected and you click **Display**, the summaries show on the Eligibility Response page. You can save the view as your favorite so that these display each time on the eligibility response.

Therapy Caps

The Therapy Caps Benefit section displays on Medicare response pages and contains OT/PT Speech Therapy Caps, Pulmonary Service Limits and Cardiac Service Limits. Once you select Therapy Caps summaries and click Display, the summaries show on the eligibility response page. You can save the view as your favorite so that these display each time you are on the eligibility response page.

Service Types

All returned Service Type Codes (STCs) show in the Service Types panel. You can choose to remove any STCs so they do not appear. Once you have selected which STCs you want to see on an eligibility response, you can save that selection as a favorite for the payer.

Service Type Codes for Non-Medicare Payers

Service Type Code 30 is sent as the default for all non-Medicare payers. You can add additional STCs to non-Medicare payers that support additional STCs by clicking **Edit** next to the Payer Name on the Eligibility Request page.

NOTE: The Edit STCs link is only available for non-Medicare payers that support multiple STCs. See **Error! Reference source not found.** for additional information.

Service Type Codes for Medicare Payers

All Service Type Codes supported by Medicare (except A7) are sent on Medicare requests. If you are a provider of mental health or psychiatric services, you can click EDIT and check the Designate this NPI as a Mental Health or Psychiatric service provider checkbox to designate that you need to view A7 STC information. This is a setting that is configured by NPI and monitored by CMS.

See **Add or Edit NPI** for additional information on how to configure your NPI to view A7 information.

Preventative

All returned Preventative Services display on Medicare response pages. You can choose to remove any Preventative services that you do not need to view on the eligibility response. Once you have selected which Preventative Services you want to see, you can save that selection as a favorite. Only Preventative Services that have been selected appear on the eligibility response.

You can choose to filter back in additional Preventative Services on any subsequent requests as all Preventative Procedure Codes are sent on Medicare eligibility requests. A Preventative Service section may be made up of multiple Preventative Procedure Codes. These codes are given in the Preventative Service filter for reference.

View Multiple Payer and Patient Requests

When more than one request is submitted at a time from the Eligibility Request page, the Eligibility Responses come back together. Some may be pending and some may have a payer response. You can horizontally scroll through and view these responses by clicking the arrows. You can select to send all or individual requests to the dashboard from this view.

If you decide to rerun an individual request, this view of multiple responses goes away. When you click **Rerun Request**, the Eligibility Request form opens for that payer and patient. You should view all of the responses before moving away from this page. You can use the back button if you want to get back to this page after going to another tab.

Request History

Requests are stored indefinitely and can be searched from the Request History Tab.

You can edit, view, and apply your Filter settings on the Filter Responses dialog box. Click **SELECT ALL** in the header to select all filters for that category.

Filter settings can be applied in one or all of the following categories:

Owner

You can choose to view just eligibility requests items run by you and/or selected people with whom you work.

Click **Apply Selections** to save your changes.

Payer

You can choose to view items by selected Payers. Your Top Payers appear at the top of this dialog box.

Click **Apply Selections** to save your changes.

NPI

You can choose to view items according to NPI (National Provider Identifier).

Click **Apply Selections** to save your changes.

Run Date (Range)

You can select a specific date or a date range for searching history for requests

Eligibility States

You can choose to filter on the eligibility response state, such as active or inactive coverage

Create Custom Favorite Filter Setting

Save your favorite filter setting by clicking **Save Selected Filters as Favorite**.

Restore your favorite filter setting by clicking **Restore Favorite Filters**.

Add or Edit NPI

Add or Edit NPI Credentials

Add an NPI

Complete the following instructions to **Add** an NPI:

1. Click the **+ Add NPI** link on the Add or Edit NPI page to open the Add NPI panel.
2. Enter information in the following fields:

   NPI – The NPI is a unique 10-digit identification number issued to health care providers in the United States by the Centers for Medicare & Medicaid Services (CMS)

   Display Name – Enter a meaningful phrase to identify the NPI.

   User Permissions – Check the box beside someone's name to give them access to this NPI. Uncheck to remove access. People without access will not see this NPI.

   Federal Tax ID – If this field appears, enter the federal Tax ID number associated with the NPI.

3. Select the checkbox if you are a provider of mental health or psychiatric services.

   All default Service Type Codes supported by Medicare (except A7) are sent on Medicare requests. If you are a provider of mental health or psychiatric services, you can click **EDIT** and select a check box to designate that you need to view A7 STC information. This is a setting that is configured by NPI and monitored by CMS.

   NOTE: NPI registration may take up to 48 hours.

Edit an NPI

Complete the following instructions to **Edit** an NPI:

1. Click **EDIT** in the Options column corresponding to the NPI you want to edit
2. Edit the information in the fields that display in the Edit NPI panel. These fields are described above.
3. Click **Submit NPI for registration** to edit the NPI.

Additional Payer Information

The Additional Payer Information Tab lets you set up the selected NPI with various payers. The tab displays the configuration status and alerts you if one of them requires additional provider information for eligibility requests. If a payer is not configured, you will not be able to send eligibility requests to that payer. This is an important aspect of account set-up.

Configure Payers

ABILITY | CHOICE™ All Payer Eligibility offers access to a variety of payers. Some payers require additional information to be sent with the eligibility request. The Configure Payers page is accessible if you have Configure Services permissions. You can see a list of all payers and scan it to see if any payers are missing required information.

You can expand the payer you want to configure and enter the information that is missing. The system displays a list of NPIs associated with the account and you are alerted to which NPIs are missing information when you select a payer row.

You select an NPI and a dialog box appears with the fields required for that payer.

You can view all payer configuration details for a selected NPI by clicking **View all payer details for this NPI** link on the Payer Details dialog box. This opens the Add or Edit NPI page for viewing payer configuration by NPI.

Manual Enrollment

Some payers require additional information in order to be registered for sending eligibility requests. Depending upon the payer, this may be a form that you fax to the payer or send to an ABILITY representative. If you have Configure Services permissions, will see instructions for these payers are provided on the Additional Payer Information tab as well as on the Payer Configuration page.

Once you have successfully enrolled the NPI(s) with that payer, you can begin to send eligibility requests to that payer. To do this, check which NPIs have completed this process so that the payer is configured within the system. You are not able to send eligibility requests for this payer until the process is complete and you have checked the “I have completed manual enrollment for this NPI” checkbox on the Payer Details page.