ABILITY | COMPLETE™

User Guide

ABILITY® Network Inc

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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)
- ABILITY | CHOICE™ Medicare Claims

About this guide

This guide provides you information for your ABILITY | COMPLETE™ product. Sections Include:

- My Dashboard
- Filter Dashboard
- Dashboard Configuration
- Make an Eligibility Request
- Eligibility Response
- Request History
- Batch History
- Create/Edit Batches
- Manage Eligibility Batches
- Add or Edit NPI
- Configure Payers

My Dashboard

The Dashboard tab (Figure 1) lets you manage all eligibility requests that require follow-up in one location. You can see requests sent to the Dashboard for all NPIs you are affiliated with.

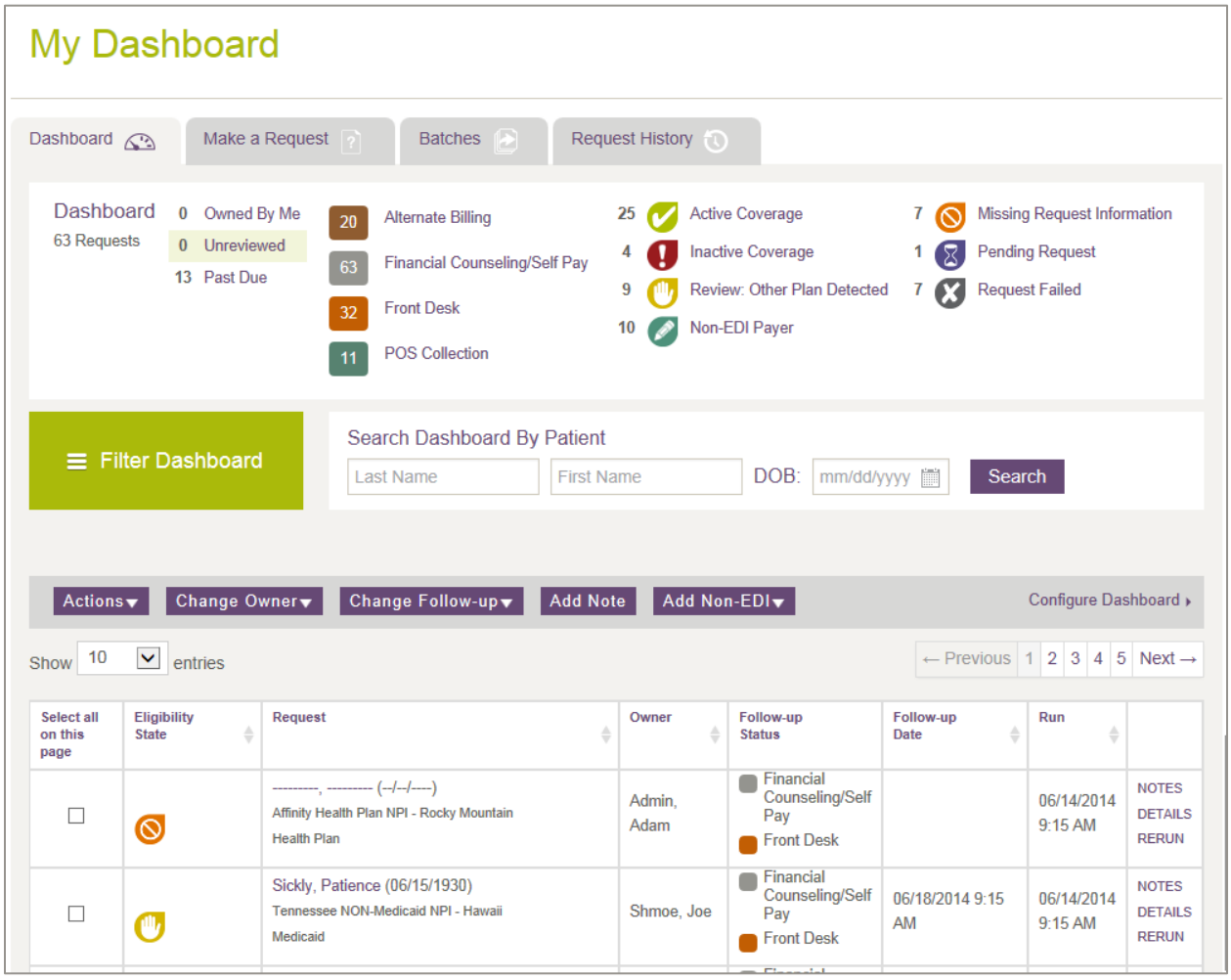

Figure 1 : Dashboard tab

Shared Workspace

You can share information about eligibility requests with other users and assign custom follow-up statuses and dates to requests that require additional follow-up. All users have access to the dashboard.

The Dashboard displays the following columns:

Column Heading	Description
Select All	toggle between selecting all and clearing all requests on this page
Eligibility State	the six types of eligibility states appear at the top of your dashboard
Request	the patient, NPI, and payer information
Owner	person at your facility handling this request
Follow-up Status	statuses are defined at the top of your screen
Follow-up Date	date and time the request to be followed-up
Run	date and time the eligibility request was submitted
(no heading)	• click **DETAILS** to open the **Eligibility Response** page • click **RERUN** to run the request directly from this page • click **NOTES** to see notes for this request

Filter Dashboard

You can customize the dashboard display by filtering the information you are working on. The Filter button opens the **Error! Reference source not found.** dialog box that lets you select which items you want to see on the dashboard at any given time and lets you access additional dashboard items when needed.

Create Custom Favorite Dashboard Filter Setting

You can save your favorite dashboard filter setting. When you log into ABILITY | COMPLETE™, you are able to quickly reference items on the dashboard that you want to work on by clicking **Restore Favorite Filter Setting**.

Commands

NOTE: You must select at least one transaction prior to using any of the following four commands. To select all transactions on the displayed page, click the **Select All** column heading on this page.

Actions

The following actions are available:

- Remove from Dashboard – Removes the selected transaction(s) from the Dashboard
- Mark as Reviewed – The eligibility response has been reviewed
- Mark as Unreviewed – This eligibility response needs to be reviewed and appears highlighted. You can update the status when you resend the request to the Dashboard.

Change Owner

From the Change Owner dropdown box, you can change the owners on the selected transactions.

Change Follow-up

You can change follow-up statuses for a request that appears on the dashboard. The following follow-up status options are available to you as defaults that you can also edit or delete.

- Front Desk
- POS Collection (Point of Service Collection)
- Financial Counseling/Self Pay

Click **Apply** to save your changes.

Add Note

Notes let you enter customized messages that can be viewed by other users. This helps to track work that has been completed or is needed for a 270/271 Medicare Eligibility request. Click **Add** to save your change.

Add Non-EDI Payer

Non-EDI payers are those who do not support the 270/271 electronic Medicare Eligibility request/response. You can use the non-EDI payer tab to document and track non-EDI payer information or self pay patient information.

Select this tab to open a drop-down dialog box to enter Payer and Patient information. Complete all required fields and click **Save**. This information is then available for you to use with your dashboard functions, just as any other type of dashboard request.

A Non-EDI Payer icon () appears on the Dashboard for eligibility requests created this way.

Restore Favorite Filters

If you have used the Filter Responses dialog box (available by clicking **Filter Dashboard**) you can create a Favorite Filter view. Click this link to restore that view.

Configure Dashboard (if available)

If you have Configure Services Permissions, you can create and edit your own Eligibility Follow-up Statuses as well as the system defaults.

Filter Dashboard

Search Dashboard by Patient

Enter as much information about the patient as you know and click **Search**. Available fields are **Last Name**, **First Name**, and **DOB** (Date of Birth). You are allowed partial entries for first name and last name searches. Searches are performed using a full wildcard or "contains" method. For example, if you enter "en" in the **First Name** search field, you will match on "Benjamin," "Wendy," "Endira," and "Loren" if those names are in your system.

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:

Status & Date

You can choose to view items by the part you have in your organization's workflow. Selections categories are Follow-up Status, Eligibility State, and Date.

Unreviewed

Click the **Show Only Unreviewed** checkbox at the top of the Filter Responses dialog box to filter requests that have not been reviewed. The system automatically marks a request as "unreviewed" if the response page has not been opened. After the response page has been viewed, you are able to mark an eligibility response as "unreviewed" manually from the eligibility response page or when you send a request to the dashboard.

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

Owner

You can choose to view just items assigned to 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.

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**.

Dashboard Configuration

You can add custom follow-up statuses if you have Configure Services permission. Follow-up statuses can be appended to customer service requests. You can use follow-up statuses to communicate to other users additional work or alerts based on the status of the eligibility request.

The Dashboard is a shared workspace for you and other users to manage eligibility requests that require follow-up. It can be configured to meet various business needs.

Create Custom Follow-up Statuses

You can add custom follow-up statuses and assign colors to those statuses. Depending on the needs of your facility, you can choose to show or hide default follow-up statuses that are available. The follow-up status you create can be up to 30 characters long.

Follow-up statuses can be filtered as a group on the Dashboard so that you and other users can easily work on similar types of requests.

Default Follow-up Statuses

POS (Point of Service) Collection, Self Pay Patient, and Front Desk are default follow up statuses ABILITY makes available to you that you can edit.

Edit Follow-up Status

If you edit a Follow-up Status, all eligibility requests with that status that appeari in filters, follow-up actions, and dropdown boxes are also updated.

Hide Follow-up Status

If you hide a Follow-up Status, the eligibility requests for that status do not display in filters, follow-up actions, and dropdown boxes, but the requests themselves previously associated with this follow-up status are not affected.

Make an Eligibility Request

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

Step 1: Select NPI

Select an NPI (National Provider Identifier) from the list provided. Click **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. You can select any NPIs that have been configured (the status is Valid). 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

A Top Payer list may appear 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 All 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 in.

Add Multiple Payers to your Payer Selection (optional)

You can choose to add multiple payers to your payer selection or submit the request with only one payer.

Make a Request for a Non-Configured Payer

If you want to select a payer that is not configured, you will see a Missing Info 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 Configure Payer link to configure this payer. Some payers require additional information to make an eligibility request. For more information on configuring payers, see the Configure Payers topic.

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 check a box on the Add or Edit NPI page to designate that you need to request A7 STC information. This setting is configured by NPI and monitored by CMS. You can configure your NPI if you have Service Configuration permission as configured on the

Add or Edit NPI page.

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 displays on the eligibility request form for codes you need to send.

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 you select, you have a choice of search options. Your search options depend on the information you have available for the patient.

If you select multiple payers, a single consolidated form for those payers appears.

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

Add Additional Patients to your Payer Selection (optional)

Click **+ Add Patient** to open a Patient Detail panel as part of this step.

If you do not have payer-specific information for a payer and patient, you can uncheck the checkbox next to the payer name for that patient.

You can add up to 20 payer/patient requests on a single eligibility request form (regardless of payers selected for a given patient).

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 | COMPLETE™ 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** - 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. Click **Restore Favorite View** to restore your 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 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 **Error! Reference source not found.**
- Patient Information Discrepancies
- Patient Demographics
- Dashboard Operations
- Payer and User Notes
- Status Alerts
- Eligibility Summary (Medicare)
- Inpatient/SNF/ESRD
- Home Health & Hospice
- Therapy Caps
- Service 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
- Dashboard Operations
- Payer and User Notes
- Eligibility Summary (Non-Medicare)
- Benefit Summary
- Service 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 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.

Eligibility Summary (non-Medicare)

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

Status Alerts

The Status Alerts section displays to notify you that the subscriber has a Medicare Part D, Medicare Advantage, and 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.

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 the eligibility state of the request.

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.

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.

Non-EDI Payer

Non-EDI Payer  icon displays for eligibility requests you created through the Non-EDI drop-down dialog box. Non-EDI payers are those who do not provide patient eligibility information in 270/271 EDI (Electronic Data Interchange) format.

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 received from the payer displays on Status Alert boxes on this page.

Request Failed

Request Failed  displays when a payer could not be reached due to payer down, if a non-271 was received due to system error, or if any information in the request is no longer valid. You can go in and address these items manually on an individual basis and rerun the batch. The presence of failed items does not stop valid items from processing.

If the system is experiencing difficulty, you are 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.
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.

Condition	Message
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 Service Type Codes on a Non-Medicare Request 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.

Dashboard Operations

Sending Requests to the Dashboard

Click the **Display on Dashboard** checkbox from an eligibility response to send a single request to the dashboard.

You can assign an owner to the request, and add a follow-up status, date and time. Custom follow-up statuses can be added by you if you have Configure Services permission. See Configure Dashboard (if available)for additional information.

Mark a Response as Unreviewed for Later Follow-up

If you send a transaction to the dashboard without viewing the Eligibility Response page first, “Unreviewed” displays and the request appears highlighted. This indicates that an eligibility response needs to be reviewed. This status can be updated when sending a request to the dashboard or when updating a request from the dashboard or elsewhere within the application.

Add a New Request into an Existing Batch

On the Eligibility Response page, there is a dropdown box available to add an individual request into a batch. If the request is already in the batch, the batch name appears and you will not see the dropdown box.

Batch information displaying on the eligibility response only appears if you have been set up with Add/Edit Batch Eligibility Requests permission. Without this permission, you will not see the batch dropdown box, but will see the batch display name if that request is currently in a batch.

Payer and User Notes

Add User Note to the Eligibility Response

You can add a User Note to a transaction so that any 271 details can be tracked for future reference. This is helpful when working with other users who may be assigned a follow up task. The maximum character limit for this field is 512 characters.

View User Notes and Payer Notes

Notes are recorded below the main Eligibility Response & Demographics display for a transaction. The Payer and User Notes section can be expanded so that you and other users can see the notes. Click the **Add Notes** link to add additional notes. The section can also be collapsed so that the eligibility information is easily found.

System-Generated Notes

System-generated notes are created automatically when you add or remove follow up statuses and when you update ownership. System-generated notes appear on requests that have been rerun manually from a previous transaction. In this case, the user can link back to the original transaction for easy reference.

Request History

View Previous Eligibility Requests

You can search for previous eligibility requests that have been completed for those NPIs you have access to on the Make a Request tab, including requests made by other users. You use filtering to narrow down the search to the requests you want to view.

Search Eligibility Requests by Patient

You can search by a patient's First Name, Last Name, and Date of Birth.

Filter Eligibility Request History

You can search eligibility requests by clicking **Filter History**. Filter selections include Eligibility States, Unreviewed Status, Follow-up Status & Date, Run Date, Owner, Payer and NPI. Click the tabs to filter on the category that you want to filter on. Click **Apply Selections** to apply the filter settings.

Save Filter as Favorite on the Request History Tab

If you want to create a Favorite Filter setting, click **Save Selected Filters as Favorite**. Once you save this setting you can click **Restore Favorite Filters** to restore that view.

View Applied Filter Settings from the Request History Tab

Filter settings display and are summarized on the Request History tab after you have applied your selections. You need to refine search criteria if the filter settings you have applied retrieve a result that is too narrow. You can also clear all filters from the filter summary.

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

Batch History

Select the Batches tab to open the **Batch History** page. Here you are able to view batches that have been previously run.

If you have Add/Edit Batch Eligibility Requests permission you will see buttons to perform the following actions:

- create new batches
- edit existing batches
- import CSV files
- manage recurring batch schedules.

If you need to be set up with permissions for these actions, contact your System Administrator. This permission can be added under Administrative Permissions on the Manage Users page.

View Previous Batch Runs

The page appears with the following columns.

Column Heading	Description
Run Date	date and time the batch was submitted
Batch	batch name and the 6 eligibility states with resulting transaction counts.
Owner	person at your facility handling this request
(no heading)	• click **RESULTS** to open the Eligibility Batch Details page • click **RERUN** to open the Eligibility Batch Rerun confirmation dialog box • click **EDIT** to open the • • • Create/Edit Batches page

View Recurring Batch Schedule

If the batch is recurring, the recurring schedule appears on the Batch History page. Users can hover over the recurring frequency icon ( ) to display a tooltip providing detailed information on specifically when the batch is run.

View Deleted Batches

If you have Add/Edit Batch Eligibility Requests permissions you have the ability to delete a batch template from the Manage Batches page. Once a batch template has been deleted, any batches run would remain on the Batch History page. You are no longer able to rerun or edit batches that have been deleted. These batches display in rows that are grayed out and have a

trash icon () to indicate to that the Batch template is now inactive.

Rerun Batch Requests

Rerun an Entire Batch

You can rerun an entire batch from the Batch History page whether or not you have Add/Edit Batch Eligibility Request permission. Before the batch is run, a dialog box containing the number of requests appears for you to confirm that you want to rerun the entire batch.

When you click **Rerun**, a new row is added into Batch History.

NOTE: You are not able to rerun a batch if the batch has been deleted from the Manage Batch page.

Rerun an Individual Transaction in a Batch

Click the Results link on a batch to see individual requests within the batch run. If you want to rerun a transaction within a batch, click the Rerun link next to the individual request. A new transaction row will be added to the batch and the batch will be updated to contain the new request.

If you want to add updated insurance information to the batch for future runs for a patient, you must go in and edit the batch. Only users with Add/Edit Batch Eligibility Request permission can edit batches.

Filter Batch Runs

Use the Filter Batch Runs panel to filter batches by any or all of the following categories:

- Owner – the person at your facility assigned to this batch
- Eligibility State – the six types appear in this panel
- Date - select a time period and corresponding date

Click **Filter** to save your settings.

Create/Edit Batches

You can view this page only if you have Add/Edit Batch Eligibility Requests permissions.

The Batches tab lets you create and view batches of eligibility requests that are either ad hoc or scheduled to run on a recurring basis.

Create a New Batch

Fill in the following batch details.

Batch Name – Enter the name of the batch.

Owner – Select the name of the owner from the dropdown box.

NOTE: When adding or updating a batch owner, the owner must be associated with all of the NPIs within the batch. You cannot view requests within batches that are associated with NPIs that you are not configured to view.

Make Recurring Batches (Optional)

Select the Make Recurring Batch checkbox to display the following three fields.

Repeats – You must enter a repeat frequency. Use the dropdown box to select the frequency the system uses to run the batches

Start Date – You must enter a date or select one from the calendar.

Runs at – Select a time on the hour when the batch will run.

Click **Save** to save your changes.

Add Requests into your Batch

The following links are available to add requests to your batch.

Add Patient – Opens the **Error! Reference source not found.** page to add an eligibility request to this batch.

Import Batch – Opens a standard Windows® "Open File" dialog that lets you upload a CSV (Comma Separated Values) file containing patient eligibility requests. You can only import CSV files (the file must have a **.csv** extension) and the file can be no larger than 15MB.

Remove Duplicate Requests from a Batch

If a patient is added into a batch with the same insurance information more than once, you may want to remove duplicate rows from your batch. You can sort the batch by patient name by clicking the Request column and selecting the checkbox in the left column to select multiple requests. Delete above the request column to remove individual requests, or you can select the Delete option on the far right of the request row.

Click **Save** to update your batch.

Learn How to Import a CSV File

Click the **Download Sample CSV** link to view the requirements for creating a CSV file. You can see the CSV template containing header information. The NPI and Provider ID are required for all rows. You may or may not use the other columns, depending on the payers you select and the required payer fields.

Download Sample CSV

You can save the Sample CSV file to your computer when you click **Import Batch** activities. To have a successful CSV batch file import, you must have the following information:

- NPI
- Payer ID (the ABILITY Internal ID for each Payer)
- Patient search information that is payer specific

You can use Microsoft Excel® to open files with a .csv file extension. Your setup work can be performed using Excel's feature set. Remember to save the file as a CSV when you are done.

NOTE: If you are using the sample as your basis for a new batch, be sure to remove all of the help content (payers and search fields) as these will cause an import to have failures on all of those rows. Also, remove the subscriber/dependent search field columns that are unused for your batch requests.

Flexible Headers for Search Option Fields

You can add search option field columns in any order you want to provide. Each payer requires payer-specific fields to make a successful eligibility request.

Add Search Options field information

Depending on the payer you select, search options will vary. See Download Sample CSV for more information.

CSV Validation

Failed Import

If the import was not successful, a pop-up message displays, notifying you that the import failed and giving a reason for that failure.

CSV Validation

If any requests are missing information, the CSV Validation dialog box appears. The dialog box indicates how many imports were successful and how many were unsuccessful. The Error column indicates the reason for those that were unsuccessful. You can choose either of the following actions:

- **Export Errors** – You can export unsuccessful imports and then import them into a new batch. You can then modify this file and use it to create a CSV import file. You can select this option if some of the requests within the batch failed and you want to update those requests and then import them back into the batch.
- **Continue** – Proceed to the batch containing only those requests successfully imported (D). In this case, you ignore the requests that were unsuccessful in the CSV upload. If you select this option, the Batch Results page appears where you can view the requests that successfully uploaded.

NOTE: If you click **Continue**, the batch will not contain any of the Unsuccessful Imports. Unsuccessful imports need to be exported, updated with missing information, and imported back into the batch.

Save CSV Imports into Batch

Click **Save** to save the CSV import.

Manage Eligibility Batches

You can only see this page if you have Add/Edit Batch Eligibility Requests permissions.

Use this page to manage, edit, or delete batches set up for a customer account.

This page displays with the following columns.

Column Heading	Description
Batch Name	toggle between Selecting All and Clearing All requests on this page
(no heading)	the number of patients in the batch. Select this heading to display the details of what is in the batch.
Owner	person at your facility handling this batch
Recurrence	if the batch is recurring, the frequency at which it recurs. Hover over the icon to see a tooltip on the recurring schedule.
Next Run	date and time the batch is next scheduled to run
Last Run	date and time the batch was last run
(no heading)	• click **EDIT** to open the • • • Create/Edit Batches page • click **DELETE** to open the Confirm Delete message box

Edit Batch From the Manage Batches Page

If you have Add or Edit Batch permissions, you can set up batches and assign them to an owner to review. You can also add or edit batch permissions, add or remove patients to the batch, and adjust run times for recurring batches. You can also delete batches.

Delete Batch From the Manage Batches Page

If a batch is deleted and there are previous batch runs on the Batch History Page, you receive a message telling you the batch has already been run and that other users will no longer be able to edit or rerun this batch if it is deleted.

If you delete a batch from the Manage Batches page, the batch cannot be edited or rerun.

View Only Recurring Batches on the Manage Batches Page

You can select the Show Only Recurring Batches checkbox to view only recurring batches from the Batch History page.

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 | COMPLETE™ offers you 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 they want to configure and enter the information that is missing. A list of the NPIs associated with the account is displayed 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 the “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.

Payer Notes

If you have Configure Services permissions, you can add Payer Notes to payers from the Payer Configuration admin page. The maximum character limit for this field is 140 characters.

Payer notes allow you to share payer-specific information with other users. These will appear on the Select Payer(s) section when creating an eligibility request and on the Eligibility Response page.

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, you 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 they you checked the “I have completed manual enrollment for this NPI” checkbox on the Payer Details page.

Product Version 3.2 / Document Revision 1.0 / Published 06.24.2014