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Log In

1. Click on the Centricity Business Globe (Icon), located on the desktop.

2. Enter the User sign-on and password.
**Eligibility Summary**

GE Centricity Business (CB) Eligibility Module is an Insurance Validation tool embedded within CB. This will streamline our insurance validation process making it possible to validate, edit, and update insurance and registration information without having to leave the Centricity Business (CB) application; however, users can still utilize their current external validation tools as well.

**IMPORTANT:** In order for consistent validation to take place we must ensure that each patient is reviewed in CB - Eligibility. Eligibility should always be reviewed at two points during the process. First Eligibility can be checked after the patient has been registered in the system to make sure that they have valid insurance and again during the check in process to ensure accurate billing. Eligibility can also be reviewed by the Central Billing Office at any time after the patient has been registered in the system to ensure all of the information is available for proper billing.

In order for the CB - Eligibility Module to maximize its potential benefit to our organization we must ensure that Patients are registered correctly with proper insurance and the following data elements are captured correctly.
- Subscriber/patient name
- Subscriber/patient date of birth
- Subscriber ID/Certificate Number

The ability of our organization to check a patient's insurance Eligibility prior to the patient's arrival for an appointment or a visit is a critical business need. We are able to set up conditions that allow us to group Eligibility requests according to our needs and then specified personnel can send out additional requests as necessary.

In addition, a critical piece of Eligibility’s functionality includes the ability to automatically update our database with variant patient data that is returned from the carrier. The Eligibility verification transaction provided by GE lets us perform both individual insurance Eligibility requests and grouped Eligibility requests.

**Eligibility Insurance Follow Up Questions**
**Eligibility Last Received:** Date of last Eligibility response. (Automatic)

**Eligibility Status:** Active, Inactive, Mixed, Pending, No Response, and Rejected. (Automatic)

**Eligibility Requested by:** User who submitted the request. (Automatic/Manual)

**Eligibility Reviewed by:** User who reviewed the request. (Automatic/Manual)

**Eligibility Reviewed Date:** Date the request was reviewed. (Automatic/Manual)

**Eligibility Outcome:** Auto Eligible, Eligible, Not Eligible, Web Site, Fax, and Phone. (Automatic/Manual)

**Eligibility Variance Name:** Discrepant information provided by the payer. (Manual)

**Eligibility Variance Date of Birth:** Date the variant data was returned by the payer. (Automatic)

**Eligibility Variance Effective From Date:** Effective date of the insurance policy if it differs from registration. (Automatic)

**Eligibility Variance PCP:** Information returned by the payer. (Automatic/Manual)

Every time you update Eligibility information you need to take responsibility for the changes that you have made by following the process outlined below.

Complete the following fields:

- Eligibility Reviewed By: User Name
- Eligibility Reviewed Date: Date reviewed
- Eligibility Outcome: Auto Elig

**Note:** There could be additional Eligibility fields that should populate depending on the type of changes that you have made as a result of reviewing Eligibility. Please review the full list of Eligibility Insurance Follow Up Questions listed above to ensure that everything has been entered correctly.

Once these questions are answered select OK.

The Results screen will now appear. In order to complete the Eligibility process check off the Reviewed field and fill out the Outcome field by selecting from the drop down. In some cases, based on Eligibility verification, Auto Eligible will default.
Because you have made changes during this Eligibility review select the Review - Action Button and select Mark As Reviewed.

Definitions

GERD - Grouped Eligibility Request Definition
Grouped Eligibility enables the submission of multiple Eligibility verification requests at one time based upon user defined reports and based upon a five day rolling schedule prior to the scheduled appointment. GERDs may also be sent after the services have been rendered. For example a GERD may be submitted to verify Eligibility for patients seen in the hospital for a particular day or group of days.

On Demand Request - Interactive Request/Response - An Eligibility response that is stored on the individual patient’s account. An interactive request may also be submitted for a single patient.

Payer Verification Lengths - The time period before another request will automatically be submitted to the payer.

Data Retention - The amount of time the Eligibility data will be stored within CB/IDX and be available for retrieval.

Benefit Service Type Information - Users have access to all benefit information regarding patients’ medical coverage as it relates to services rendered. This information may vary from payer to payer.

Deductible - A fixed amount a person must pay or satisfy before the insurer will make any benefit payments. Deductibles are annual expenses that are applied by calendar year or benefit year.

Co-insurance - A method of cost-sharing in a health insurance policy that requires a person to pay a stated percentage of all remaining Eligible medical expenses after the deductible amount has been paid and after the claim has been processed by the insurance company.

Third Party Liability (TPL) - refers to the legal obligation of third parties (e.g. certain individuals, entities, insurers, or programs) to pay part or all of the medical expenditures prior to billing the patient’s basic medical policy.
- Workers compensation
- Motor Vehicle Accident

Coordination of Benefits (COB) - is required when there are two more insurance carries with potential liability for a claim - The Flag indicates users will need to review this data to confirm the other payer.
Co-Pay - Required specified amount for each visit, either inpatient/outpatient testing or physician services and is generally shown on the patient’s insurance validation response.

An Eligibility request is submitted to the payer and the response data is stored within the CB/IDX database. This information will coincide with financial revenue for patients with:

- Scheduled Appointments
- Walk-in Visits
- Physician services provided to patients within a facility

Eligibility Definition Links
- Medicaid 15 days
- Medicare 30 days
- Commercial/Managed Care 30 days

Payer Grouped Eligibility Response Definitions (GERD) data will be available to view for 10 days.

Patient Interactive Eligibility Response data will be retained for 180 days. (6 months)

Eligibility Request List - A patient's Eligibility Request List (or Eligibility List) displays the requests that have been made for an individual patient. You can access this list from Patient Services, or from several integration points in the Centricity Business application.

Eligibility Rejection Codes and Statuses:

- **Active** - Screens display an Active status when an eligibility response is returned showing the patient has active insurance coverage.

- **Inactive** - Screens display an Inactive status when an eligibility response is returned showing the patient no longer has insurance coverage.

- **Mixed Results** - With a mixed status contain a combination of active and inactive results. For example, on a specific date, a patient may be covered for psychiatric services, but not covered for chiropractic services. Since results for both services are returned, the overall status is mixed.

- **Rejected** - Screens display a Rejected status when the insurance carrier is unable to respond to the Eligibility request because of missing or inaccurate data.
- **Unable to Respond at the Current Time**
- **Provider Not On File**
- **Invalid/Missing Patient ID**
- **Invalid/Missing Patient Name**
- **Patient Not Found**
- **Duplicate Patient ID Number**
- **No Response** - Screens display a No Response status when a response was not received from the payer.
- **Pending** - Screens display a pended status when the responses contain Y in field 4 indicating that the payer has received the request and will respond shortly. You should not resubmit the request.

- **Variant Data** - Refers to a difference between the data that is stored in your GE database for demographics and insurance, versus what is returned from the insurance carrier (payer, trading partner). This information will show up as highlighted on the results screen.
How to Access Eligibility

1. You can navigate to Eligibility from multiple locations throughout the system depending upon what you are trying to accomplish. Here are the six access points for Eligibility.

- Eligibility
- Patient Services
- Registration
- Insurance
- Scheduler
- Check In

Primary Access Point for Pre-Reg: Eligibility

![Image of Eligibility Access Point]

Patient Services:

![Image of Patient Services Interface]
How to Access Eligibility (cont’d)

Registration

![Registration Image]

Insurance

![Insurance Image]
How to Access Eligibility (cont’d)

Scheduler

Check In
Eligibility Summary Tab

1. Using the Vertical Toolbar navigate to Eligibility.

2. Click on the Eligibility Summary Tab.

3. The Eligibility Summary workspace displays the payer GERDS alphabetically, with multiple dates per payer.
Workspace Column Definitions

The Eligibility Summary workspace contains 11 total columns.

1. Request Def (Request Definition)
2. Date (date the specific GERD ran)
3. Time (timeframe when the GERD ran)
4. Active (total number of active accounts contained with the GERD)
5. Inact (Inactive - total number of inactive accounts contained with the GERD)
6. Mixed (Total number of accounts with mixed responses i.e. components of the patients benefits were deemed active; as well, non-covered)
7. Reject (potentially, the payer could not process the request for a variety of reasons)
8. No Resp (No Response, the payer could render a response at the time the eligibility request was submitted)
9. Edits (Patient qualifies for the GERD; however another recent request is available for review)
10. Pend (Pending)
11. Total (the column displays the total number of requests for the selected run)
Action Codes

1. Action Code Buttons are displayed at the bottom of the screen.

- Group Req. (Group Request)
- Edit List
- V-Alt View (Alternate View)
- Actions
- Ok

Group Req.

1. Based on the highlighted/selected line (Request Definition), this line indicates the date the eligibility requests were submitted to the payer. Click the <Group Req> button located at the bottom of the screen.
Action Codes (cont’d)

2. The Grouped Eligibility Request List workspace opens. (providing the following detail)
   - Name of the selected GERD
   - Date the GERD processed

3. Headers for each of the following type:
   - Active Responses
   - (Inact) Inactive Responses
   - Rejected Responses
   - (No Resp) No Responses
   - Mixed Responses
   - (Edits) Edit Responses
   - (Pend) Pending Responses
   - Total Responses
Action Codes (cont’d)

4. Here are the Grouped Eligibility Request List workspace headers:
   - Patient Names
   - Appt Date (Appointment Date)
   - Appt Time (Appointment Time)
   - Status (Eligibility Response Status)
   - Var (Variant Data Contained In Responses)
   - Rej (Rejected Response Indicator)
   - Insurance (Plan Name)
   - Eligibility Outcome
   - Rev’d (Reviewed Yes/No)
   - Rev’d By (?)
   - Service Date (Date the GERD was processed)
   - Department (Scheduled Appointment Department)
   - Location (Scheduled Appointment Location)
Action Codes (cont’d)

- Appt Type (Appointment Type)
- Provider (Scheduling Provider)
- Appt Number (Appointment Number)

5. Here are the Action Buttons that are also displayed on the screen:

**Benefits** - This action code will display benefits rendered from the payer for the selected/highlighted patient i.e. Office Visit, Lab Services, Hospitalization.

**Results** - This action code provides detail on response rendered from the payer including:
- Patient Demographics/Insurance
- COB (multiple screens)
- Subscriber/Family
- Payer Information

**Requests** - This action code enables users to:
- Submit a New Eligibility request from the GERD.
- (Based on security)
- Review the Patient’s individual Eligibility List i.e. specific dates eligibility requests were submitted.

**Audit Trail** - This action code displays Old/New values of eligibility items captured within the specific request.
Action Codes (cont’d)

Resp Liab (Responsibility Liability) - This action code enables users to individually or collectively view the patient payment responsibility.
- Coinsurance
- Co-pay
- Deductible
- All

Actions - This action code enables users perform addition screen configurations in Advanced Web.

Ok - This action code enables users file/return Eligibility Summary Workspace.

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Results</th>
<th>Requests ▼</th>
<th>Audit Trail</th>
<th>Resp Liab ▼</th>
<th>Actions ▼</th>
<th>OK</th>
</tr>
</thead>
</table>

Edit List

1. Based on the highlighted/selected line (Request Definition), this line indicates the date the eligibility requests were submitted to the payer. Click the <Edit List> button located at the bottom of the screen.

<table>
<thead>
<tr>
<th>Group Req</th>
<th>Edit List</th>
<th>Alt View</th>
<th>Actions ▼</th>
<th>OK</th>
</tr>
</thead>
</table>

2. The Grouped Eligibility Request Edit List workspace opens. The Edit List lets you view patients who met the request definition criteria, but did not need a new request. (providing the following detail):
- Name of the selected GERD
- Date and Time the GERD processed

3. Headers for each of the following type of response indicators. (when applicable):
- Active Response
- (Inact) Inactive Response
- Rejected Responses
- (No Resp) No Responses
- Mixed Responses
- (Edits) Edit Responses
- (Pend) Pending Responses
- Total Responses
### Action Codes (cont’d)

<table>
<thead>
<tr>
<th>Grouped Eligibility Request Edit List</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name: AETNA</td>
</tr>
<tr>
<td>Date: 08/27/2014</td>
</tr>
<tr>
<td>Active: 1</td>
</tr>
<tr>
<td>Reverts: 0</td>
</tr>
<tr>
<td>Mixed: 1</td>
</tr>
<tr>
<td>Inact: 0</td>
</tr>
<tr>
<td>No Resp: 0</td>
</tr>
<tr>
<td>Edits: 6</td>
</tr>
<tr>
<td>Total: 8</td>
</tr>
</tbody>
</table>

4. The Grouped Eligibility Request Edit List workspace opens providing the following detail in column formatting:
   - Patient Name
   - Appt Date (Appointment Date)
   - Reason (a previous request exists)
   - Rec’d (Date the request was received)
   - Status
   - Var (Variant Data Contained In Responses)
   - Eligibility Outcome
   - Rev’d (Reviewed Yes/No)
   - Rev’d By (Reviewed By)
   - Service Date (Date this request was processed)

5. The Grouped Eligibility Edit List workspace opens. (Displaying action codes at the bottom of the screen)

**Benefits** - This action code will display benefits rendered from the payer for the selected/highlighted patient i.e. office visit, Lab services, Hospitalization.

**Results** - This action code provides detail on response rendered from the payer including:
   - Patient Demographics/Insurance
   - COB (multiple screens)
   - Subscriber/Family
   - Payer Information
Action Codes (cont’d)

**Requests** - This action code enables users to:
- Submit a New Eligibility request from the GERD. (based on security)
- Review the Patient’s individual Eligibility List i.e. specific dates eligibility requests were submitted.

**Audit Trail** - This action code displays Old/New values of eligibility items captured within the specific request.

**Resp Liab** (Responsibility Liability) - This action code enables users to individually or collectively view the patient payment responsibility:
- Coinsurance
- Co-pay
- Deductible
- All

**Actions** - This action code enables users perform addition screen configurations in Advanced Web.

**Ok** - This action code enables users file/return Eligibility Summary Workspace.

### V-Alt View

1. Based on the highlighted/selected line (Request Definition), this line indicates the date the eligibility requests were submitted to the payer. Click the <V-Alt View> button located at the bottom of the screen.

2. When the <V-Alt View> button is selected the column display changes to the following:
- Request Def (Request Definition - constant column)
- Date (date the specific GERD ran - constant column)
- Time (timeframe when the GERD ran - constant column)
- Not Rev’d (Not Reviewed) - Total number of accounts that have not been marked as reviewed.
- No Outcome - Total number of accounts that do not have the Outcome field populated.
- No Rev INI (No Reviewed Initials) - Total number of accounts that do not have the Reviewed Initials populated.
- Total - This column displays the total number impacted by the previously mentioned.
3. When the <V-Alt View> button is selected again the column display changes to the following:
   - Request Def (Request Definition - constant column)
   - Date (date the specific GERD ran - constant column)
   - Time (timeframe when the GERD ran - constant column)
   - Rev'd (Reviewed) Total number of reviewed accounts
   - W/Outcome (With Outcome) Total number of accounts that have the Outcome field populated
   - W/Rev INI (With Reviewed Initials) Total number of accounts that have the Reviewed Initials populated
   - Total - The column displays the total number impacted by the previously mentioned.

4. When the <V-Alt View> button is selected a third time the columns change to display the original view:
   - Request Def (Request Definition)
   - Date (date the specific GERD ran)
   - Time (timeframe when the GERD ran)
   - Active (total number of active accounts contained with the GERD)
   - Inact (Inactive - total number of inactive accounts contained with the GERD)
   - Mixed (Total number of accounts with mixed responses i.e. components of the patients benefits were deemed active; as well, non-covered)
   - Reject (potentially, the payer could not process the request for a variety of reasons)
   - No Resp (No Response, the payer could render a response at the time the eligibility request was submitted)
   - Edits (Patient qualifies for the GERD; however another recent request is available for review)
   - Total (the column displays the total number of requests for the selected run)
Actions

1. The Eligibility Summary Workspace space opens displaying the Payer GERDS. Click the <Actions> button located at the bottom of the screen.

![Actions Button Image]

2. When the <Actions> button is selected the following Actions are displayed:
   - Print Entire List
   - Print Current Screen
   - Find
   - Sort
   - Export (*Do not use)
   - Show Entire Row
   - Show More
   - Configure Display
   - Filter
   - Reset

![Actions Menu Image]

3. When the <Actions> button is selected the following Actions are displayed:

   - **Print Entire List** - User will be prompted to enter the designated IDX printer device (enter your device, click <OK>)
Action Codes (cont’d)

Print Current Screen - User will be prompted to enter the designated IDX printer device (enter your device, click <OK>). This functionality prints items displayed on the screen, not the entire list.

Find - Another format of filtering the columns, allowing users to display specific data:
- Request Def (Request Definition)
- Date
- Time
- Active
- Inact (Inactive)
- Mixed
- Rejected
- No Resp (No Response)
- Edits
- Pend (Pending)
- Total

Sort - Another format of filtering the columns, allowing users to display specific data in ascending or descending order:
- Request Def (Request Definition)
- Date
- Time
- Active
- Inact (Inactive)
- Mixed
- Rejected
- No Resp (No Response)
- Edits
- Pend (Pending)
- Total

**Sort:**
1. Request Def
2.
3.

**Order By:**
- Ascending

**Export** - Users DO NOT export the Payer GERDS into a data. (text file)

**Show Entire Row** -

**Show More** - Enables users to scroll through the lines of the payer GERDS.

**Configure Display** - Enables users to define their personal view. (order in which the columns are displayed)
- Request Def (Request Definition) cannot be modified
- Date
- Time
- Active
- Inact (Inactive)
- Mixed
- Rejected
- No Resp (No Response)
Action Codes (cont’d)

- Edits
- Pend (Pending)
- Total

- Move Down
- Edit
- Hide/Unhide
- Restore (restores the original display)
- Move Up
- View

- Reset - Enables users to reset <actions> selection to the original display.
My Eligibility Request List Tab

1. Using the Vertical Toolbar navigate to Eligibility.

2. The Eligibility Workspace opens displaying two Horizontal toolbar items:
   - Eligibility Summary
   - My Eligibility List

3. Click on the My Eligibility Request List Tab.

4. The My Eligibility Request List Workspace space opens displaying the patients for whom you submitted eligibility requests today. (current date)

5. The My Eligibility Request List workspace displays the patients alphabetically.

6. The My Eligibility Request List Workspace space displays the following header information:
   - User Name
   - Date
   - Active - Total number of accounts with an active status on this date
   - Inact (Inactive) - Total of accounts with an inactive status on this date
   - Rejects - Total of accounts with a rejected status on this date
   - No Response (No Response) - Total of accounts with a no response status on this date
   - Mixed - Total of accounts with a mixed status on this date
   - Pend (Pending) - Total of accounts with a pending status on this date
   - Total - Grand Total of accounts access on this date
**Workspace Column Definitions**

The My Eligibility Request List Workspace contains 9 total columns. The Eligibility Summary workspace columns names are:
- Patient Name
- Status
- Var (Variant Data Contained In Responses)
- Rej (Rejected Response Indicator)
- Insurance (Name of the patient's Insurance Plan)
- Outcome
- Rev'd (Reviewed Date)
- Rev'd By (Reviewed By)
- Service Date

**Action Codes**

Action Codes include the following:
- Benefits
- Results
- Requests (Look Here First!)
- Change Date
- More
- Actions
- OK
**Action Codes (cont’d)**

**Benefits**

1. Based on the highlighted/selected line (My Eligibility Request List Workspace), this line indicates the date the eligibility requests were submitted to the payer. Click the <**Benefits**> button located at the bottom of the screen.

2. The My Eligibility Request List/Eligibility Benefits screen displays the following Action Codes:
   - Guided Filter
   - Actions
   - OK

**Guided Filter**

1. When the <Guided Filter> button is selected users can filter the columns to display specified criteria and create default setting to always display the established filter from the columns listed below:

   - Service Type (specific benefits available to the patient)
   - Coverage (Family Individual)
   - Network Restrictions (Y-Yes/N-No)
   - Authorization Required Y-Yes/N-No)
   - Amount (Patient Payment Responsibility)
   - Benefit
   - Qty - (quantity of the service)
Action Codes (cont’d)

- Plan Description
- Time Qualifier (time period qualifier - if it exists)

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Cov</th>
<th>Net</th>
<th>Plan Description</th>
<th>Time Qual</th>
</tr>
</thead>
<tbody>
<tr>
<td>00 No Service Type</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- ITC (insurance type code)
- QQ - (quantity qualifier - if it exists)
- Proc Code (Procedure Code)

2. When the <Guided Filter> button is selected users can filter the columns to display specified criteria and create default setting to always display:
   - Indicate desired Column
   - Set operator 'Like'
   - Indicate additional criteria 'And/Or'
   - Indicate default setting 'Save as Default'
   - Indicate when desired filter should be deleted 'Delete

**Example:** Filter to show Service Benefit Type:
- 98 is the Office Visit
- 96 is the Physician
- 30 is the Health Benefit
- 60 is the General Benefit

**Mixed Response:** Make sure that when you are reviewing benefits that they include the benefits that are needed in your office. If the system picks up on the out of network benefit you will get a mixed response. If the specific benefit that you need, based upon your service location, is not included in the standard benefit level as listed above. You will always need to review the entire benefit selection to ensure that your patient is covered.

**Note:** Based on the benefit rendered and non-covered services users will need to follow their department protocol. Reference in all Mixed Response

3. Click <OK> once the desired filter has been established or <Cancel> to exit Guided Filter settings
Action Codes (cont’d)

Results

1. Based on the highlighted/selected line (My Eligibility Request List workspace), this line indicates the date the eligibility requests were submitted to the payer. Click the <Results> button located at the bottom of the screen.

2. Results - The My Eligibility Request List/Results Workspace contains the following screens:
   - Patient Name/Insurance Plan Name
   - Coordination of Benefits - COB (when applicable)
   - Subscriber/Family
   - Payer

3. The My Eligibility Request List/Results Workspace - Patient Demo/Insurance screen contains following Information:
   - Patient Information vs. Eligibility Results Columns
   - The Patient column indicates information contained in the registration. The Eligibility Results Column contains data rendered from the payer. Any variant/discrepant information will be highlighted indicating the difference.
   - Patient Name
   - Patient SSN (when applicable)
   - Patient DOB - Date of Birth (when applicable)
   - Patient Address
   - Payer Name
   - Cert No - Certificate Number (When applicable)
   - Group No - Group Number
   - Group Name
   - Eff (Effective) From/To
   - Ins Type -Insurance Type (when applicable)
   - PCP - Primary Care Physician (when applicable)
   - PCP Tel -Primary Care Physician Telephone (when applicable)
   - Subscriber's Name
   - Rel to Sub (Relationship to Subscriber)
   - Status
   - Rev'd (Reviewed Date), Outcome, and Rec'd (Received Date)
Action Codes (cont’d)

4. Based on the highlighted/selected line (My Eligibility Request List workspace), this line indicates the date the eligibility requests were submitted to the payer. Click the <Results> button located at the bottom of the screen.

Eligibility Results Screen Action Buttons

1. The My Eligibility Request List/Results Workspace - Patient Demo/Insurance screen contains following Action Codes:
   - Benefits
   - Edit
   - View
   - Review
   - Review
   - Resp Liab (Responsibility Liability)
   - OK
   - Cancel
Action Codes (cont’d)

Benefits

1. The My Eligibility Request List/Results Workspace - Patient Demo/Insurance screen **Benefits** screen displays the following columns:

   - Service Type (specific benefits available to the patient)
   - Coverage (Family Individual)
   - Network Restrictions (Y-Yes/N-No)
   - Authorization Required Y-Yes/N-No)
   - Amount (Patient Payment Responsibility)
   - Benefit
   - Qty - (quantity of the service)
   - Plan Description
   - Time Qualifier (time period qualifier - if it exists)
   - ITC (insurance type code)
   - QQ - (quantity qualifier - if it exists)
   - Proc Code (Procedure Code)

2. The My Eligibility Request List/Results Workspace - Patient Demo/Insurance screen contains the <Edit> action code and subsequent <Demographics> & <Insurance> action codes click <Demographics>: 

   ![Image of the Benefits screen]

   ![Image of the Edit screen]

   ![Image of the Demographics and Insurance selection]

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Action Codes (cont’d)

Demographics:

1. The patient Demographic screen opens displaying the Patient Registration Screen, users can depress the <Tab> key to navigate through all of the registration screens or select the page <button> to select a desired screen:
   - GT2 - Guarantor Information
   - CO2 - Contacts
   - PHI - Protected Health Information
   - GC4 - General Comments
   - AKA - Additional Aliases
   - LOC - Chart Location

2. Once the appropriate information has been update click <OK>. The Results screen will display.

Insurance:

1. The My Eligibility Request List/Results Workspace - Patient Demo/Insurance screen contains the <Edit> action code and subsequent <Demographic> & <Insurance> action codes, click <Insurance>:

2. The Manage Insurance Information opens displaying the Patient's Insurance information (FSCs). This screen enables users add/edit patient's insurance when applicable:
   - A - Add
   - E - Edit
   - H - Change Order
   - I - Insert
   - J - Documents
   - S - Show/Clear Deleted
   - T - View Audit Trail
   - V - View
Action Codes (cont’d)

Review:

1. Once the appropriate information has been update click <OK>. The Results screen will display.

2. The My Eligibility Request List/Results Workspace - Patient Demo/Insurance screen contains the <Reviewed> action code and subsequent <Mark as Reviewed> & <Mark as Not Reviewed> action codes.

3. The Mark as Reviewed action code will be required for Eligibility Outcomes selected by the user:
Action Codes (cont’d)

- Auto Elig
- Eligible
- Fax
- Not Eligible
- Patient Mismatch
- Phone
- Web Site

4. Make the appropriate (when applicable) selection and click <OK>, the My Eligibility Request List displays.

Resp Liab (Responsibility Liability):

1. The My Eligibility Request List/Results Workspace - Patient Demo/Insurance screen contains the <Resp Liability> (Responsibility Liability) action code and following subsequent action codes:

   - Co Ins  (Co-Insurance)
   - Co Pay  (Co Payment)
   - Deduct  (Deductible)
   - ALL

   Click <Co Ins>:
**Action Codes (cont’d)**

1. The Eligibility Benefits workspace opens displaying the Service type benefits with applicable coinsurance listings. Click <OK>. The My Eligibility Request List/Results Workspace - Patient Demo/Insurance screen displays.

2. The My Eligibility Request List/Results Workspace - Patient Demo/Insurance screen contains the <Resp Liability> (Responsibility Liability) action code and following subsequent action codes:
   - Co Ins (Co-Insurance)
   - Co Pay (Co Payment)
   - Deduct (Deductible)
   - ALL

   **Click <Co Pay>:**

   ![Image of Co Pay selection]

   1. The Eligibility Benefits workspace opens displaying the Service type benefits with applicable co-pay listings. Click <OK>. The My Eligibility Request List/Results Workspace - Patient Demo/Insurance screen displays.

2. The My Eligibility Request List/Results Workspace - Patient Demo/Insurance screen contains the <Resp Liability> (Responsibility Liability) action code and following subsequent action codes:
   - Co Ins (Co-Insurance)
   - Co Pay (Co Payment)
   - Deduct (Deductible)
   - ALL

   **Click <Deduct>:**

   ![Image of Deduct selection]
Action Codes (cont’d)

1. The Eligibility Benefits Workspace opens displaying the Service type benefits with applicable deductible listings. Click <OK>. The My Eligibility Request List/Results Workspace - Patient Demo/Insurance screen displays.

2. The My Eligibility Request List/Results Workspace - Patient Demo/Insurance screen contains the <Resp Liability> (Responsibility Liability) action code and following subsequent action codes:
   • Co Ins  (Co-insurance)
   • Co Pay   (Co Payment)
   • Deduct  (Deductible)
   • ALL

Click <ALL>:

1. The Eligibility Benefits workspace opens displaying All of Service type benefits and associated patient payment responsibility. Click <OK>, the My Eligibility Request List/Results Workspace - Patient Demo/Insurance screen displays.
Action Codes (cont’d)

2. The My Eligibility Request List/Results Workspace contains the following screens:
   ● Patient Name/Insurance Plan Name
   ● Coordination of Benefits - COB (when applicable)
   ● Subscriber/Family
   ● Payer

3. Users can depress the <Page Down> key to navigate to the Eligibility Results - Coordination of Benefits – COB
Action Codes (cont’d)

4. Users can depress the <Page Down> key to navigate to the Eligibility Results - Subscriber/Family Screen. The screen includes the following details:

- Subscriber's/Dependent's Name
- Subscriber's/Dependent's Address
- Subscriber's/Dependent's SSN
- Subscriber's/Dependent's Employer
- Subscriber's/Dependent's Group Number
- Dependent's Re to Sub (Relationship to Subscriber)
Action Codes (cont’d)

5. Users can depress the <Page Down> key to navigate to the Eligibility Results - Payer Screen. The screen includes the following details:
   - Payer
   - Payer’s Name
   - Payer’s Address
   - Payer’s Telephone
   - Payer’s Plan Name
   - Request Information
   - Date Request was submitted (Req’d)
   - Date Request was received (Rec’d)
   - Date Request was reviewed (Rev’d)
   - Requested by User (Req’d By)
   - Reviewed by User (Rev’d By)

6. Click <OK>. The My Eligibility Request List.

7. Based on the highlighted/selected line (My Eligibility Request List workspace), this line indicates the date the eligibility requests were submitted to the payer. The My Eligibility Request List Action Code buttons are displayed at the bottom of the screen. The <Requests> action code contains the following subsequent action codes:
   - Elig List (Eligibility List)
   - New Request
Action Codes (cont’d)

Click <Elig List>

1. The selected patient’s Eligibility Request List opens displaying the following columns:
   - FSC
   - Insurance
   - Req’d (Request Date)
   - Status
   - Var (Variant Data Contained In Reponses)
   - Rej (Rejected Response Indicator)
   - Outcome
   - Rev’d (Reviewed Date)
   - Rev’d By (Reviewed By)
   - Service Date (Date the eligibility request was processed)
   - Autofile
   - Request Number
   - Outbound Run (systematic number)
   - Inbound Run (systematic number)
   - Appt Number (Appointment Number)

<table>
<thead>
<tr>
<th>Eligibility Request List</th>
</tr>
</thead>
<tbody>
<tr>
<td>Filter Code</td>
</tr>
<tr>
<td>420</td>
</tr>
<tr>
<td>420</td>
</tr>
<tr>
<td>420</td>
</tr>
<tr>
<td>420</td>
</tr>
<tr>
<td>420</td>
</tr>
<tr>
<td>420</td>
</tr>
<tr>
<td>420</td>
</tr>
</tbody>
</table>

Note: User must scroll over to see additional columns.
   - Appt Date (Appointment Date)
   - Appt Time (Appointment Time)
   - Provider
   - Location
   - Department
PRE-REG: Work Flow

Medicare

Scenario: Learn to process an active Medicare patient if they also have an active Medicare Replacement Plan using Eligibility.

Important Reminder: Whenever Eligibility information is updated we must follow through and complete the Eligibility questions, reviewed check box, and outcome. Refer back to the definitions section for a detailed review.

1. Click on the Centricity Business Globe (Icon), located on the desktop.
2. Enter the User sign-on and password.
3. Using the Vertical Toolbar navigate to Eligibility.
4. The Eligibility Workspace opens displaying two Horizontal toolbar items:
   - Eligibility Summary
   - My Eligibility List
5. Click on the toolbar item Eligibility Summary Tab. The Eligibility Summary workspace displays the Payer GERDS alphabetically, with multiple dates per payer.
Medicare (cont’d)

Create a Personal Custom View

6. On the Eligibility tab, in the Eligibility Summary screen; Click the <Actions> button at the bottom of the screen and select <Filter>.

Filter - Enables users to define their personal view. (Order in which the columns are displayed)
Additionally, user can name and save/delete filter(s) as desired. Below is a list of the columns that can be filtered:
- Request Def (Request Definition)
- Date
- Time
- Active
- Inact (Inactive)
- Mixed
- Rejected
- No Resp (No Response)
- Edits
- Pend (Pending)
- Total

7. When the <Filter> button is selected users can filter the columns to display specified criteria and create default setting to always display. Below is an example of filtering the “Request Def” column to view Medicare:

- Indicate desired Column - Request Def
- Set operator : equal to (=)
- Set Value: MEDICARE
- Indicate additional criteria 'And/Or' ('And' will default)
- Indicate default Filter (name: Medicare)/ 'Save as Default'
- Click <OK>
Medicare (cont’d)

8. The Grouped Definitions Eligibility Summary Screen workspace now indicates the 'Medicare' Filter.

Note: V-Alt View (Alternate View)
The V-Alt View button, located at the bottom of the screen, enables a user to see additional columns that may aid in identifying patients insurance validation that may require further action.
Medicare (cont’d)

Note: Edit List
The Edit List button, located at the bottom of the screen, enables users to view patients who met the request definition criteria, but did not need a new request.

Based on the highlighted/selected line (Request Definition), this line indicates the date the eligibility requests were submitted to the payer. The GERD will only be available for ten days. Please work your GERDS oldest to newest.

9. Click the <Group Request> button located at the bottom of the screen.
Medicare (cont’d)

10. Now you will see the Grouped Eligibility Request List Workspace. Regardless of the patient’s status all patients will need to be reviewed. Accounts should be worked in the following order of priority:
   - Inactive
   - Rejected
   - Active / Mixed
   - No Response
   - Pending

11. Also on the Grouped Eligibility Request List workspace each patient must also be reviewed to verify Co Payment amounts. However, patients that are marked as Auto Eligible in the Outcome Column do not need to be reviewed further for Co Payments if they have Traditional Medicare, Railroad Medicare, Traditional Medicaid (All other GERDS you must check the Results Screen for Co-Pays).

12. Click on the <Status> Column to further filter. (Patient Names have been removed)
**Medicare (cont’d)**

13. The Medicare GERD display changes to reflect the following order:

**Active Accounts**
All Eligibility FSC follow up questions updated systematically.

**Inactive Accounts**
User will need to review & update FSC follow questions and contact the patient to confirm new information.

**Mixed (informational)**
Although the patient has active coverage, potentially one of the following has an indication of non-covered.
- 98 - Profession Physician Office Visit
- 96 - Professional Physician
- 30 - Health Benefit Plan
- 60 - General Benefit Plan

**Rejected**
The insurance carrier is unable to respond to the eligibility request because of missing or inaccurate data:
- 42 - Unable to Respond at the Current Time
- 51 - Provider Not On File
- 64 - Invalid/Missing Patient ID
- 65 - Invalid/Missing Patient Name
- 67 - Patient Not Found
- 68 - Duplicate Patient ID Number
- 72 - Invalid/Missing subscriber ID number
- 73 - Invalid/Missing subscriber name

14. Select the appropriate patient, click <Requests>, and subsequently <Eligibility List> located at the bottom of the screen.

15. The Patient's Eligibility Request List screen workspace opens and will contain the following Patient Information: **Including Patient Banner**
Medicare (cont’d)

16. Analyze the results that are listed to see if there is more than one listed that could be active. By using this screen you will be able to look at multiple payer requests so that you can quickly retrieve the needed information instead of having to process it separately.

17. Select the appropriate FSC to review for the patient by using the up and down arrows to make your selection. You can look to the Status and Outcome columns to best identify where to take action. (In this example we want to look at Medicare because it might still be in an Active Status and Medicare should not remain active if the patient has a replacement plan)
Medicare (cont’d)

18. Select the Results Action Button at the bottom of the screen.

**Note:** Based upon what caused the Eligibility Request it might first be displayed in a Pop Up so that you can better understand the status. Select Yes if you want to continue to the Results page.
19. Review the results screen to make sure all of the Eligibility Information has been populated. Look to the Status line to see if there are any identified items that need to be edited on the Demographic or Insurance screen. Review if there are any Flags indicating a Replacement Plan. Review the fields that are highlighted because they represent non matching data (Variant Data).

Note: Appt Detail could be accessed now to enter the appropriate Billing Comment.

Reminder: On the Results Screen make sure to check and see if there are any Flags. If there is a Replacement Plan the Flag will be marked with a Y.
**Medicare (cont’d)**

20. Page down on the Results screen to see the additional Replacement Plan data that was returned by Eligibility. (In this example some Replacement Plan info appears)

![Medicare Results - COB Detail Pg 1](image)

21. Select the Edit Action Button at the bottom of the screen to review and then make any necessary changes. (In our example Insurance)

![Benefits Edit](image)

22. The Insurance Screen will now appear. Select Edit from the bottom of the Manage Insurance Information screen to review the insurance information.

![Manage Insurance Information](image)
Medicare (cont’d)

Note: Medicare cannot have a replacement plan and be active at the same time. You will need to expire Medicare in this example. Then you will need to contact the patient or use an alternate validation tool to gather further information about the replacement plan so that you can register it appropriately. Additional Action outside Eligibility will be needed to register the Replacement Plan.

Important: Once you have retrieved the proper Replacement Plan data you will need to follow your normal CB steps for entering insurance (CB Training Manual Section 3 Page 25). Once the Replacement plan is entered the Traditional Medicare plan should be expired.

23. Expire Traditional Medicare. Scroll down through the insurance questions until you reach Expiration Date and enter the date the insurance should be expired.

24. Once the Traditional Medicare is expired you will need to enter some Eligibility specific questions.

Eligibility Specific Questions:

Complete the following fields:

- Eligibility Reviewed By: User Name
- Eligibility Reviewed Date: Date reviewed
- Eligibility Outcome: Auto Elig

Note: In this example Eligibility would have initially automatically populated these questions with the following fields because Eligibility would have seen this insurance as Auto Eligible.

- Auto
- Date Eligibility Ran
- Auto Eligible
Medicare (cont’d)

25. Because we needed to take action within Eligibility, during the process outlined above, we must replace these fields with the following. It remains Auto Eligible because it is in fact eligible insurance we just needed to update our records to include the Medicare Replacement plan.

- Name
- Date Reviewed
- Auto Elig

26. Once these questions are answered select OK.
27. You will now see the Insurance screen again.
28. You must now select the Replacement Plan that was added outside the Eligibility Module and move it into the primary insurance position by first selecting Change Order and then Move Up or Move Down to correct the order.
29. Once the Insurance is properly entered select OK.
**Medicare (cont’d)**

30. The Results screen will now appear. In order to complete the Eligibility process check off the Reviewed field and fill out the Outcome field by selecting from the drop down. Identify if the patient is either Eligible or Not Eligible. (In this example Auto Eligible)

![Status: Active, Rev'd: 08/20/14, Outcome: AUTO Elig]

31. Because you have made changes during this Eligibility Review select the Review Action Button and select Mark as Reviewed.

![Review options: Mark as Reviewed, Mark as NOT reviewed]

32. Once you have completed these steps select OK and the changes will be filed.

33. Navigate back to your patient list to begin the process again.
**Medicaid**

**Scenario:** Learn to process an active Medicaid patient if they also have an active Medicaid Replacement Plan using Eligibility.

**Important Reminder:** Whenever Eligibility information is updated we must follow through and complete the Eligibility questions, reviewed check box, and outcome. Refer back to the definitions section for a detailed review.

1. Click on the Centricity Business Globe (Icon), located on the desktop.
2. Enter the User sign-on and password.
3. Using the Vertical Toolbar navigate to Eligibility.
4. The Eligibility Workspace opens displaying two Horizontal toolbar items:
   - Eligibility Summary
   - My Eligibility List
5. Click on the toolbar item **Eligibility Summary Tab**. The Eligibility Summary workspace displays the Payer GERDS alphabetically, with multiple dates per payer.
Medicaid (cont’d)

Create a Personal Custom View

6. On the Eligibility tab, in the Eligibility Summary screen; Click the <Actions> button and select <Filter>.

**Filter** - Enables users to define their personal view. (Order in which the columns are displayed)
Additionally, user can name and save/delete filter(s) as desired. Below is a list of the columns that can be filtered:
- Request Def (Request Definition)
- Date
- Time
- Active
- Inact (Inactive)
- Mixed
- Rejected
- No Resp (No Response)
- Edits
- Pend (Pending)
- Total

7. When the <Filter> button is selected users can filter the columns to display specified criteria and create default setting to always display. Below is an example of filtering the “Request Def” column to view Medicaid:

- Indicate desired Column - Request Def
- Set operator : equal to (=)
- Set Value: MEDICAID
- Indicate additional criteria 'And/Or' ('And' will default)
- Indicate default Filter (name: Medicaid)/ 'Save as Default'
- Click <OK>
Medicaid (cont’d)

8. The Grouped Definitions Eligibility Summary Screen workspace now indicates the 'Medicaid' Filter.

**Note:** View: Click <V-Alt View> (Alternate View).

**Note:** Edit: Click the <Edit List> button. Clicking the Edit List button, located at the bottom of the screen, enables users to view patients who met the request definition criteria, but did not need a new request.

9. Based on the highlighted/selected line (Request Definition), this line indicates the date the eligibility requests were submitted to the payer. GERD should be worked from oldest to newest. Click the <Group Request> button located at the bottom of the screen.
Medicaid (cont’d)

10. The Grouped Eligibility Request List workspace opens displaying action codes at the bottom of the screen.

11. You will see the Grouped Eligibility Request List Workspace. Regardless of the patient’s status all patients will need to be reviewed. Accounts should be worked in the following order of priority:
   - Inactive
   - Rejected
   - Active / Mixed
   - No Response
   - Pending

12. Also on the Grouped Eligibility Request List workspace each patient must also be reviewed to verify Co Payment amounts. However, patients that are marked as Auto Eligible in the Outcome Column do not need to be reviewed further for Co Payments if they have Traditional Medicare, Railroad Medicare, Traditional Medicaid (All other GERDS you must check the Results Screen for Co-Pays).

13. Click on the <Status> Column to further filter. (Patient Names have been removed)

14. The Medicaid GERD display changes to reflect the following order:
**Medicaid (cont’d)**

**Active Accounts**  
All Eligibility FSC follow up questions updated systematically.

**Inactive Accounts**  
User will need to review & update FSC follow questions and contact the patient to confirm new information.

**Mixed (informational)**  
Although the patient has active coverage, potentially one of the following has an indication of non-covered.  
- 98 - Profession Physician Office Visit  
- 96 - Professional Physician  
- 30 - Health Benefit Plan  
- 60 - General Benefit Plan

**Rejected**  
The insurance carrier is unable to respond to the eligibility request because of missing or inaccurate data:  
- 42 - Unable to Respond at the Current Time  
- 51 - Provider Not On File  
- 64 - Invalid/Missing Patient ID  
- 65 - Invalid/Missing Patient Name  
- 67 - Patient Not Found  
- 68 - Duplicate Patient ID Number  
- 72 - Invalid/Missing subscriber ID number  
- 73 - Invalid/Missing subscriber name  

15. Once a patient is selected choose the Action Button - Requests and then Eligibility List.

16. Analyze the results that are listed to see if there is more than one listed that could be active. By using this screen you will be able to look at multiple payer requests so that you can quickly retrieve the needed information instead of having to process it separately.

17. Use the down arrow to select the appropriate FSC.
Medicaid (cont’d)

18. Select the Results Action Button to display the Eligibility Results page. Check to see if there are any Flags.

Note: Based upon what caused the Eligibility Request it might first be displayed in a Pop Up so that you can better understand the status. Select Yes if you want to continue to the Results page.
**Medicaid (cont’d)**

19. If the there is a Replacement Plan the Flag will be marked with a Y
   - CBO Flag
   - HMO Flag
   - TPL Flag

<table>
<thead>
<tr>
<th>COB Flag</th>
<th>TPL Flag</th>
<th>HMO Flag</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
<td>N</td>
<td>Y</td>
</tr>
</tbody>
</table>

20. If there is a Flag you can use the Page Down key to see the Flag details.

   ![Eligibility Medicaid Rls - Medicaid COB](image)

   - **Horizon NJ Health**: Add the Member ID number in Registration. (As seen in our example)

**Other Examples:**
- United Healthcare NJ (Formerly Americhoice): **DO NOT POPULATE** the Member ID because the number on the card will be different from the number that comes back from Eligibility. The number on the card is the correct number.
- Ameri Group: Add the Member ID number in Registration.

21. You will now be able to take the Member ID Number from Eligibility and register the Medicaid replacement plan. Please follow the normal procedure for registering insurance (Section 3 Page 25 in the CB Manual). To streamline the process you can access the insurance screen from Eligibility by selecting Edit on the Results screen and then Insurance.

22. In this example the Replacement Plan should be added. Then Medicaid should be moved to the second position and the replacement plan should be entered in the primary position. Both Insurances should remain active.
**Medicaid (cont’d)**

**Note:** If it is Medicaid it might not have an effective date. If Eligibility returns a date that is later than what is found in the FSC follow up questions do not modify the date displayed on the Eligibility results screen to reflect.

23. Make sure to file through after you have entered the replacement plan by selecting OK on the Manage Insurance screen.

24. Then Select OK again on the Results screen, which will bring you back to the Eligibility Request List, to file through your changes completely.

25. Now we must manually run Eligibility on the Medicaid Replacement Plan. Select the New button.

26. Now select the OK button to run the request.
27. Now we must answer some Eligibility specific questions for the Traditional Medicaid. Select Edit and then Insurance to access the Eligibility questions.

**Eligibility Specific Questions:**

Complete the following fields:

- Eligibility Reviewed By: User Name
- Eligibility Reviewed Date: Date reviewed
- Eligibility Outcome: Auto Elig

**Note:** In this example Eligibility would have initially automatically populated these questions with the following fields because Eligibility would have seen this insurance as Auto Eligible.

- Auto
- Date Eligibility Ran
- Auto Eligible
Medicaid (cont’d)

Because we needed to take action within Eligibility, during the process outlined above, we must replace these fields with the following. It remains Auto Eligible because it is in fact eligible insurance we just needed to update our records to include the Medicaid Replacement plan.

- Name
- Date Reviewed
- Auto Elig

28. Now we must update these fields on the results screen to reflect that we have reviewed this eligibility request and the date that we worked on it. The Eligibility Outcome should remain Auto Eligible.

29. Navigate back to the Results screen and fill out the Outcome field by selecting from the drop down. Identify if the patient is either Eligible or Not Eligible. (In this example Auto Eligible)

30. If you have made changes during this Eligibility Review select the Review Action Button and select Mark as Reviewed.

31. Once you have completed these steps select OK and the changes will be filed.

32. Navigate back to your patient list to begin the process again.
Medicaid (cont’d)
Mixed Results

Scenario: Patient has a mixed response because they have an insurance plan that is not capitated to Rowan SOM. Review the copayment amounts for PCP and Specialist. (Example PHO Preferred Health Organization)

Important Reminder: Whenever Eligibility information is updated we must follow through and complete the Eligibility questions, reviewed check box, and outcome. Refer back to the definitions section for a detailed review.

1. Click on the Centricity Business Globe (Icon), located on the desktop.
2. Enter the User sign-on and password.
3. Using the Vertical Toolbar navigate to Eligibility.
4. The Eligibility Workspace opens displaying two Horizontal toolbar items:
   - Eligibility Summary
   - My Eligibility List
5. Click on the toolbar item Eligibility Summary Tab. The Eligibility Summary workspace displays the Payer GERDS alphabetically, with multiple dates per payer.
Mixed Results (con’t)

Create a Personal Custom View

6. On the Eligibility tab, in the Eligibility Summary screen; Click the <Actions> button and select <Filter>.

Filter - Enables users to define their personal view. (Order in which the columns are displayed) Additionally, user can name and save/delete filter(s) as desired. Below is a list of the columns that can be filtered:

- Request Def (Request Definition)
- Date
- Time
- Active
- Inact (Inactive)
- Mixed
- Rejected
- No Resp (No Response)
- Edits
- Pend (Pending)
- Total

7. When the <Filter> button is selected users can filter the columns to display specified criteria and create default setting to always display. Below is an example of filtering the “Request Def” column to view Ameri Health:

- Indicate desired Column - Request Def
- Set operator : equal to (LIKE) to filters on less specific criteria
- Set Value: Ameri Health
- Indicate additional criteria 'And/Or' ('And' will default)
- Indicate default Filter (name: Medicaid)/ 'Save as Default'
- Click <OK>
Mixed Results (con’t)

8. Mixed Results appear in the Eligibility Summary

9. Select Group Requests. (Patients removed for training)
Mixed Results (con’t)

10. Select the Requests button and then Eligibility List.

![Eligibility Request List]

11. Select Benefits.

12. Review the Benefits screen to see if the patient is covered for the services that they are requesting based upon the department location they will be receiving services and their Benefit.

13. If the system shows the patient has insurance but is a non-covered patient they would utilize out of network benefits. However user must confirm the patients can receive services at Rowan SOM.

![Filter: Service Type LIKE 30 Or Service Type LIKE 60 Or Service Type LIKE 96 Or]

**Note:** Look for both the PCP and Specialist Co Payment amount. If the Co Pay is defined as Office Visit it will be the amount for both PCP and Specialist.
Mixed Results (con't)

14. Patients that are marked as Auto Eligible in the Outcome Column do not need to be reviewed further for Co Payments if they have Traditional Medicare, Railroad Medicare, or Traditional Medicaid (All other GERDS you must check for Co-Pays).

15. Filter on 98 (Office Visit) to review co-payment by referencing Actions Button - Detail

16. Guided Filter - Select Service Type is equal to 98 (Office Visit)

17. Highlight the benefit - Select Actions Button - Select Detail
Mixed Results (con’t)

18. If necessary update the correct PCP and Specialist Co-Pay on the insurance screen. (In our example the Co Payment amounts are correct)

19. Select OK to return back to the Eligibility Request List.

20. Select the appropriate FSC and select Results.

21. Select Edit – Insurance

22. Update the Eligibility insurance Info.

Eligibility Specific Questions:

Complete the following fields:

- Eligibility Reviewed By: User Name
- Eligibility Reviewed Date: Date reviewed
- Eligibility Outcome: Auto Elig

Note: In this example Eligibility would have done nothing because it returned a Mixed Response. Make sure that if there are multiple valid insurances registered that these questions are filled out appropriately for each. The user is responsible to update the following fields.

- Auto
- Date Eligibility Ran
- Auto Eligible
Mixed Results (con’t)

Because we needed to take action within Eligibility, during the process outlined above, we must replace these fields with the following. (In this example the patient will be marked as eligible because they can still use their out of network benefit).

- Name
- Date Reviewed
- Auto Elig

23. Navigate back to the Results screen and fill out the Outcome field by selecting from the drop down. Identify if the patient is either Eligible or Not Eligible. (In this example Eligible)

24. Because you have made changes during this Eligibility Review select the Review Action Button and select Mark as Reviewed.

25. Select OK to file the changes.

26. Navigate back to your Grouped Eligibility Request List to begin the process again.
Rejected

Scenario: The Patient was rejected because of Name, Date of Birth, Member ID, Subscriber Name if different, or Patient Miss-Match. (In this example patient mismatch)

Important Reminder: Whenever Eligibility information is updated we must follow through and complete the Eligibility questions, reviewed check box, and outcome. Refer back to the definitions section for a detailed review.

1. Search for a patient by selecting the HTB - Patient Services and then selecting the ellipsis (Three dots). Search the patients name and then select OK.

2. Select Eligibility List.

3. Review the information provided in the Eligibility Request List and look in the column Status and Outcome. In this example we can see that Eligibility is bringing back a patient mismatch.
Rejected (con’t)

4. Highlight the appropriate FSC based upon most recent date Eligibility ran and select Results.

5. Review the Results screen to understand what has caused the Patient Mismatch. (In this example patient name)
Rejected (con’t)

6. In this case you must use the information that is provided in Eligibility to lookup the patient with an alternative validation tool or contact the patient directly to gather the missing information to manually complete Eligibility. (In our example the subscriber name is sufficient to be entered as the patient variant name.)

7. Select Edit and then Insurance to navigate back to the Eligibility Insurance Follow Up Questions.

8. Update the Insurance Eligibility Screen including the Eligibility Variance Name.

9. By updating this field you enable the information to be resubmitted to Eligibility for proper verification when you select OK.

10. Select OK to continue to file through the appropriate screens until you return to the Eligibility Request List. From this screen select New and follow the procedure for running an On Demand Eligibility Request (Page 84).

11. The Results screen will now appear. In order to complete the Eligibility process check off the Reviewed field and fill out the Outcome field by selecting from the drop down. Identify if the patient is either Eligible or Not Eligible. (In this example Eligible)
Rejected (con’t)

12. Because you have made changes during this Eligibility Review select the Review - Action Button and select Mark as Reviewed.

13. Once you have completed these steps select OK and the changes will be filed.

14. Select OK again on the Eligibility Request List or select Patient Services from the VTB to return back to Patient Services to begin the process again.
**Active**

**Scenario:** If the Status is marked as Active and the Insurance coverage is not Traditional Medicare or Traditional Medicaid you must still verify the Co-Pay even if the insurance is Active - Auto Eligible.

**Important Reminder:** Whenever Eligibility information is updated we must follow through and complete the Eligibility questions, reviewed check box, and outcome. Refer back to the definitions section for a detailed review.

1. Click on the Centricity Business Globe (Icon), located on the desktop.
2. Enter the User sign-on and password.
3. Using the Vertical Toolbar navigate to Eligibility.
4. The Eligibility Workspace opens displaying two Horizontal toolbar items:
   - Eligibility Summary
   - My Eligibility List
5. Click on the toolbar item **Eligibility Summary Tab**. The Eligibility Summary workspace displays the Payer GERDS alphabetically, with multiple dates per payer.
Active (con’t)

Create a Personal Custom View

6. On the Eligibility tab, in the Eligibility Summary screen; Click the <Actions> button at the bottom of the screen and select <Filter>.

Filter - Enables users to define their personal view. (Order in which the columns are displayed) Additionally, user can name and save/delete filter(s) as desired. Below is a list of the columns that can be filtered:
- Request Def (Request Definition)
- Date
- Time
- Active
- Inact (Inactive)
- Mixed
- Rejected
- No Resp (No Response)
- Edits
- Pend (Pending)
- Total

7. When the <Filter> button is selected users can filter the columns to display specified criteria and create default setting to always display. Below is an example of filtering the “Request Def” column to view BCBS:

<table>
<thead>
<tr>
<th>Filter Column</th>
<th>Operator</th>
<th>Value</th>
<th>And/Or</th>
</tr>
</thead>
<tbody>
<tr>
<td>Request Def</td>
<td>LIKE</td>
<td>BCBS</td>
<td></td>
</tr>
</tbody>
</table>

- Indicate desired Column - Request Def
- Set operator : equal to (LIKE) to filter on less specific criteria
- Set Value: BCBS
- Indicate additional criteria 'And/Or' ('And' will default)
- Indicate default Filter (name: Medicare) / 'Save as Default'
- Click <OK>
Active (con’t)

8. Select the appropriate GERD select Group Request.

9. Highlight the patient for which you need to verify the Co Payment.

10. Select Responsible Liability action button.
Active (con’t)

11. Select Co Pay.

12. Use the Guided Filter for 98 (Office Visit)

13. Select Service Type, Like, 98 (Office Visit)

14. Results for Co Payment (Office Visit) display.
Active (con’t)

15. Select Actions, and then Detail.

16. Use this to determine the Specialist Co Pay and the PCP Co Pay.

17. Then compare to the Co Payment amounts in the Banner. If they do not match edit the insurance screen to update the Co Payment amount in the FSC follow up questions. (In our Example the Co Pay amounts match) Please follow the normal procedure for registering insurance (Section 3 Page 25 in the CB Manual).

18. Select OK to file through each screen.

19. Once back to the Grouped Eligibility Request List continue on to the next patient.
On Demand Eligibility Requests

1. Click on the Centricity Business Globe (Icon), located on the desktop.
2. Enter the User sign-on and password.
3. Using the Vertical Toolbar navigate to Eligibility.
4. The Eligibility Workspace opens displaying two Horizontal toolbar items:
   - Eligibility Summary
   - My Eligibility List
5. Click on the toolbar item **Eligibility Summary Tab**. The Eligibility Summary workspace displays the Payer GERDS alphabetically, with multiple dates per payer.
On Demand Eligibility Requests (con’t)

Create a Personal Custom View

6. On the Eligibility tab, in the Eligibility Summary screen; Click the <Actions> button at the bottom of the screen and select <Filter>.

Filter - Enables users to define their personal view. (Order in which the columns are displayed) Additionally, user can name and save/delete filter(s) as desired. Below is a list of the columns that can be filtered:
- Request Def (Request Definition)
- Date
- Time
- Active
- Inact (Inactive)
- Mixed
- Rejected
- No Resp (No Response)
- Edits
- Pend (Pending)
- Total

7. When the <Filter> button is selected users can filter the columns to display specified criteria and create default setting to always display. Below is an example of filtering the “Request Def” column to view Medicare:

<table>
<thead>
<tr>
<th>Filter Column</th>
<th>Operator</th>
<th>Value</th>
<th>And/Or</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Request Def</td>
<td>=</td>
<td>Medicare</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Indicate desired Column - Request Def
- Set operator : equal to (=)
- Set Value: MEDICARE
- Indicate additional criteria 'And/Or' ('And' will default)
- Indicate default Filter (name: Medicare)/ 'Save as Default'
- Click <OK>
On Demand Eligibility Requests (con’t)

8. The Grouped Definitions Eligibility Summary Screen workspace now indicates the 'Medicare' Filter.

![Eligibility Summary Screen](image)

9. Highlight the appropriate GERD and select Group Request.

10. Now highlight the appropriate patient by using the up and down arrows and then select Requests – New Requests.

![Grouped Eligibility Request List](image)
On Demand Eligibility Requests (con’t)

11. The Patient Eligibility Request screen <Elig List>, <New> action workspace opens displaying Eligibility Request - Select Insurance Screen.

The Eligibility Request - Select Insurance screen displays the following information:
- Insurance:
- Ins Co:
- Received:
- Status:
- From Date:
- To Date:
- Ins List:

12. If there is only one FSC select OK to initiate a new request.

Reminder: If you do not have the proper security access you will not be able to run On Demand responses unless you fall into one of the following scenarios. Individuals can run On Demand responses for patients that have never been run through Eligibility or patients that have exceeded the 15 - 30 day window. The following work instructions pertain to users that currently can run an On Demand response.
On Demand Eligibility Requests (con’t)

Note: When the patient has been registered with Multiple FSCs.

13. User must depress the <page down> button and click the Insurance 2, 3 etc. checkbox in order to group the remaining FSC in the eligibility request.

14. Page down past the first screen. (Not being used for Eligibility)

15. Check off the Insurance that you wish to group together (if any).

On Demand Eligibility Requests (con’t)

17. OK button - submits the request to the payer. Other users with restricted ability to submit multiple requests will receive a prompt indicating 'An active eligibility response has been received with the last 15 - 30 days based upon payer. Do you want to view the previous response?

18. Yes/No' Should the user click 'Yes' the prior response is displayed Should the user click 'No' the new request is submitted to the payer indicating 'Waiting 35 seconds. Press any key to stop waiting.'

Note: If you see the security prompt listed above you do not have access to run an On Demand request unless your patient falls outside of the 15 - 30 day window.

19. Once the response starts you will see a message indicating; waiting _ seconds. Press any key to stop waiting.
On Demand Eligibility Requests (con’t)

20. When the response has been received a prompt will display indicating 'Reply received' and the Eligibility Results - Patient Demo/Insurance screen displays.

Note: Once you have run an On Demand request remember to follow through with Eligibility as referenced in all of our previous scenarios based on payer and the results that they receive from Eligibility. In some instances you must complete the Eligibility Insurance Follow Up Questions, mark as reviewed, select the proper outcome and file appropriately.
FRONT DESK: Work Flow

IMPORTANT: In order for validation to take place we must ensure that each patient is reviewed in CB - Eligibility. Eligibility should always be reviewed at two places during the process. First CB - Eligibility can be checked after the patient has been registered in the system to make sure that they have valid insurance and again during the check in process to ensure accurate billing.

Validation from Patient Services

Scenario One: Patient needs to have their insurance validated after registration has been completed including checking to make sure we document the appropriate Co-Pay amount.

1. Click on the Centricity Business Globe (Icon), located on the desktop.

2. Enter the User sign-on and password.

3. Select the Patient Services Vertical Toolbar menu item.

4. Type in the name of the patient that you would like to validate.

5. Select the Eligibility List option.
Validation from Patient Services (con’t)

6. Review the Request List by newest run date which should appear at the top. Check to ensure that the Status is Active and that the Outcome is Auto Eligible. If some other combination of results comes back from Eligibility you must review the patient’s insurance further and correct or update the information that caused Eligibility to not accept the insurance information as valid.

7. Once we have taken the appropriate steps to make sure that the insurance is valid we must still check to make sure that we collect the appropriate Co-Pay for each patient.

8. Select the Resp-Liab button and select Co-Pay.

9. Now set up a Guided Filter to view only 98 - Office Visit.
Validation from Patient Services (con’t)

10. The results will now display PCP Office Visit amount and Specialist Office Visit amount.

11. The lower denomination is normally the PCP and the higher amount is usually the specialist however you should highlight the Co Pay you wish to review further and then select Detail from the Actions Button.
Validation from Patient Services (con’t)

12. This will allow you to view the detailed information for each line item.

13. Review the detail to ensure that it is either the PCP Co Pay or the specialist Co Pay.

14. Check the patient banner to make sure that the same amounts are registered.

15. If the amounts match then there is nothing further to do. However if the Co Pay amounts do not match you will now need to go on to update the insurance information with the correct Co-Payment amount. (Refer to Section 3 Page 25 in the CB Manual for proper instruction on Insurance registration)
Validation during Check In

Scenario Two: Patient needs to have their insurance validated during the Check In process to ensure that proper billing occurs during the Check Out process.

1. Click on the Centricity Business Globe (Icon), located on the desktop.

2. Enter the User sign-on and password.

3. Select the Scheduler Vertical Toolbar Menu.

4. Select the Appt. Manager Horizontal Toolbar Menu.

5. Highlight the name of the patient that you are ready to Check In.

6. Follow the CB Check In process. (Reference the CB Training Manual Section 3)
Validation from patient services (con’t)

7. After you complete the review of the patient’s registration information select OK.

8. The next screen will be the Eligibility List.

9. From this screen follow the steps outlined for Medicare, Medicaid, Mixed Results, Rejected, or Active to complete the Eligibility review process as previously defined above.
**On Demand Requests - Front Desk**

1. Click on the Centricity Business Globe (Icon), located on the desktop.
2. Enter the User sign-on and password.
3. Follow the procedure outlined in the CB Training Manual for registering a new patient. (Refer to Section 3 Registration)
4. Once you have completed registering the patient insurance select Eligibility List.

5. You will now see the Eligibility Request List. This screen should be blank if you are registering this patient for the first time.
On Demand Request Front Desk (con’t)

6. Select the New button.

7. If there is only one FSC select OK to initiate a new request.

Reminder: If you do not have the proper security access you will not be able to run On Demand responses unless you fall into one of the following scenarios. Individuals can run On Demand responses for patients that have never been run through Eligibility or patients that have exceeded the 15 - 30 day window. The following work instructions pertain to user that currently can run an On Demand response. Note: When the patient has been registered with Multiple FSCs.

8. User must depress the <page down> button and click the Insurance 2, 3 etc. checkbox in order to group the remaining FSC in the eligibility request
On Demand Request Front Desk (con’t)

9. Page down past the first screen. (Not being used for Eligibility)

<table>
<thead>
<tr>
<th>Benefit Type</th>
<th>CPT Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Benefit Plan Coverage</td>
<td></td>
</tr>
</tbody>
</table>

10. Check off the Insurance that you wish to group together (If any).

11. Cancel Button - cancels the eligibility inquiry.

12. OK button - submits the request to the payer. Other users with restricted ability to submit multiple requests will receive a prompt indicating 'An active eligibility response has been received with the last 15 - 30 days based upon payer. Do you want to view the previous response?'
On Demand Request Front Desk (con’t)

13. Yes/No' Should the user click 'Yes' the prior response is displayed
    Should the user click 'No' the new request is submitted to the payer indicating 'Waiting 35 seconds.
    Press any key to stop waiting.'

![Image]

Note: If you see the security prompt listed above you do not have access to run an On Demand request
unless your patient falls outside of the 15 - 30 day window.

14. Once the response starts you will see a message indicating; waiting _ seconds. Press any key to stop
    waiting.

![Image]

15. When the response has been received a prompt will display indicating 'Reply received' and the
    Eligibility Results - Patient Demo/Insurance screen displays.
**On Demand Request Front Desk (con’t)**

**Eligibility Results - Patient Demo/Insurance**

- **Name:** [Redacted]
- **SSN:** [Redacted]
- **DOB:** 09/10/1955
- **Address:** [Redacted]
- **Payer:** KEYSNHEALTH PLAN EAST
- **Cert No.:** [Redacted]
- **Group No.:** [Redacted]
- **Eff From:** 07/01/2014
- **Ins Type:** HMO
- **To:** [Redacted]
- **PCP:** [Redacted]
- **PCP Tel:** [Redacted]
- **Subscriber:** [Redacted]
- **Rel to Sub:** SPOUSE
- **Status:** Active
- **Rev’d:** 10/27/14
- **Outcome:** AUTO Elig
- **Rec’d:** 10/27/14
- **Svc:** [Redacted]

**Note:** Once you have run an On Demand request remember to follow through with Eligibility as referenced in all of our previous scenarios based on payer and the results that they receive from Eligibility. In some instances you must complete the Eligibility Insurance Follow Up Questions, mark as reviewed, select the proper outcome and file appropriately.
## Reports

1. Click on VTB Reports

2. Click on HTB Eligibility Reports

<table>
<thead>
<tr>
<th>Reports</th>
<th>BAR Reports</th>
<th>Eligibility Reports</th>
<th>Sched Reports</th>
<th>Reg Reports</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Services</td>
<td>Registration</td>
<td>Eligibility Department User Report</td>
<td>Eligibility Department Payer Report</td>
<td>Eligibility Rejection Report</td>
</tr>
<tr>
<td>Registration</td>
<td>Enter Charges</td>
<td>Eligibility Group Request Productivity Report</td>
<td>Eligibility Payer Report</td>
<td>Eligibility User Productivity Report</td>
</tr>
<tr>
<td>Batch Maintenance</td>
<td>Comments</td>
<td>Eligibility Group Request Department User Report</td>
<td>Eligibility FSC Department Report</td>
<td>Eligibility Utilization Rate Report</td>
</tr>
<tr>
<td>Invoice Inquiry</td>
<td>Dictionaries</td>
<td>Eligibility Results Variant Audit Report</td>
<td>Eligibility Rejections Report</td>
<td>Eligibility Automation Rate Report</td>
</tr>
<tr>
<td>Patient Inquiry</td>
<td>Add/Edit Referral</td>
<td></td>
<td></td>
<td>Eligibility Results Variant Audit Report</td>
</tr>
<tr>
<td>Scheduler</td>
<td>Sched Setup</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. Select from the list of available reports:
   - Eligibility Department User Report: Includes summary information with the status listed below by department.
   - Eligibility Department Payer Report: Includes summary information with the status listed below by payer.
   - Eligibility Grouped Request Productivity Report: Includes summary information with the status listed below by GERD.
   - Eligibility Payer Report: Includes summary information with the status listed below by payer.
   - Eligibility Group Request Department User Report: Includes summary information with the status listed below by department and user.
   - Eligibility FSC Department Report: Includes summary information with the status listed below by department.
   - Eligibility Rejection Report: Includes rejected accounts by department and user.
   - Eligibility User Productivity Report: Includes summary information with the status listed below by user.
   - Eligibility Utilization Report: Includes utilization on the number of arrived appointments with Eligibility FSC and Eligibility requested date.
   - Eligibility Automation Rate Report: Includes the number of accounts with an auto file status.
   - Eligibility Results Variant Audit Report: Includes all of the variant field information on the results screen by user.
Reports (con’t)

4. Select the appropriate report.

5. Select Bar Group (Multi Group) no action required.

6. Select OK.

7. On the following screen (Department and User) select the from and to date as needed.

8. Select Ok.

9. Enter in your IDX Printer / Device.

10. Select OK.

11. The data will print in a landscape format. Each report at a summary level is showing the number of accounts.
   - Inactive
   - Rejected
   - Active / Mixed
   - No Response
   - Pending

12. These reports can also be run by Department, User, or FSC as listed above.