Eligibility Inquiry User Guide

for NextGen® Enterprise PM, Fall 2018

Product Name Crosswalk for NextGen Enterprise

The following terms may be used interchangeably throughout this guide:

Current Name	Former Name
NextGen® Enterprise	NextGen® Ambulatory
NextGen Go®	NextGen EHR Mobi™
NextGen® Background Business Processor (BBP)	
NextGen Care® Outreach	
NextGen Care® Population Management Hub	Population Management Hub
NextGen® Adaptive Content Engine	NextGen® Knowledge Base Model (KBM) or NextGen® Clinical Templates
NextGen® Document Management	
NextGen® Electronic Data Interchange (EDI)	
NextGen® Eligibility Inquiry	NextGen Real Time Services (RTS) or NextGen® Eligibility Check
NextGen® Enterprise	NextGen Ambulatory EHR & NextGen Practice Management Software Suite
NextGen® Enterprise EHR	NextGen Ambulatory EHR
NextGen® Enterprise API	NextGen Foundation API
NextGen® Enterprise PM	NextGen Practice Management
NextGen® Financial Insight	InSight Reporting™
NextGen® In-line Edits	NextGen Real-Time Edits (NextGen RTE)
NextGen® Mobile	EHR Mobile
NextGen® Optical Management	NextGen Optik
NextGen® Patient Access API	NextGen Ambulatory Patient API
NextGen® Patient Chart Sync	NextGen Remote Patient Chart Synchronization
NextGen® Enterprise Patient Portal	NextGen® Patient Portal
NextGen® Patient Portal Mobile	
NextGen™ Digital Pen	NextPen Write

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CHAPTER 1

Eligibility Inquiry

NextGen® Eligibility Inquiry (formerly NextGen Real Time Services, or RTS) is also referred to as the Managed Care System or the Eligibility/Referral System. Eligibility Inquiry (EI) is an electronic method of verifying patient eligibility and benefit coverage online. EI allows you to check for authorization and prior authorization, make referral requests, check referral history, and check a claim status.

The rules governing eligibility and referrals are based on a patient's managed care coverage plan. NextGen Eligibility Inquiry features include the following:

- Eligibility verification - enables you to verify a patient's insurance coverage in real-time or in a batch using the Background Business Processor. The results of the inquiry can flow directly into the patient's chart.
- Referral requests - are made to generate a referral number, so that a Primary Care Physician (PCP) can send a patient to an authorized specialist.
- Referral history - enables you to view a patient's referral history. This history lists all previous referrals made for a patient.
- Claim status check - enables you to find out the status of a claim and where it is in the adjudication process.
- Eligibility Inquiry Manager - allows you to track eligibility transactions and status using a user-friendly visual graph and detailed grid.
- Prior Authorization - an option available to Eligibility Inquiry clients hosted on Amazon Web Services (AWS), requesting authorization for future visits and procedures is automated with prior authorization. The authorization request processes and records response information from the payer source. Historical tracking and reporting of the responses is done in NextGen Enterprise® PM (formerly NextGen® Practice Management).
- Pre-Services - Office managers, front office administrators, and billing managers want to see updated copays and deductibles from the eligibility benefit response in the subscriber insurance when configured so that the copay and deductible are updated. In addition, this feature provides the most up-to-date copay and deductible in Enterprise PM as received in the 271 response. Payer and Practice levels are configurable to designate the service type to use and if the provider is in-network or out-of-network. Pre-Services is setup and configured with the assistance of a NextGen Eligibility Inquiry Analyst and documented in the Eligibility Inquiry Administrator Guide.

Enable Eligibility Inquiry User Interface

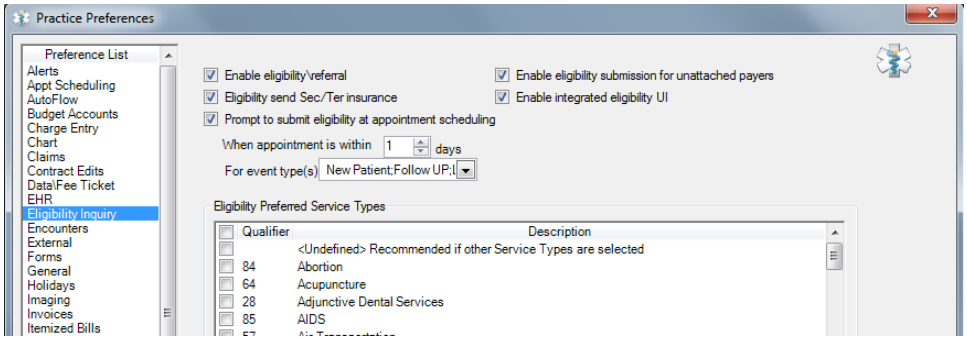
Eligibility Inquiry supports two types of interfaces: *Standard interface* and *Eligibility Inquiry Integrated User Interface (UI)*. Any mention of 'UI' or User Interface refers to the Eligibility Inquiry

Integrated User Interface.

Note: This guide uses User Interface images for its examples.

The Integrated Eligibility User Interface is an option located in Practice Preferences. It can only be enabled by a user with administrator rights to Practice Preferences.

1. In NextGen Enterprise PM click **Admin**, click **Preferences**, and then click **Practice**.
   The Practice Preferences appear.



2. From the Preference List click **Eligibility Inquiry**.
3. Click the **Enable integrated eligibility UI** check-box.
4. Click **OK**.

CHAPTER 2

Eligibility Requests

When an eligibility inquiry is submitted from the NextGen Enterprise PM application, it is electronically sent to the Transaction Server, and then the inquiry is sent to a designated trading partner. The trading partner sends the response back through Eligibility Inquiry where the inquiry results are saved in the patient's chart on the Clinical History/Notes tab under Chart Notes and in the patient's insurance maintenance on the Elig/Ref tab. If a chart does not exist, the results are saved until a chart is created. Once the chart is created, the results are automatically attached to the patient's chart.

Note: Only users who have security rights for this function can submit inquiries.

Submit Eligibility Requests

There are several ways to submit eligibility inquiries:

- Real Time Submission
- Real Time Batch
- Scheduled Batch through the Business Background Processor (BBP)

Eligibility Inquiry transactions are submitted from different NextGen Enterprise® PM access points. The access points are:

- Patient Lookup
- Appointment Book
- Appointment List
- Encounter Lookup

From any of these access points an eligibility inquiry can be submitted for a single patient by right-clicking on the patient, appointment, or encounter, and then clicking Eligibility Inquiry. Regardless of the access point, the User Interface is the same.

Several inquiries can be submitted at one time using batch mode. Manually submitting a batch of eligibility inquiries can be done from the *Appointment Lookup* and *Encounter Lookup*. This *manual batch was referred to* as *Real Time batch*. (Long time RTS users also know this as pseudo-batch.)

Finally, batch eligibility inquiries can be submitted automatically at scheduled intervals through the BBP. For example, eligibility inquiries for future appointments can be scheduled to process overnight.

Eligibility Inquiry Submission

Eligibility Inquiry can be accessed from multiple access points within NextGen Enterprise PM. No matter where Eligibility is accessed, the User Interface is identical. The following table shows the

access points for Eligibility.

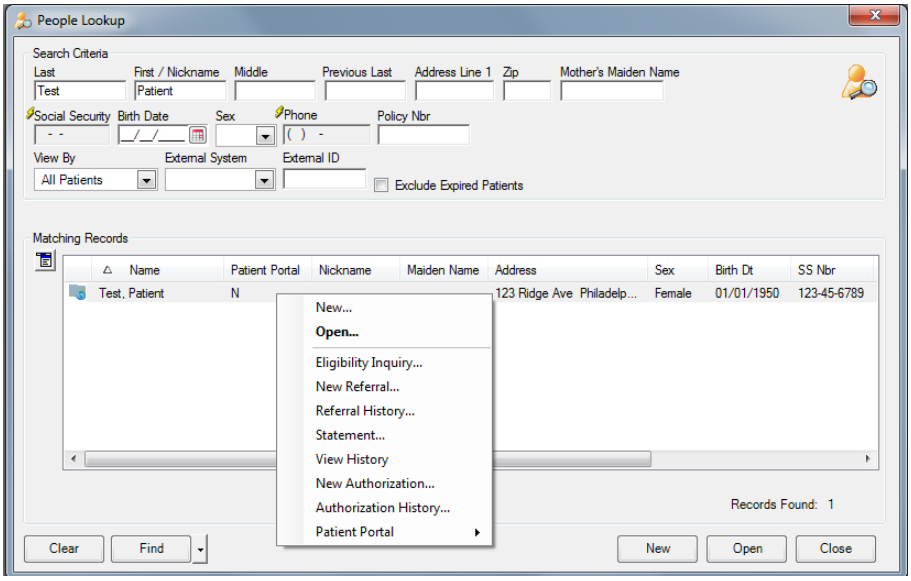
From the…	Use this access path
People/Patient Lookup	Click Tasks menu, then click Lookup, and then click People. Enter search criteria and then click Find. Right-click on the applicable person.
Encounter Lookup	Click Tasks menu, then click Lookup, and then click Encounters. Enter search criteria and then click Find. Right-click on the applicable encounter
Appointment List	Click the Appointment List icon. Enter search criteria and then click Find. Right-click on the applicable appointment
Patient Chart	From a patient's chart click the Encounters tab and then right-click on the applicable encounter From a patient's chart click the Financial tab. Right-click on the applicable encounter.
Appointment Book (Daily, Weekly List, Weekly Schedule, or Multi-View view)	Right-click on the applicable appointment.
Insurance Listing	Click Tasks menu, then click Lookup, and then click People. Enter search criteria and then click Find. Right-click on the applicable patient. Click Open, and then click Insurance on the *People Maintenance* details. Right-click on the applicable Insurance.
Insurance Maintenance	Click on a patient's chart and then click the Insurance tab. Double-click on the applicable insurance, and then click the Elig/Referral tab. Right-click in the window. Note: You can also access the *Insurance Maintenance* dialog box from the Ins/Diag tab on the Appointment Book.

The following example uses the Patient Lookup to run an Eligibility Inquiry on a specific person.

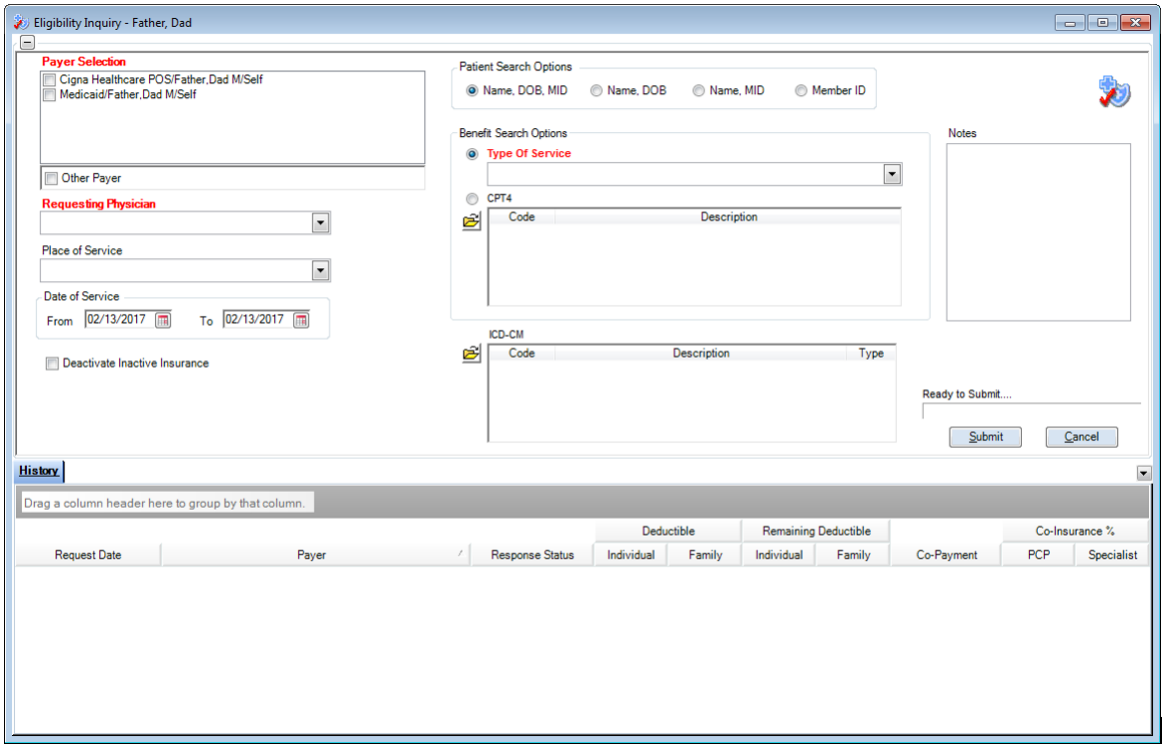
1 Click Lookup  .

The Patient Lookup appears.

2 Select a record, right-click and then click Eligibility Inquiry.



The Eligibility Inquiry appears.



3 Complete the required fields that appear in red:

a) Payer Selection - this field lists all the active payers that are attached to the patients and are marked available in the insurance maintenance.

b) Requesting Physician - this field lists all providers with Eligibility Inquiry license and valid NPI.

c) Benefit Search Options - This field lists all available type of services. This is a required field the first time you use Eligibility Inquiry. On subsequent searches the field is populated with your previous search criteria. You must select at least one type of services to obtain successful response from the payer.

4 Optional fields

a) Other Payer - an optional feature to allow you to send transaction to an unattached payer. For more information, please see the Submit Eligibility for Unattached Payers section.

b) Date Range (allows back date to 1 year) - an optional way to allow you to use date range instead of specific date as a date of service. It defaults to today's date as many payers only provide benefits information for the current date. It allows you to back date up to one calendar year to get historical information.

c) Deactivate Inactive Insurance - an optional way to mark the insurance inactive in the event the insurance response status received from the payer is *INACTIVE*.

Note: Deactivate also marks the payer as inactive in Insurance Maintenance.

Patient Search Options - this option is defaulted to Name/DOB/MI because most payers require you to provide this information for your patient. However, you have the option to change this and use alternate search options. Remember, it is the payer's responsibility to provide you information to submit successful transactions. The search options you select can result in a rejected transaction.

d) Benefit Search Options

- Type of Services – you have many Type of Services to choose from and you need to select at least one service type.
- CPT4 – an optional field to send transaction by CPT code.
- ICD-CM (based on payer availability) – an optional field to send transaction by ICD codes.

Note: CPT4 and ICD codes are not mandated by the industry therefore all payers may not respond to the request.

e) Place of Service - this option allows you to send place of service with the request; however, no payer is requiring this information and the field can be left blank.

f) Notes (not sent to payer but displays on response - 255-character limit)

Other Payers

The Other Payer option allows you to submit eligibility on an unattached payer for the patient. The Payers list displays the available payers and the included payers. Highlight a payer (or double-click the payer) from the *Available* list and then click the right arrow to place the payer in the Included list.

Note: If the option to Submit Other Payer is not displayed, go to Practice Preference to enable.

5 Click Submit.

Once the inquiry is complete the Real-Time Eligibility Response appears.

Run an Eligibility Batch Manually (Real Time Batch)

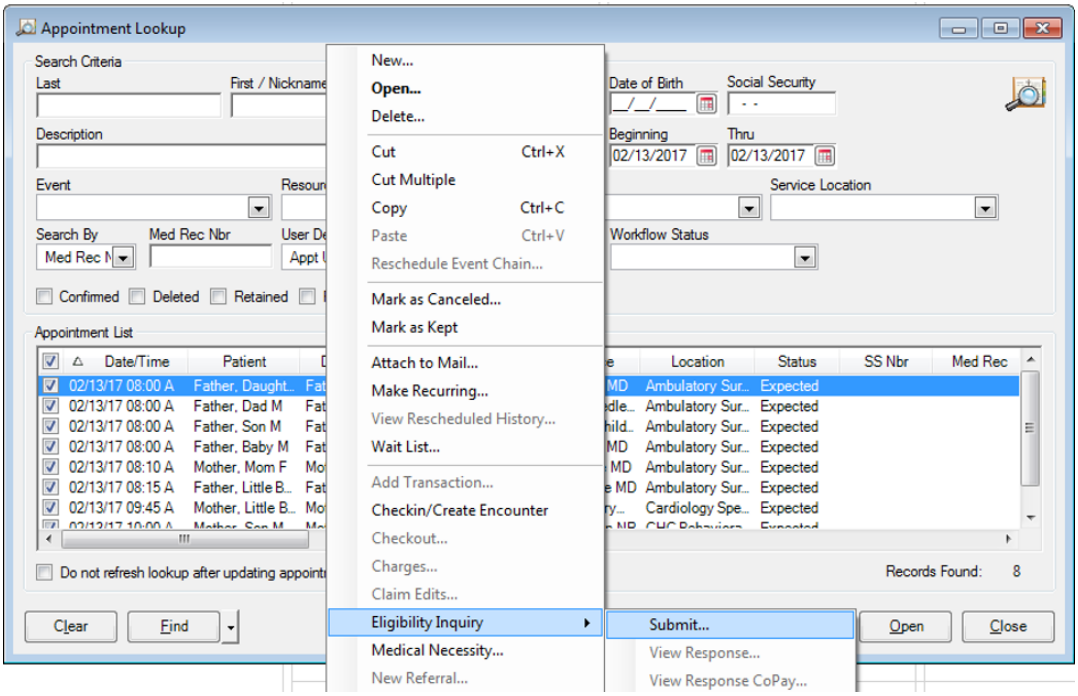
Multiple eligibility inquiries can be manually selected then submitted as a batch from the *Appointment Lookup* and *Encounter Lookup*. This type of select-and-submit batch submission is a Real Time Batch. (Long time RTS users may know this as a pseudo-batch.)

To run a batch manually from the Appointment Lookup:

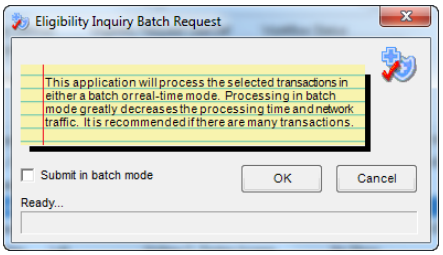
1. In NextGen Enterprise PM, click the Tasks menu, click Lookup, and then click Appointments.

   The *Appointment Lookup* appears depending on whether you are submitting the inquiry from an appointment.
2. Enter the search criteria and click Find.
3. Select the appointments for the patients that you want to include in your batch submission.

   You must select more than one appointment from the list for batch processing.
4. Right-click on a patient and click Eligibility Inquiry and then click Submit.



The *Eligibility Inquiry Batch Request* message appears.



5. Uncheck the Submit in Batch Mode to queue and process one at a time. You get your result in real

time. The amount of time it takes to complete is based on the number of appointments.

Note: If you leave the Submit in batch mode box checked, the inquiries are queued and sent to the Background Business Processor (BBP). The results are not available until after your run a response job.

6 Click OK. The *Eligibility Submit* report appears.

This report shows the submitted inquiries and the status of the submission. For transactions not submitted successfully, the status is 'Unable to Submit.' For unsuccessful submissions, the report provides the reason for the failure. Use the Error Description and Error Location columns to determine why an error occurred and where a correction is needed.

Note: When an Unable to submit status appears, the Elig Status and Elig Response columns on the Appointment List and Encounter List are blank, because the inquiry could not be submitted.

7 Click  to exit from the report.

Note: The report does not save in this view unless you use the export option to save the file in excel or html.

Submit Eligibility in Batch Mode Using Background Business Processor

Eligibility inquiries can be submitted in batch mode using the Background Business Processor (BBP). With BBP, appointment queries are submitted automatically.

Before you can run eligibility inquiries in batch mode, the Eligibility Profiles library must be defined. This library enables you to set up rules to automatically complete the required fields and additional data in batch mode that you would manually enter in the Eligibility Inquiry in real time. These libraries are setup during implementation by your administrator with the help of an Analyst.

Prior to submitting eligibility inquiries in batch mode using the BBP, two jobs must be created: Eligibility Inquiry Request and Eligibility Inquiry Response. The request job queries the appointments and submits the data to NextGen for processing while your response job later takes the results from the NextGen server and delivers the response to your database.

For information on creating a job in BBP for eligibility requests and responses, refer to Eligibility Requests and Creating a Schedule in the "NextGen Background Business Processor User Guide."

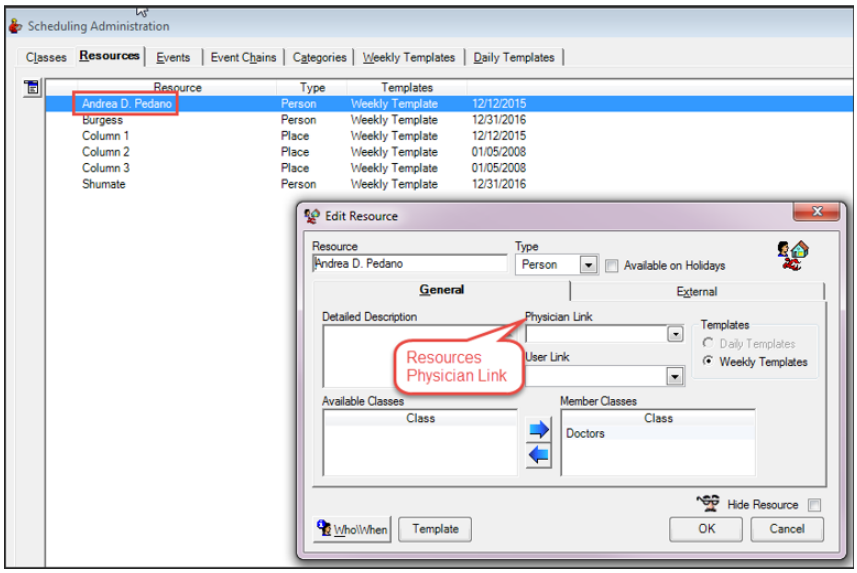
Batch Eligibility when NPI is Missing

Additional examples of how NextGen® Eligibility Inquiries manages eligibility when specific information is missing, or not defined, are listed below:

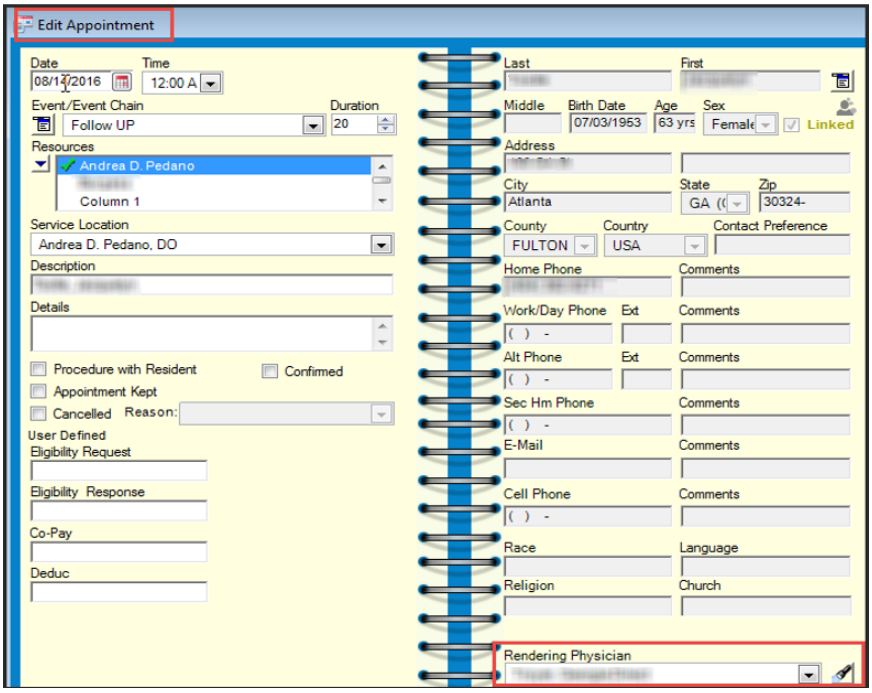
- If the Resources Physician Link does not contain an NPI, Eligibility Inquiry batch eligibility sends the Appointment Rendering Physician NPI as the provider if the Resources Physician Link record does not contain an NPI.
- If the Appointment Resources Physician Link is populated but an NPI does not exist, the Appointment Rendering Physician NPI is used.

- If the Appointment Rendering Physician is not populated, then the Eligibility Profile Library (2100B Loop NM1 Segment(s) Identification Code (NM109) is used.
- If the Appointment Rendering Physician is populated but an NPI does not exist, then the Eligibility Profile Library (2100B Loop NM1 Segment(s) Identification Code (NM109) is used.

The following two images are in sequence and provide an example of editing a response from Scheduling Administration. The first image shows an open Edit Resource accessed through the Admin menu in NextGen Enterprise® PM. When the resource is opened, the Physician Link is blank.



The image below provides an example from the Edit Appointment. When the Physician Link is missing the Rendering Physician is used.



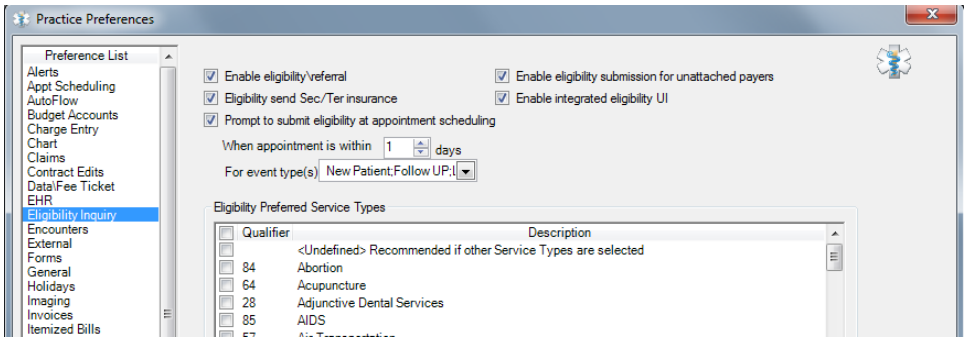
Submit Eligibility for Unattached Payers

Eligibility inquiries can be submitted for a payer without first attaching it to a patient's chart. In the case of Medicare/Medicaid replacements, this process can occur multiple times per patient. This feature allows you to submit an eligibility inquiry for a payer that is not attached to a patient's chart. If active coverage is obtained, then the payer can be attached to the patient with one click. This feature is optional and enabled in Practice Preferences.

Submit Eligibility for Unattached Payers

1 In NextGen Enterprise PM click Admin, click Preferences, and then click Practice.

Practice Preferences display.

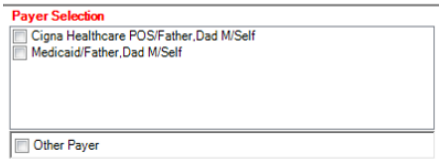


2 Check Enable eligibility submission for unattached payers.

3 Click OK.

To submit eligibility for an unattached payer

1 Select Other Payer.



2 If available, enter MemberID. If MemberID is not available, use another alternate search option.

3 Click Submit.

4 Click OK when prompted with an eligibility message to confirm submission.

The Eligibility Response displays.

5 If you want to attach the payer to the patient, click Add to Patient.

6 Click OK when prompted that the payer has been successfully added to the patient.

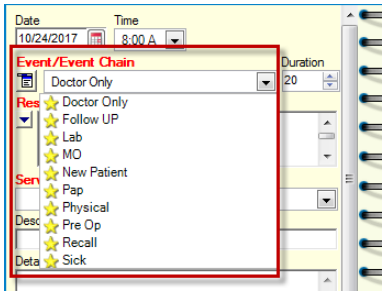
The next time you submit an eligibility for this patient the previous unattached payer automatically displays in the Payer Selection.

Option to Submit Eligibility from Appointment Scheduling

If the Prompt to submit eligibility at appointment scheduling option is enabled in Practice Preferences users are prompted to submit an eligibility request during appointment scheduling. *By default, the option is enabled*.

When enabled from File Maintenance, the eligibility inquiry appears when users create an appointment and the following conditions are met:

- The user has security rights to submit eligibility inquiries.
- The patient has at least one eligibility-enabled payer attached.
- The appointment creation date is within the number of days specified in Practice Preferences.
- An eligibility inquiry for the first payer listed for the patient, that is eligibility-enabled, has not successfully processed an inquiry within the time-frame specified in the payer's Eligibility Profile Library.
- Event chosen on appointment is selected in Practice Preferences to submit eligibility during appointment scheduling.

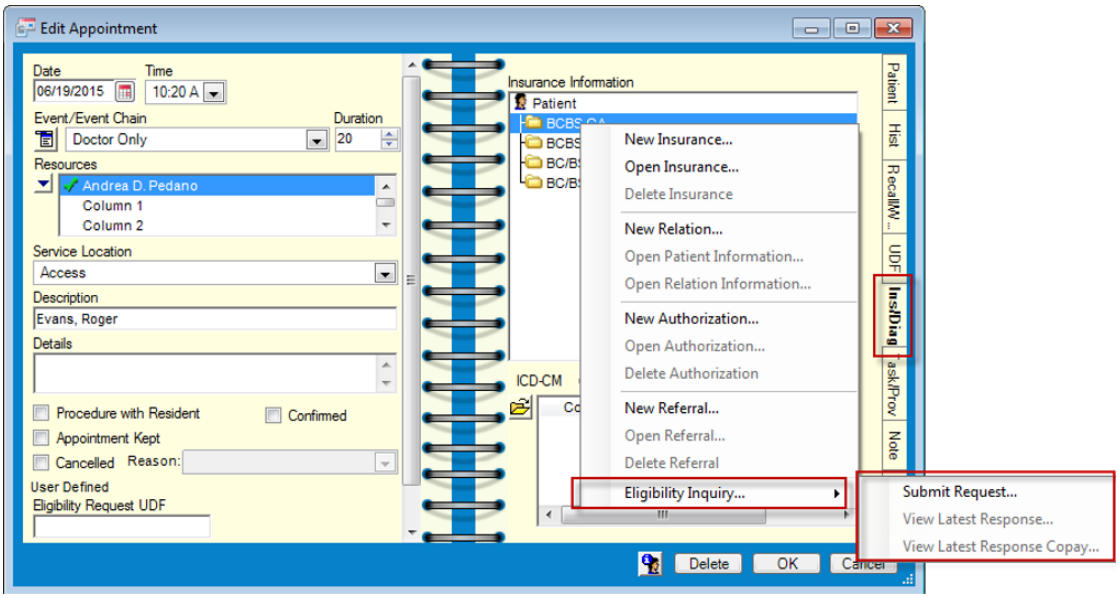


The standard eligibility inquiry window appears when all conditions are met.

Submit Eligibility Inquiry from Add or Edit Appointment

You can submit a patient Eligibility Inquiry when adding or editing an appointment.

1 Add or edit an appointment.



2 From the Add/Edit Appointment, click the Ins/Diag tab.

3 Right-click in the Insurance Information section, and then click Eligibility Inquiry, and then click Submit Request.

The patient's Eligibility Response appears.

CHAPTER 3

Eligibility Responses

Once a successful eligibility is submitted a response is returned by the payer(s). The response displays to the user and is automatically saved to the patient chart. The following sections explains the NextGen® Eligibility Inquiry Response received from the payer.

The User Interface for the Eligibility Response is a powerful, informative feature that is fast to navigate. Color codes and symbols make data easy to understand. With a quick glance you can confirm successful responses as well as alerts notifying you that additional action is required. The responses are Active, Inactive, and Mixed.

When a payer returns a Mixed response, the message is advising providers to contact the payer with further verification. An example is an eligibility response record with a type 'V' (Cannot Process) is handled like type 'U' (Contact for Verification).

The Eligibility Response

Navigation Bar

On the left side of the Eligibility Response a navigation bar appears. The Navigation Bar assists you in locating specific data within the response.

Alerts

Clicking Alerts from the Navigation bar prompts the response to scroll to the alert section at the top of the screen. This allows you to identify if the plan is *active* (green alert) or *inactive* (red alert). Other messages such as when additional payers are found, or if additional verification is needed, orange alerts appear. Furthermore, a blue alert means that the response returned *limited* benefits for service types and need to be reviewed. The Limited panel holds service types with mixed coverage. For instance, Limited coverage could be ACTIVE for insurance when it's in-network but NON-COVERED if the patient is out-of-network.

Summary

The Summary section includes the following:

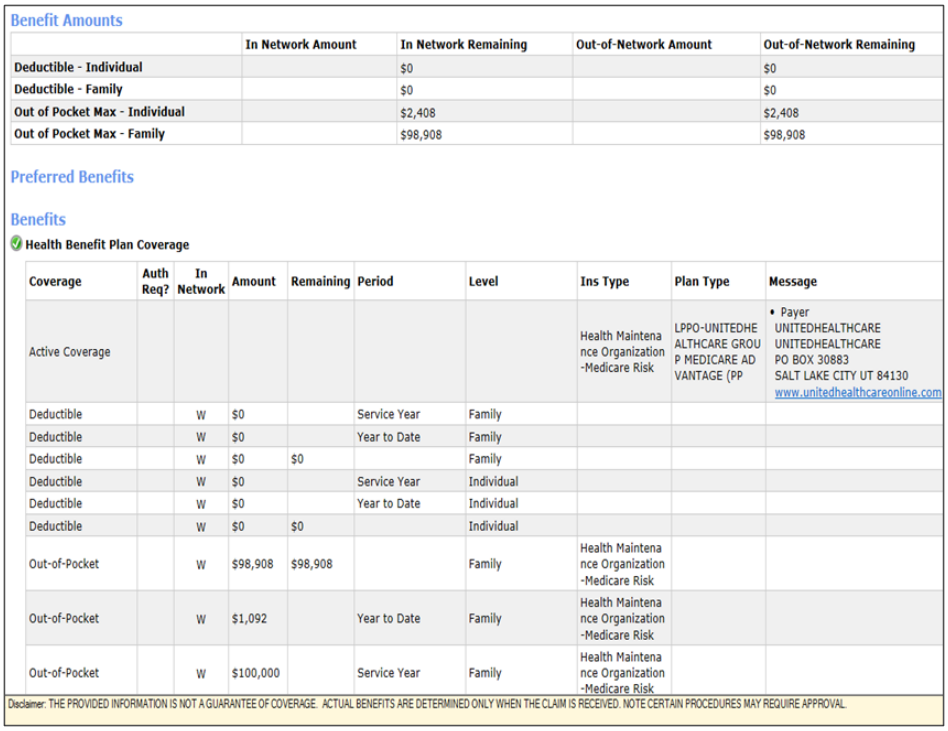
- Patient Demographics
  - Displays information as returned from the payer
  - Displays information as it exists in the NextGen application. A yellow warning symbol appears when discrepancies exist.
- Additional Identification
  - Includes other identifying values as returned the payer such as group number, plan number, or social security number.
- Date Details
  - Includes date information for the payer (policy begin date, for example).
- Payer Details
  - Includes payer details and provider name.
- Payer Information
  - Includes payer related information such as payer name, payer ID, and payer address.

Benefit Details

Benefits data include information such as type of coverage, in and out of network deductible, copay, and out-of-pocket amounts.

Note: When expanded, the Benefit Details option on the Navigation Bar displays the different Types of Service included in the Eligibility request.

Sample Benefits Data:



Benefit Amounts

	In Network Amount	In Network Remaining	Out-of-Network Amount	Out-of-Network Remaining
Deductible - Individual		$0		$0
Deductible - Family		$0		$0
Out of Pocket Max - Individual		$2,408		$2,408
Out of Pocket Max - Family		$98,908		$98,908

Preferred Benefits

Benefits

Health Benefit Plan Coverage

Coverage	Auth Req?	In Network	Amount	Remaining	Period	Level	Ins Type	Plan Type	Message
Active Coverage							Health Maintenance Organization -Medicare Risk	LPPO-UNITEDHEALTHCARE GROUP MEDICARE ADVANTAGE (PP	• Payer UNITEDHEALTHCARE UNITEDHEALTHCARE PO BOX 30883 SALT LAKE CITY UT 84130 www.unitedhealthcareonline.com
Deductible		W	$0		Service Year	Family			
Deductible		W	$0		Year to Date	Family			
Deductible		W	$0	$0		Family			
Deductible		W	$0		Service Year	Individual			
Deductible		W	$0		Year to Date	Individual			
Deductible		W	$0	$0		Individual			
Out-of-Pocket		W	$98,908	$98,908		Family	Health Maintenance Organization -Medicare Risk		
Out-of-Pocket		W	$1,092		Year to Date	Family	Health Maintenance Organization -Medicare Risk		
Out-of-Pocket		W	$100,000		Service Year	Family	Health Maintenance Organization -Medicare Risk		

Disclaimer: THE PROVIDED INFORMATION IS NOT A GUARANTEE OF COVERAGE. ACTUAL BENEFITS ARE DETERMINED ONLY WHEN THE CLAIM IS RECEIVED. NOTE CERTAIN PROCEDURES MAY REQUIRE APPROVAL.

Transaction

Transaction information is used by NextGen to troubleshoot any possible transaction issues. Clients do not need to access this information unless working with a NextGen Support Analyst.

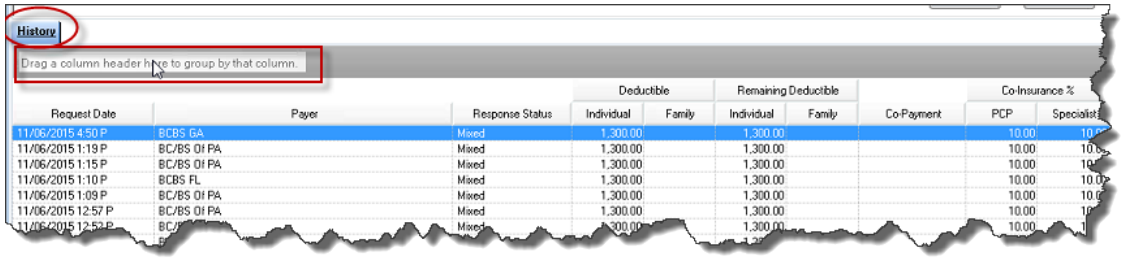
Transaction Data displays technical details related to the Eligibility Inquiry transaction.

Comparison Responses

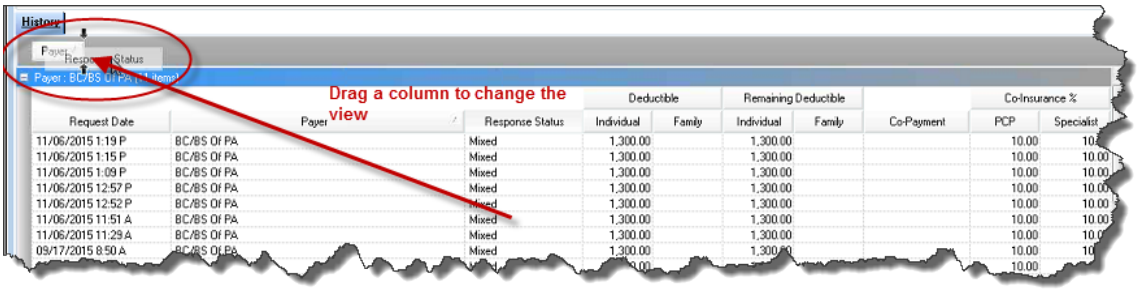
The Response Summary provides a side-by-side comparison between the patient demographics saved in NextGen Enterprise PM and the payer details from the Payer Response. A yellow warning icon displays when there is an inconsistency between the patient's NextGen demographic data and the patient's payer demographic data. The alerts make it easy to know what data needs editing.

History Section

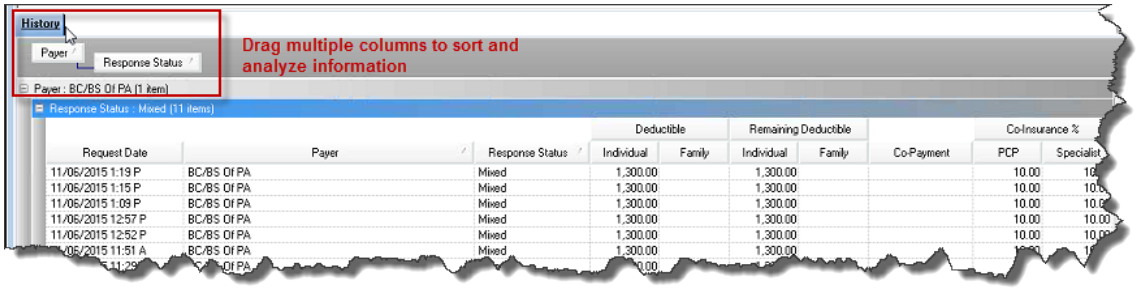
The History section - or History Grid - allows you to view the patient's history over the last 13 months.



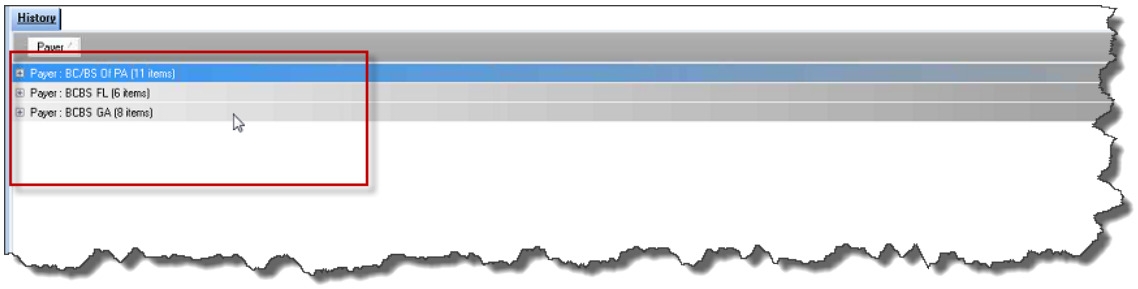
You have several features in the History section including dragging a column to change the view.

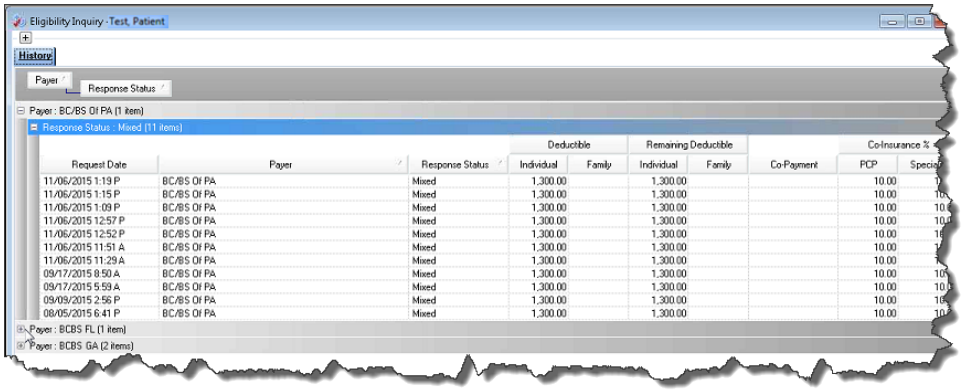


And drag multiple columns to sort and analyze information.



Expand and retract data by clicking + or - symbols.




Eligibility Inquiry - Test, Patient
History
Payer
Response Status
Payer : BC/BS Of PA (1 item)
Response Status : Mixed (11 items)
Deductible
Remaining Deductible
Co-Insurance %
Request Date
Payer
Response Status
Individual
Family
Individual
Family
Co-Payment
PCP
11/06/2015 1:19 P BC/BS Of PA Mixed 1,300.00 1,300.00 10.00
11/06/2015 1:15 P BC/BS Of PA Mixed 1,300.00 1,300.00 10.00
11/06/2015 1:09 P BC/BS Of PA Mixed 1,300.00 1,300.00 10.00
11/06/2015 12:57 P BC/BS Of PA Mixed 1,300.00 1,300.00 10.00
11/06/2015 12:52 P BC/BS Of PA Mixed 1,300.00 1,300.00 10.00
11/06/2015 11:51 A BC/BS Of PA Mixed 1,300.00 1,300.00 10.00
11/06/2015 11:29 A BC/BS Of PA Mixed 1,300.00 1,300.00 10.00
09/17/2015 8:50 A BC/BS Of PA Mixed 1,300.00 1,300.00 10.00
09/17/2015 5:59 A BC/BS Of PA Mixed 1,300.00 1,300.00 10.00
09/09/2015 2:56 P BC/BS Of PA Mixed 1,300.00 1,300.00 10.00
08/05/2015 6:41 P BC/BS Of PA Mixed 1,300.00 1,300.00 10.00
Payer : BCBS FL (1 item)
Payer : BCBS GA (2 items)

CHAPTER 4

Prior Authorization

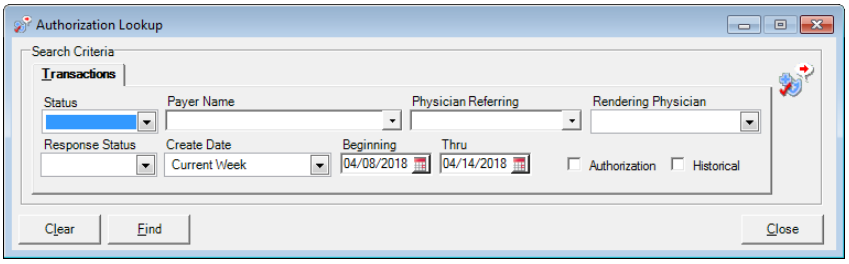
Prior Authorization automatically sends requests to determine a patient's eligibility for future visits and procedures. The authorization request processes and records response information received from the payer. Historical tracking and reporting of the responses is done in NextGen Enterprise PM.

The New Authorization Entry option appears where New/Lookup Referral options are available.

Authorization Lookup

In NextGen Enterprise® PM, click the Tasks menu, then click Lookup, and then click Authorization.

The Authorization Lookup displays.



Here are additional access points to Authorization.

New Authorization Access Points

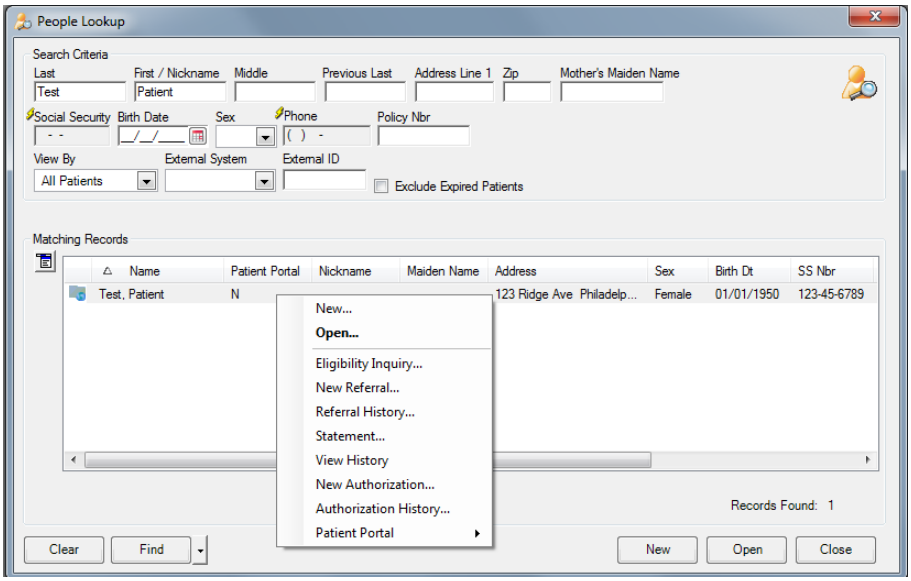
From the…	Use this access path
People/Patient Lookup	Click Tasks menu, then click Lookup, and then click People. Enter search criteria and then click Find. Right-click on the applicable person. Click Authorization History. ▪ Note: There are two distinct views of Person Lookup. Both support authorization transactions. By default, the new look is used by NextGen Enterprise® PM; this can be overridden with the NGConfig.INI file. Contact your NextGen® Eligibility Inquiry Analyst before editing any NGConfig.ini file.
Encounter Lookup	Click Tasks menu, then click Lookup, and then click Encounters. Enter search criteria and then click Find. Right-click on the applicable encounter. Click Authorization History.
Appointment List	Click the Appointment List icon. Enter search criteria and then click Find. Right-click on the applicable appointment
Patient Chart	From a patient's chart click the Encounters tab and then right-click on the applicable encounter. From a patient's chart click the Financial tab. Right-click on

From the…	Use this access path
	the applicable encounter.
Appointment Book (Daily, Weekly List, Weekly Schedule, or Multi-View view)	Right-click on the applicable appointment.
Insurance Listing	Click Tasks menu, then click Lookup, and then click People. Enter search criteria and then click Find. Right-click on the applicable patient. Click Open, and then click Insurance on the *People Maintenance* details. Right-click on the applicable Insurance.
Insurance Maintenance	Click on a patient's chart and then click the Insurance tab. Double-click on the applicable insurance, and then click the Elig/Referral tab. Right-click in the window. Note: You can also access the *Insurance Maintenance* dialog box from the Ins/Diag tab on the Appointment Book.
Update Patient Information	Click Demographics, and then right-click in the Available Insurance section.

Prior Authorization Query from People Lookup

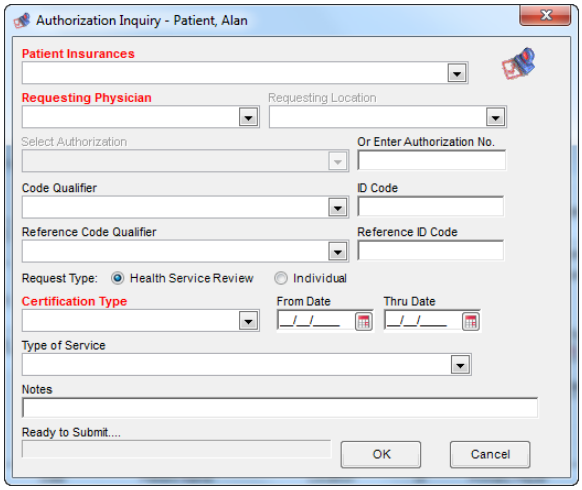
1 Access People Lookup by clicking the Tasks menu, clicking Lookup, and then clicking People.

2 Search for a person.

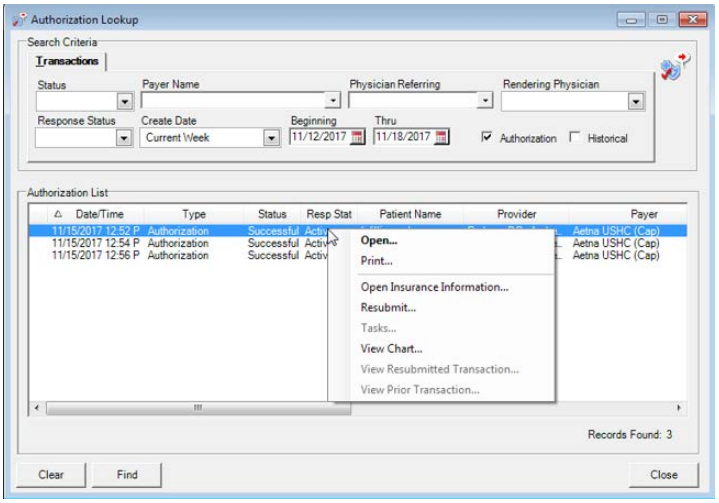


3 Right-click on the person and then click Authorization History.

4 The Authorization Inquiry displays.



Working with Authorization Lookup



From the Authorization Lookup use the following fields to streamline the search.

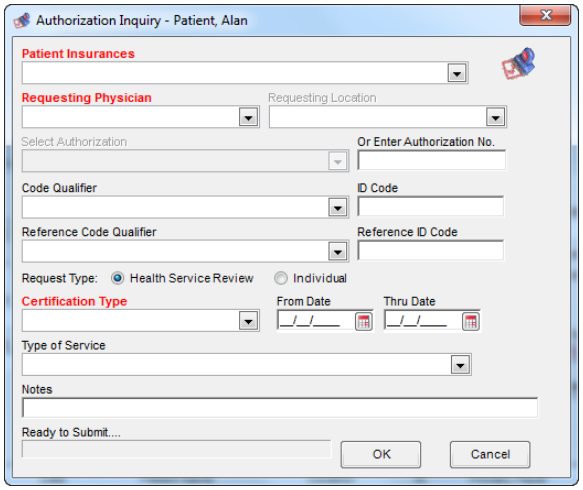
Field	Filter Options
Status	▪ Incomplete ▪ Pending ▪ Successful ▪ Submit Error
Payer Name	Select Payer

Field	Filter Options
Physician Referring	The Referring physician is captured when an encounter is created and reflects the provider that referred the patient for the encounter. If the encounter is created from the Appointment Book check-in process, the provider defaults from the appointment Referring Physician.
Rendering Physician	The rendering physician is captured when an encounter is created and reflects the provider that saw the patient for the encounter. If the encounter is created from the Appointment Book check-in process, the provider defaults from the appointment Rendering Physician.
Response Status	▪ Active ▪ Inactive ▪ Mixed
Create Date	From the list, choose the creation date or date range to filter the search. Click on Custom Date to use the calendar to the right of the Create Date field to filter the search between a specific date range. Clicking in either calendar prompts the Create Date to automatically display Custom Date.

After defining the search filters click Find to view the results.

Authorization Inquiry

1 Select Authorization Inquiry from one of the defined access paths.
The Authorization Inquiry appears.



2 Enter field information according to the following table.

Field	Description
Patient Insurances (Required)	Select the patient's insurance(s). Note: In order for the payer to display in the Patient Insurances field, it must be listed on the *Insurance Listing* dialog box for the specified patient and it must be added to the Eligibility/Referral system.
Requesting Physician (Required)	Select the physician requesting eligibility verification
Requesting Location	Select the location for the requesting physician. If there are no additional locations in the practice, this field does not display. Note: If the list in the Requesting Location field is empty, you do not have a valid provider number for that location and payer. Check the Group Information section of the Provider master file to see if the payer name and a provider number exist for the Requesting Physician
Select Authorization or Enter Authorization Number	Select either the Authorization from the list or enter the Authorization Number in the field.
Code Qualifier	Select a code qualifier from the list.
ID Code	Field available for ID Code.
Reference Code Qualifier	Select the Reference Code Qualifier from the list
Reference ID Code	Enter the Reference ID Code
Certification Type (Required)	A required field, select the Certification Type from the list.

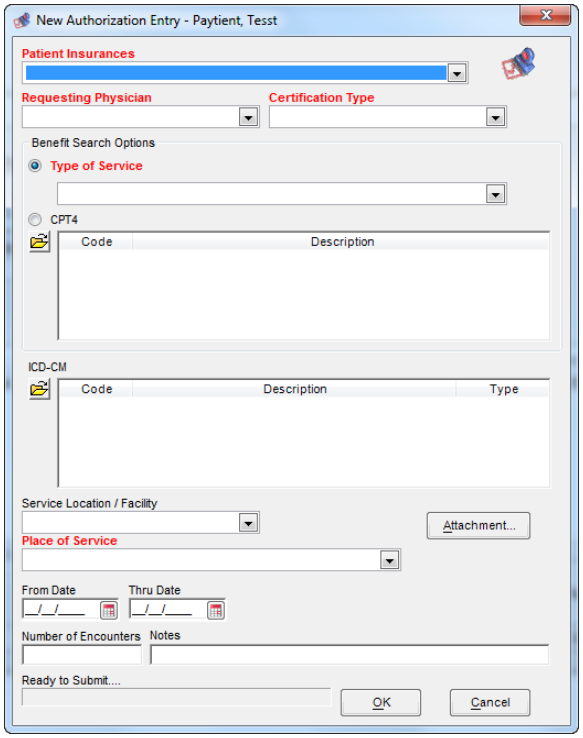
Field	Description
Request Type	Select Health Service Review or Individual
From Date **Thru Date**	Select this option to enter a date range for the date of service. Enter the beginning date in the From Date field and enter the ending date in the Thru Date field. Click the calendar button to select the dates from the calendar.
Type of Service	Select the type of service from the list.
Notes	Enter any additional information. The field length is a maximum of 255 characters. Note: The data in the Notes field is not sent with the transaction but is returned with the transaction response. If this is printed and provided to the patient, the notes displays, so it is recommended for internal use only.

3 Click OK.

Adding a New Authorization Entry

Enter the information for the new authorization.

1 Select Add New Authorization from one of the defined access paths.
The New Authorization Entry appears with the patient's name.



2 Enter field information using the following table.

Field	Description
Patient Insurances (Required)	Select the patient's insurance(s). Note: For the payer to display in the Patient Insurances field, it must be listed on the *Insurance Listing* for the specified patient and it must be added to the Eligibility/Referral system.
Requesting Physician (Required)	Select the physician requesting eligibility verification
Certification Type (Required)	Select the Certification Type.
Type of Service (Required)	Select one or more types of service.

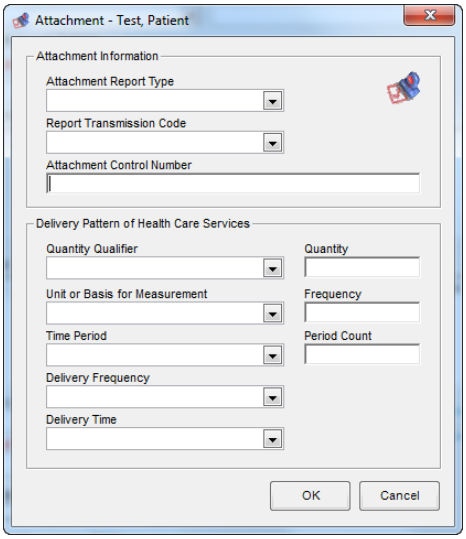
Field	Description
CPT4	Select a procedure code by clicking the Open Record button. This field enables you to determine coverage for the treatment of a specific procedure. You can select up to 99 CPT codes. If you exceed 99 codes, you receive a message that you have exceeded the number of codes allowed. NOTE: Currently Medicare is the only payer that is processing explicit benefit requests by submitting CPT codes; however all payers are required to return a standard eligibility response if CPT codes are submitted.
ICD-CM	Select a diagnosis code by clicking the Open Record button. This field enables you to determine coverage for the treatment of a specific diagnosis. This is an optional field and cannot be submitted in batch mode.
Date of Service	Select this option to enter a single date of service. Enter the date of service or select a date using the calendar button. Do NOT select a future date.
Service Location/Facility	Select the location or facility for the requesting physician. If there are no additional locations in the practice, this field does not display. Note: If the list in the Requesting Location or Facility field is empty, you do not have a valid provider number for that location and payer. Check the Group Information section of the Provider master file to see if the payer name and a provider number exist for the Requesting Physician.
Place of Service (Required)	Select the place of service for the encounter from the list.
From Date **Thru Date**	Select this option to enter a date range for the date of service. Enter the beginning date in the From Date field and enter the ending date in the Thru Date field. Click the calendar button to select the dates from the calendar.
Number of Encounters	Type the number of encounters for this authorization.

Field	Description
Notes	Enter any additional information. The field length is a maximum of 255 characters. Note: The data in the Notes field is not sent with the transaction but is returned with the transaction response. If this is printed and provided to the patient, the notes displays, so it is recommended for internal use only.

3 Click OK.

New Authorization Attachment

The Authorization Attachment appears.



Select the fields to attach to the authorization.

Attachment Information:

Field	Description
Attachment Report Type	The data displayed in this list is data defined in the Encounter Maintenance Claims tab, Attachments sub-tab.
Report Transmission Code	The data displayed in this list is data defined in the Encounter Maintenance Claims tab, Attachments sub-tab.
Attachment Control Number	The data displayed in this list is data defined in the Encounter Maintenance Claims tab, Attachments sub-tab.

Delivery Pattern of Health Care Services

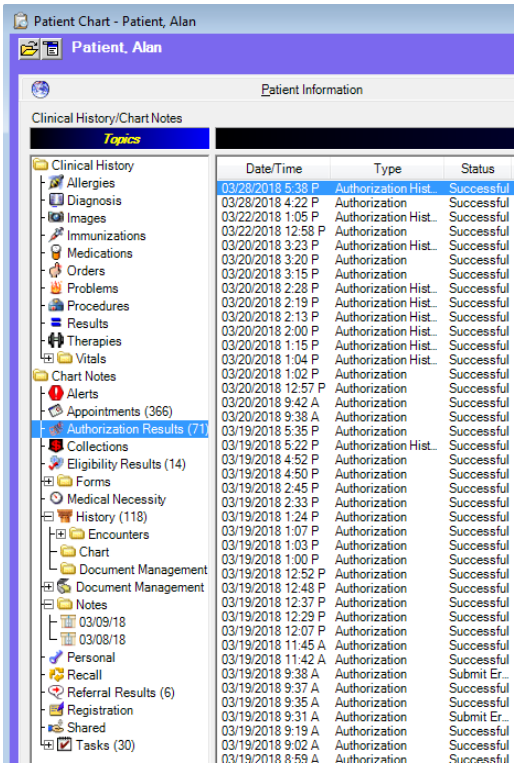
Select any additional information from this section to attach to the entry. Click OK to save changes.

Authorization Results

Authorization Results are saved to a patient's chart and are available for review and reporting.

Access Authorization Results on Patient Chart

1. In NextGen Enterprise PM, open a patient's chart.
2. From the Topics list on the far left click the Clinical History/Notes tab. This expands the Chart Notes folder.
3. From the Chart Notes folder click Authorization Results. The patient's Authorization History appears.



The Authorization Details displayed are the following:

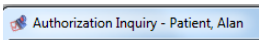
- Date/Time
- Type (Authorization)
- Status
- Patient Name
- Provider
- Payer
- Insured
- Rendering Provider

4 From the authorization details you can right-click and do the following:

- Open - View the authorization results
- Resubmit - Resubmit a previously submitted authorization
- New Authorization - Submit a new authorization
- Authorization History - opens Authorization Inquiry

Authorization History to Authorization Inquiry

When Authorization History is selected from any of the available access points, the Authorization Inquiry appears. The patient's name also displays at the top of the Authorization Inquiry.



CHAPTER 5

Pre-Services and Estimate Patient Cost

Pre-Services is an optional service available to clients using Eligibility Inquiry. Patients are often confused by medical bills and confusion is one of the main reasons bills are unpaid. To reduce confusion, Pre-Services is a service solution that provides clear, explained cost estimates prior to services being rendered. This helps to improve the revenue cycle process and collections at the time of service.

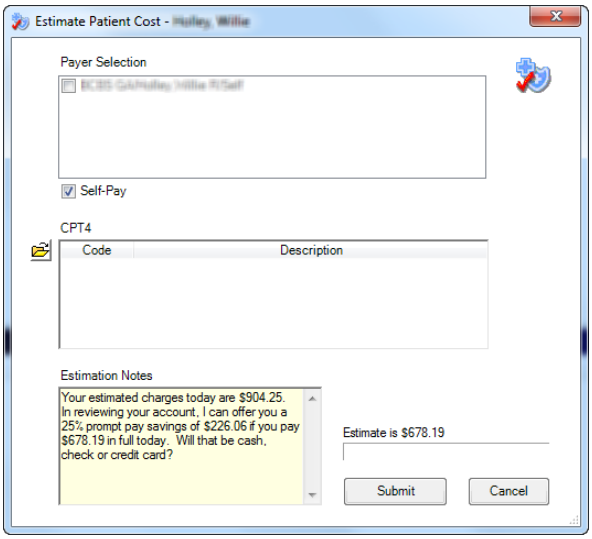
This is AN OPTIONAL SERVICE and this chapter covers end-user features AFTER implementation and Administrator training.

Pre-Services setup is covered in detail in the Eligibility Inquiry Admin Guide.

Estimate Patient Cost

The Estimate Patient Cost feature is accessed from the Appointment Book.

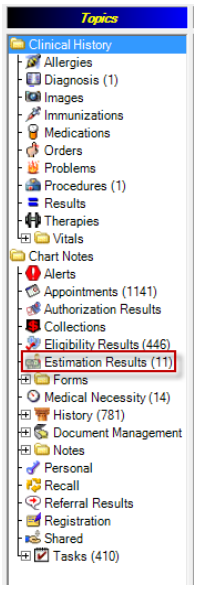
1. From PM, open the Appointment Book.
2. Right-click on an appointment and then click **Estimate Payment Cost**.
   The Estimate Patient Cost for that patient appears.



Note: If you receive a message: *Unable to process your request. The patient does not have a supported insurance.* check the insurance maintenance.

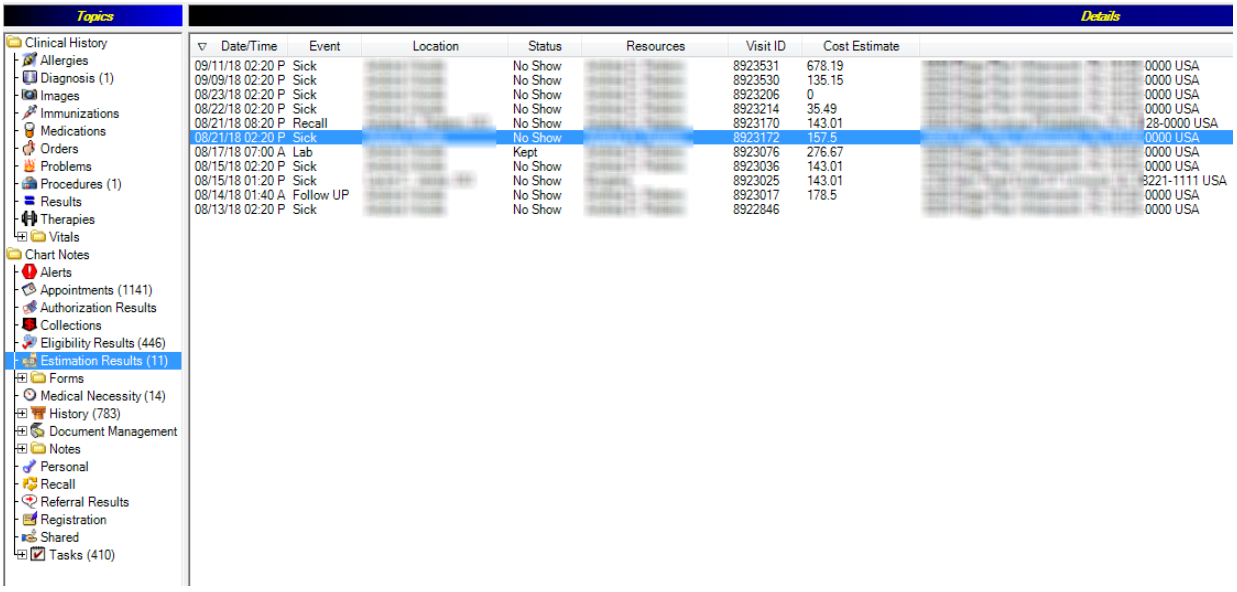
Once submitted, a letter is generated that shows patient responsibility.

All cost automation is saved and accessible in the patient's Clinical History Chart.



Estimation Results

Click the Estimation Results from the Topics menu and view details and cost estimates of the patient.



Double-clicking on a specific appointment allows you to view and edit the details of the appointment.

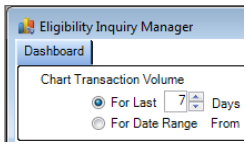
CHAPTER 6

Eligibility Inquiry Manager

When activated, access Eligibility Inquiry Manager by clicking one of the following:

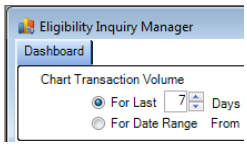
Eligibility Inquiry Manager button	
Tasks menu	Eligibility Inquiry Manager

Eligibility Inquiry Manager appears.



Eligibility Manager Eligibility Graph

The Transaction Chart displays from the NGEI Manager Dashboard. The bar graph is a display of transactions grouped by request date.



The Chart Transaction Volume allows you to chart transactions for the last 62 days. You can also click to enable Date Range fields.

A legend in the right of the chart explains the meaning of each color in the chart.

Transaction Dates

The Eligibility Manager Dashboard allows you to view transaction on a specific date or date range. The robust feature allows you to search for transactions up to 62 days from the current date. You can also click to enable Date Range fields. The range remains 62 days.

Clicking on any colored portion of a bar changes what appears.

Eligibility Inquiry from Eligibility Manager

To perform an eligibility inquiry from Eligibility Inquiry Manager click on a patient from the Eligibility Inquiry Manager grid. With the patient row highlighted, right-mouse click and then click Eligibility Inquiry.

The Eligibility Inquiry appears with the patient's name highlighted in the Title bar.

View Eligibility Response

Double-click a patient's name displayed in the Dashboard grid to view that patient's eligibility response.

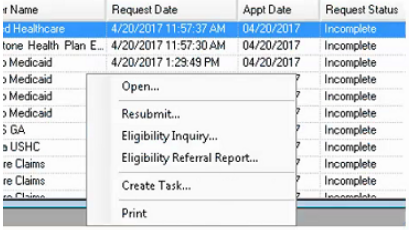
To return to the Dashboard click the Dashboard tab next to the patient's name in Eligibility Response.

Double-clicking another patient's name from the Dashboard grid displays that patient's eligibility response. You can open multiple patient's eligibility response information and tab through each by clicking the patient's tab.

Task Creation from Eligibility Inquiry Manager

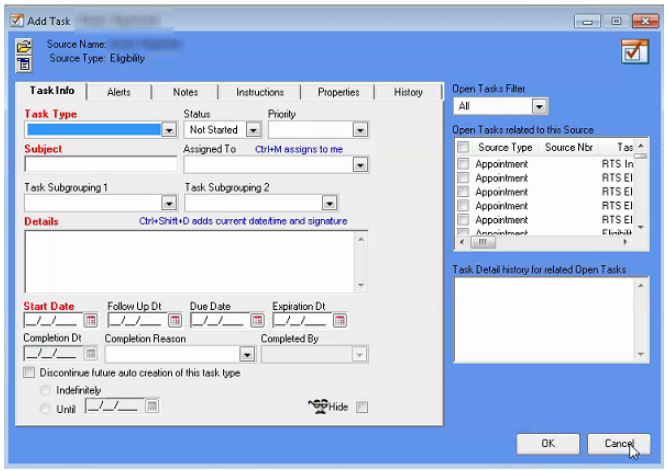
You can easily create tasks from Eligibility Inquiry Manager following these instructions:

1 Right-click on any item listed in the Eligibility Inquiry Manager grid.



2 Click Create Task from the menu.

The Add Task feature appears.



3 Create the task.

Print from Eligibility Manager

You can print the Transaction Chart or the Dashboard Grid from the Eligibility Inquiry Manager by doing one of the following:

- Right click on the chart and click Print.

  The chart prints in landscape mode and fits 1 page tall by 1 page wide.
- Right click on the grid and click Print.

  The grid prints in landscape mode and fits 1 page wide.

Generate Eligibility Report from Eligibility Manager

To perform an Eligibility Referral Report from the Eligibility Inquiry Dashboard right-click anywhere in the Dashboard grid. Click Eligibility Referral Report.

The NextGen Report Filter appears. Use the Settings List and the available columns to create your Eligibility Referral Report.

CHAPTER 7

Claim Status

Claim status enables you to find out the status of a claim and where it is in the adjudication process. Claim status inquiries can be submitted in batch mode or one at a time for electronic claims with a status of archived. You can schedule claim status checks to run in batch mode automatically at set intervals through BBP.

The results of an inquiry display the following information:

- If the claim was rejected and why
- The check number the claim is associated with, if the information is available.

Before you can submit claim status inquiries, you must set up the Claim Status Profile library. This library enables you to set up rules to automatically complete the required fields and additional data required for processing.

Set Claim Status to Run Automatically

You can schedule claim status inquiries to run in batch mode automatically at set intervals through BBP.

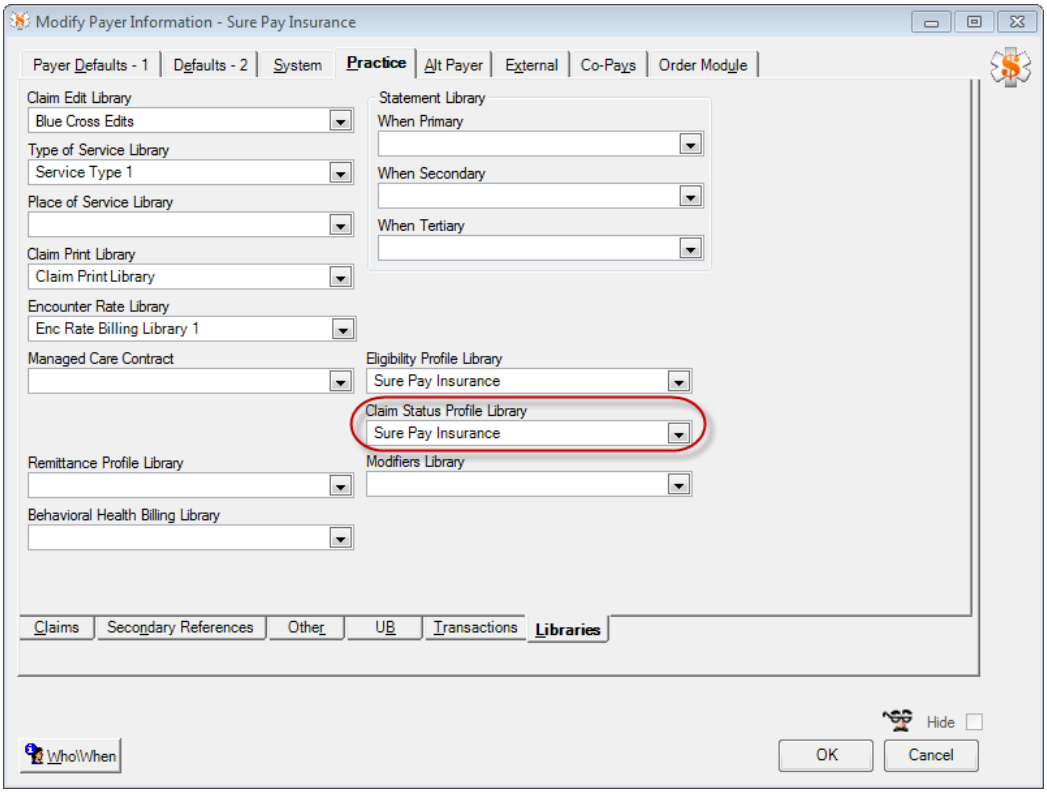
To run a batch automatically:

1. In BBP, create an Eligibility Inquiry Claim Status Request job.

   Reference: For information on creating a job in BBP for a claim status check, refer to the *NextGen Background Business Processor User Guide.*

2. In File Maintenance, set up a Claim Status Profiles library defining the rules for submitting claim status inquiries.
3. In File Maintenance, click Master Files - System list > Payers > Practice tab > Libraries sub-tab.

   The *Modify Payer Information* appears.
4. Attach the Claim Status Profile Library to the payer and click OK.



5 Your Eligibility Inquiry Analyst assists with this setup.

When you complete these steps, claim status inquiries are automatically generated from BBP.

Run a Claims Status Batch Manually

Claim status inquiries can be submitted manually, in batch mode, from the *Claim Request Lookup*. Individual inquiries can be submitted manually or multiple inquiries submitted in batches.

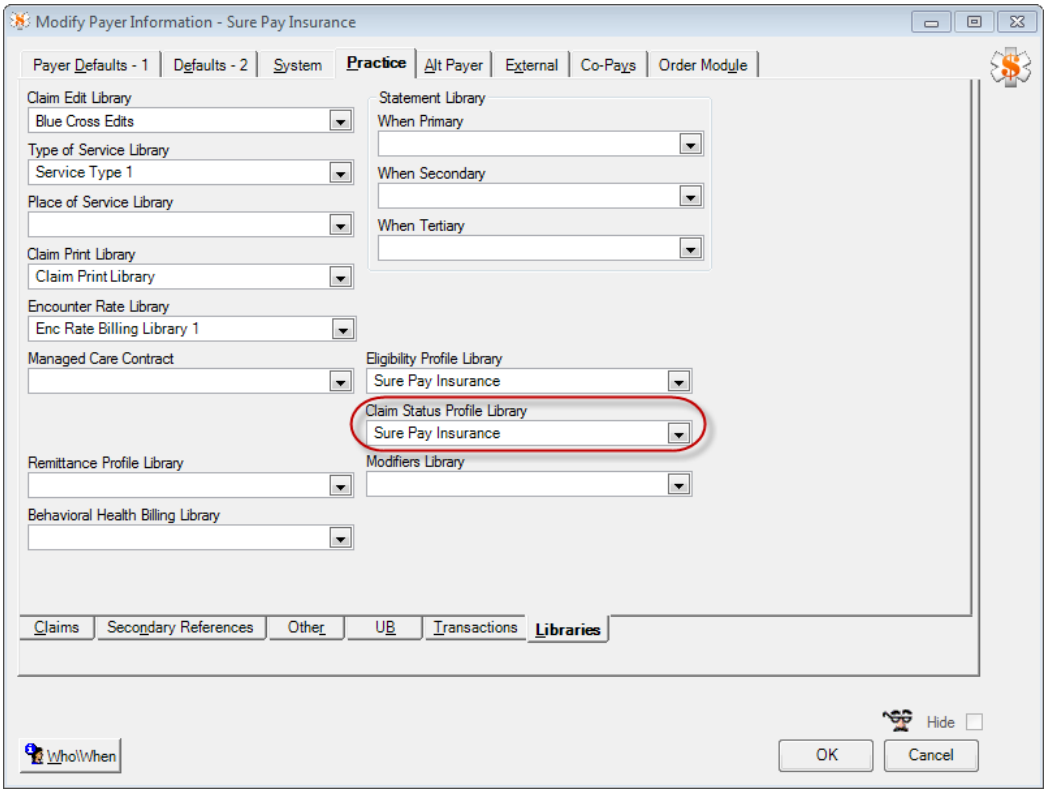
To run a batch manually:

1 In File Maintenance, set up a Claim Status Profiles library defining the rules for submitting claim status inquiries.

2 In File Maintenance, click Master Files - System list > Payers > Practice tab > Libraries sub-tab.

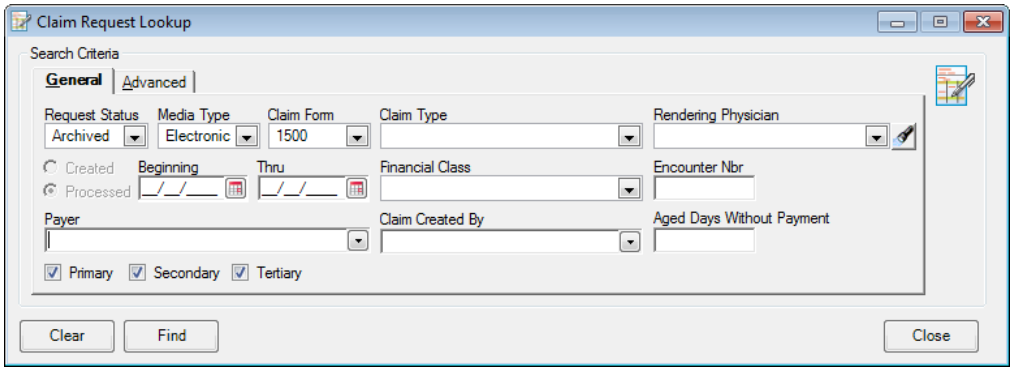
The *Modify Payer Information* appears.

3 Attach the Claim Status Profile Library to the payer and click OK.



4 Click the Tasks menu > Lookup > Claims.

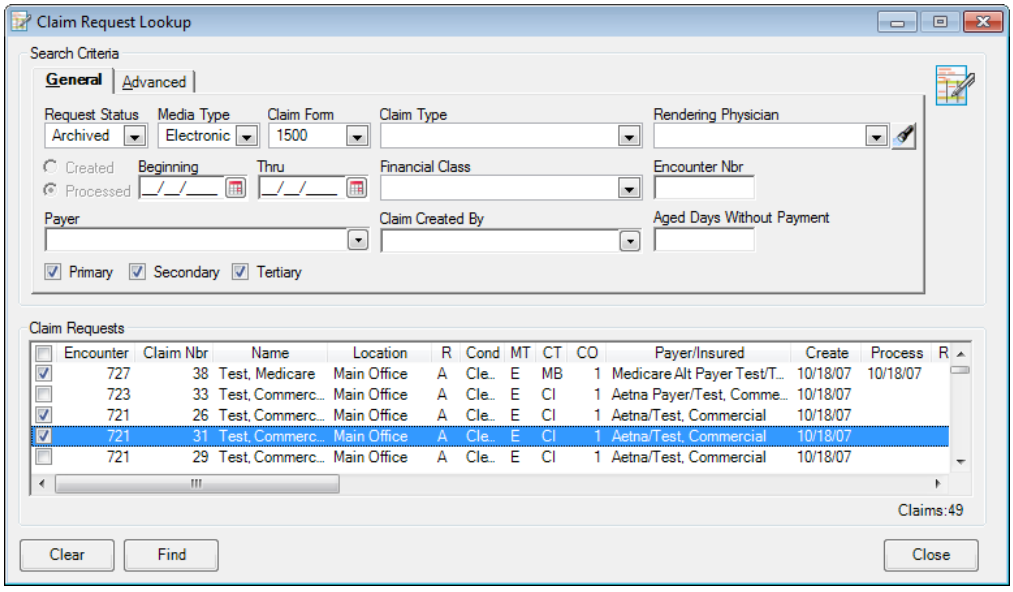
The *Claims Request Lookup* appears.



5 In the Request Status field, select Archived.

6 In the Media Type field, select Electronic.

7 Enter additional search criteria, if applicable and click Find.

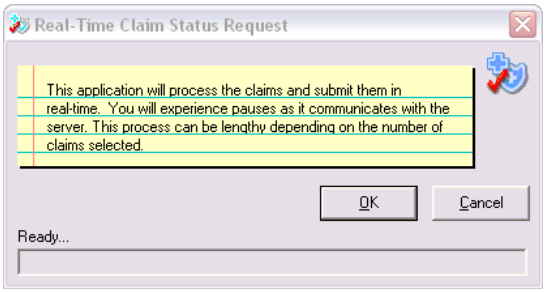


8 Select the claim(s) that you want to include in your batch submission.

You can select one or more claims.

9 Right-click and select Claim Status Request.

The *Real-Time Claim Status Request* appears.



10 Click OK.

The *Claim Status Import* report appears. This report shows the inquiries that were submitted and displays the claims' status. Use the Additional Status Information and Message columns to determine why an error occurred and where to make the correction. Click ✖ to exit from the report.

View Claim Status Results on the Patient Chart

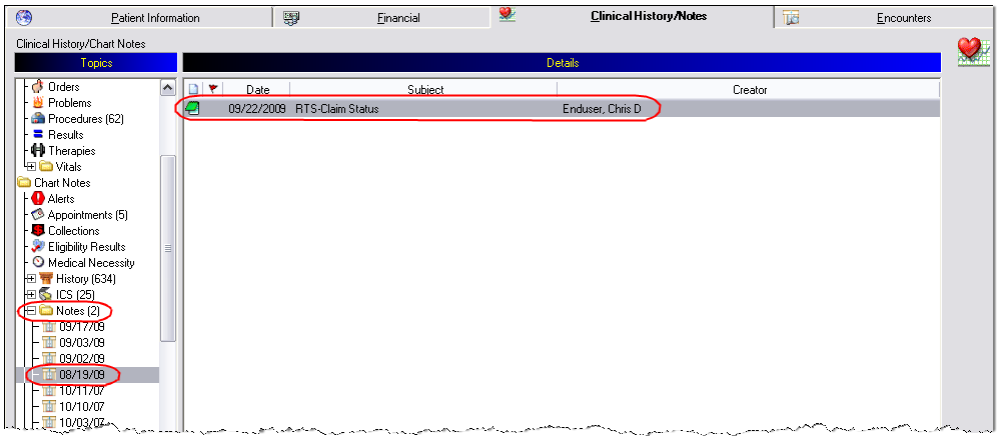
Quicknotes are automatically added to the patient chart when the claim status is run. You can view solicited and unsolicited claim status results from the claim status batch in a quicknote, which is attached to an encounter. Quicknotes are only created if the referenced 277 finds the encounter ID and the patient ID.

1 Open the patient chart and click the Clinical History/Notes tab.

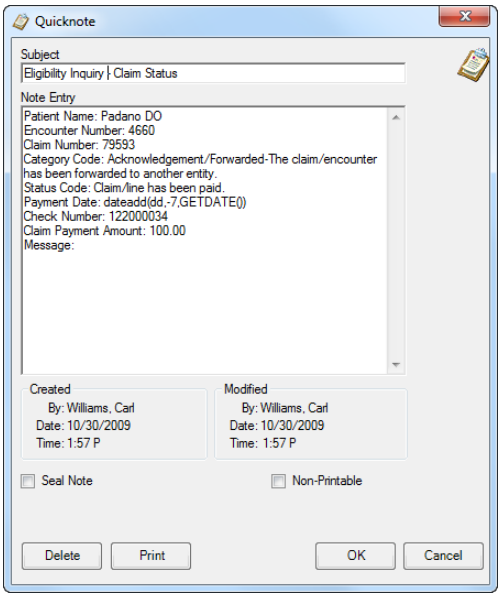
The *Clinical History/Notes* window lists the Topics section on the left and the Description section on the right.

2 In the Topics section, expand the Notes folder under the Chart Notes.

3 Double-click on the note you want to access or right-click and select Open from the shortcut menu.



The *Quicknote* appears.



CHAPTER 8

Reports

This section provides information on the reports used in NextGen® Eligibility Inquiry. These reports include:

- The *Eligibility Referral Listing* report
- *Reconciliation Reports*
- The *Claims Requests* report

  See the *NextGen Enterprise® PM Reports Guide* for detailed information on Reporting.

In addition, Eligibility Inquiry users have Enhanced Reports. Enhanced reports are not available for Legacy reporting. These enhanced reports are:

- The Eligibility Inquiry Benefit report
- The Eligibility Inquiry Status report

Modify Eligibility Referral Listing Report

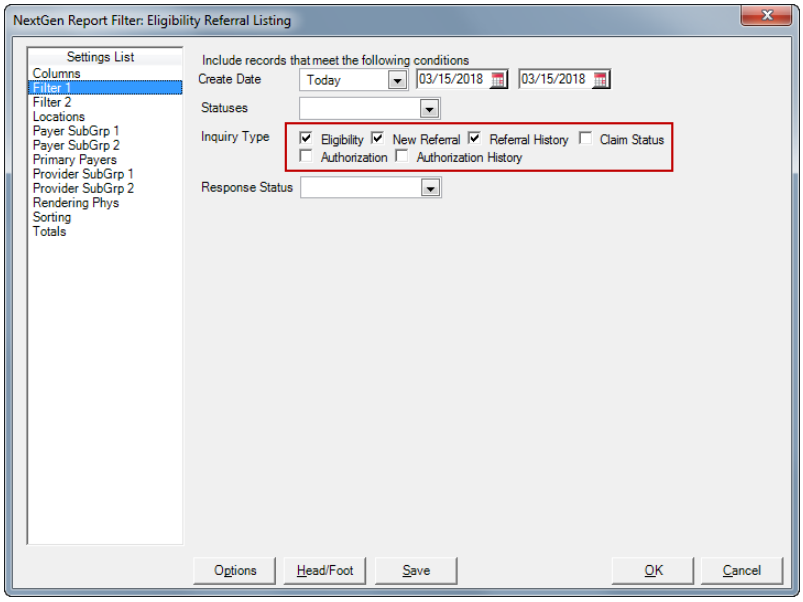
The Eligibility Referral Listing Report tracks eligibility and referral inquiries. Generate reports for specific time periods, statuses, and specific eligibility information. Access the patient's chart by double clicking on the patient name in the report. Double click on the response status to open the eligibility response. If the item selected in the report is in either a Pending or a Submit Error status, only the current status appears.

Modify Eligibility Referral Listing Report

Customize the Eligibility Referral Listing Report:

1 Click the Reports menu and then click General, and then click Eligibility Referral.

The *Report Filter: Eligibility Referral Listing* appears.



2 In the Settings List, click **Filter 1**. The Filter 1 appears.

The Inquiry Type section provides eligibility, referral, claim status, and authorization filters including history.

3 Select the criteria that you want to base your report on. For example, you may want the report to show listings for the current month or for an individual rendering physician.

4 You have the option to filter by Response Status. The options are Active, Inactive, and Mixed.

5 Click **OK** to generate the report.

The *Eligibility Referral Listing* report appears, displaying any selected columns.

Reference: For information on the report toolbar buttons, refer to the *Reports Guide for NextGen Enterprise PM*.

---

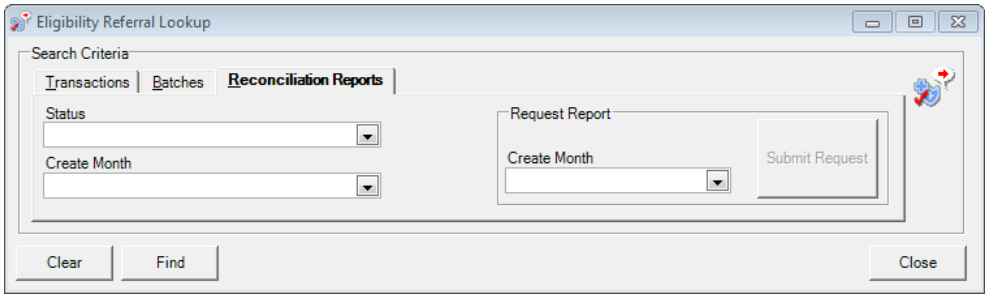
6 Click ⊠ to exit from the report.

Reconciliation Reports

The Reconciliation Report allows you to match the Eligibility Inquiry monthly invoice with the monthly transaction. This report is designed specifically for clients with a "per transaction" billing model. If you are currently being billed by the number of providers you have, this option is *not* designed for you.

1 Click the **Reconciliation Report** tab.

The *Reconciliation Report* tab appears.



2 In the Request Report section, select the month in the Create Month field.

3 Click the Submit Request button.

A request is sent to the Eligibility Inquiry server and BBP to generate the report. You must have the Eligibility Inquiry reconciliation report response job set up in the BBP.

4 Use the BBP Manager to import the report from the server.

5 To view the submitted reports, select a status in the Status field.

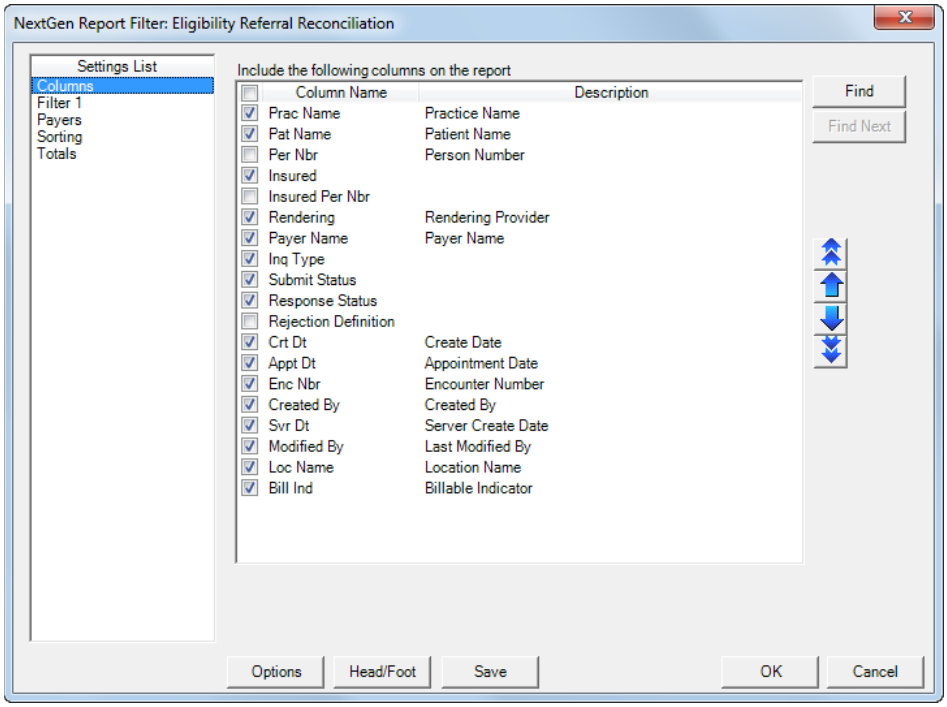
6 Select an option in the Create Month field.

Note: You can leave the Status field blank. The 1 Month Back option is recommended, unless you need to select a longer time period for auditing purposes.

7 Click Find to display the results.

8 To view the report in NextGen Enterprise PM, click Reports, click General, and then click Eligibility Referral Reconciliation.

The *NextGen Report Filter: Eligibility Referral Reconciliation* appears.



9 Use the Settings List column to select specific options, and then click OK.

Modify Payer Listing Report

The Payer Listing Report uses fields defined in File Maintenance's *Modify Payer Information*. The Payer Listing Report provides additional information for Eligibility Inquiry users *if* the option is enabled.

Claim Requests Report

The Claim Requests report enables you to generate a list of claims for specific practices, encounters, and service locations.

The Acknowledgment Status and Claim Status Category columns can be included on the report to include results from 997 and 277/277u transactions submitted to payers using NextGen Eligibility Inquiry.

To access the report in NextGen Enterprise PM, click the Reports menu and select General and then select Claim Requests.

Claim Requests Report Columns

The following columns are available on the *Claim Requests* report:

Column Name	Description	Data Populates From
Ack Status	Acknowledgment Status	997 Transaction
Attachment Indicator	Attachment Indicator	Encounter Maintenance > Claims > Attachments
Billed Amt	Billed Amount	Charge Posting
Case #	Case Management Number	Case Management > General
Case CSC Prog	Case Management CSC Program	Case Management > Financial
Case Desc	Case Management Description	Case Management > General
Case Eff Date	Case Management Effective Date	Case Management > General
Case Exp Date	Case Management Expiration Date	Case Management > General
Case Sts	Case Management Status	Case Management > General
Church	Church	Patient Information
Claim Cond	Claim Condition (Abbreviated)	Claim Information
Claim Cond Desc	Claim Condition Description	Claim Information

Column Name	Description	Data Populates From
Claim Form	Claim Form: 1500, UB, ADA	Insurance Information
Claim ID Nbr	Claim ID Number	System Assigned Number
Claim Status Category Desc	Claim Status Category Description	277 or 277u Transaction
Claim Status Code Desc	Claim Status Code Description	277 or 277u Transaction
Claim Type	Claim Type	Insurance Information
COB	COB Indicator	Encounter Insurance Selection
Contracted Ind	Contracted Payer Indicator	Payers Master File
Created By	Created By	Modification Information
Crt Dt	Create Date	Modification Information
CSC	Consolidated Services Claim	Displays Y (Yes) for CSC claims in Pending or Archived status Displays N (No) for all other claims, including Candidate Encounter claims in HOLD or Consolidated status
CSC TS	CSC Timespan	Displays one of the following for claims in HOLD or Consolidated status: Daily / Weekly / Monthly / Case
Ctrl Nbr	Control Number	Encounter Maintenance > Claims > Attachments
Encounter	Encounter Number	Encounter Maintenance
Ethnicity Category	Ethnicity Category	Ethnicity Category Mapping Master File Note: Multiple entries are separated by commas.
Financial Class	Financial Class	Insurance Information
Insured Addr	Insured Address	Insured Information
Insured CityStZip	Insured City/State/Zip	Insured Information
Insured Name	Insured Name	Insured Information
Insured Policy #	Insured Policy Number	Insurance Information
Media Type	Media Type (Abbreviated)	Insurance Information

Column Name	Description	Data Populates From
Media Type Desc	Media Type Description	Insurance Information
Mod Dt	Last Modified Date	Modification Information
Modified By	Last Modified By	Modification Information
Pat Addr	Patient Address	Patient Information
Pat BDate	Patient Birth Date	Patient Information
Pat CitySt Zip	Patient City/State/Zip	Patient Information
Pat Day Phone	Patient Day Phone	Patient Information
Pat EMail	Patient Email	Patient Information
Pat Expired	Expired Indicator	Patient Information
Pat Expired Date	Patient Expired Date	Patient Information
Pat Home Phone	Patient Home Phone	Patient Information
Pat Marital	Patient Marital Status	Patient Information
Pat Marital Desc	Patient Marital Status Description	Patient Information
Pat Name	Patient Name	Patient Information
Pat Smoker	Patient Smoker Indicator	Patient Information
Pat Student	Patient Student Status (Abbreviated)	File Maintenance > Code Table
Pat Student Desc	Patient Student Status Description	Patient Information
Pat Veteran	Patient Veteran Indicator	Patient Information
Payer Name	Payer Name	Claim Payer
Per Nbr	Person Number	Patient Information
Prac Name	Practice Name	The practice in which the patient has the recall plan
Pref Language	Preferred Language	Patient Information
Proc Date	Process Date	Claim Information
Race	Race	Patient Information Note: Multiple entries are separated by commas.

Column Name	Description	Data Populates From
Race Category	Race Category	Race Category Mapping Master File Note: Multiple entries are separated by commas.
Religion	Religion	Patient Information
Rendering Phys	Charge Rendering Provider	Charge Posting
Req Status	Request Status (Abbreviated)	Claim Information
Req Status Desc	Request Status Description	Claim Information
Rpt Type	Report Type	Encounter Maintenance > Claims > Attachments
RPT Trans Cd	Report Trans Code	Encounter Maintenance > Claims > Attachments
Serv Loc	Service Location	Encounter Maintenance
Serv Loc St	Service Location State	Locations Master File
Sex Code	Sex at Birth Abbreviation (M/F/U)	Patient Information
Sex	Sex at Birth	Patient Information
SSN	Social Security Number	Patient Information

Filter 1

Filter	Description
Create Date	Select a Create Date range for claims
Processed Date	Select a Process Date range for claims
Request Status	Select one or more of the following to be included on the report: ▪ Pending ▪ Archived ▪ HOLD ▪ Consolidated
Payer Seq	Select one or more of the following to be included on the report: ▪ Primary ▪ Secondary ▪ Tertiary

Filter	Description
Create Date	Select a Create Date range for claims
Media Type	Select one or both of the following to be included on the report: ▪ Paper ▪ Electronic
Name	Used to narrow the focus of the report to Patient Names that fall within the beginning and ending name range you enter. You can enter: ▪ whole names ▪ partial names ▪ first initials only
Status Cat Code	Select a 997 acknowledgement transaction Status Category Code to be included on the report
Status Code	Select a 277/277u claim Status Code to be included on the report

Filter 2

Use columns to filter data on the report. Column filter options include the following:

- Between
- Equals
- Not Equals
- Greater Than
- Less Than
- Like

Additional Filters

Use additional filters to filter data on the report. Additional filters include the following:

- Claim Forms
- Claim Types
- Financial Classes
- Locations
- Primary Payers
- Rendering Providers

Sorting

Use columns to sort and group data on the report. Column sorting options include the following:

- Ascending
- Descending
- Group By
- Page Break

Note: Columns that are not available for Group By or Page Break are indicated by 'n/a'.

Totals

Use columns to sub-total and total data on the report. Column total options include the following:

- Sum
- Average
- Count
- Totals

Note: Columns that are not available for totals are indicated by 'n/a'.

Eligibility Inquiry Benefit Report

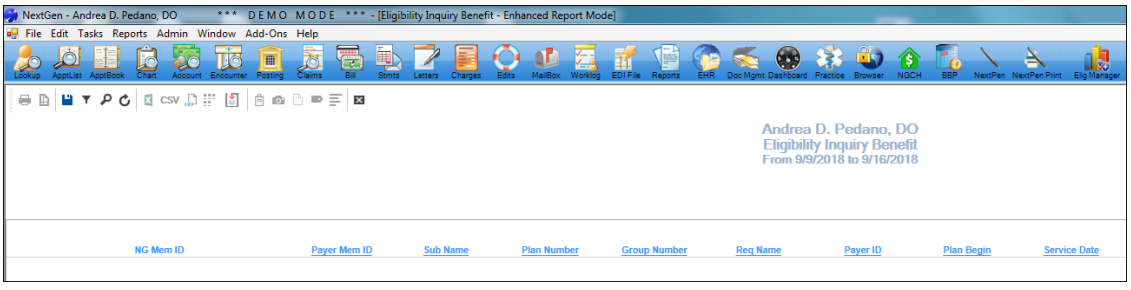
Use the Eligibility Inquiry Benefit report to view patient benefit information. In addition, use the report to flag and view responses with Fiscal Intermediary (FI) or other replacement plans.

This report is not available for Legacy reporting. Since it is an enhanced report there it is no asterisk '*' mark against the report name. In addition, no configurations are required in preferences to differentiate between a Legacy and Enhanced report.

View Eligibility Inquiry Benefit Report

To view the Eligibility Inquiry Benefit report from Enterprise® PM, click **Reports** > **General** > **Eligibility Inquiry Benefit**.

The Eligibility Inquiry Benefit report opens.

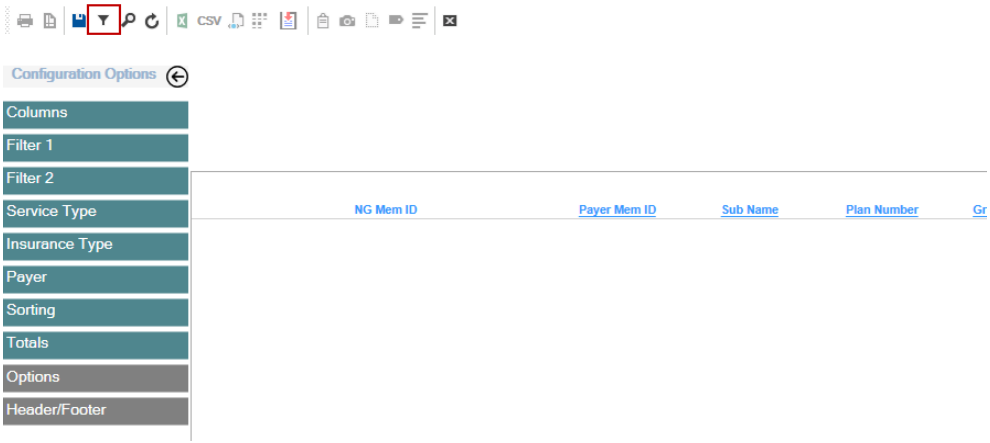


Set Filters for Eligibility Inquiry Benefit Report

Easily set custom filters for the Eligibility Benefit Report.

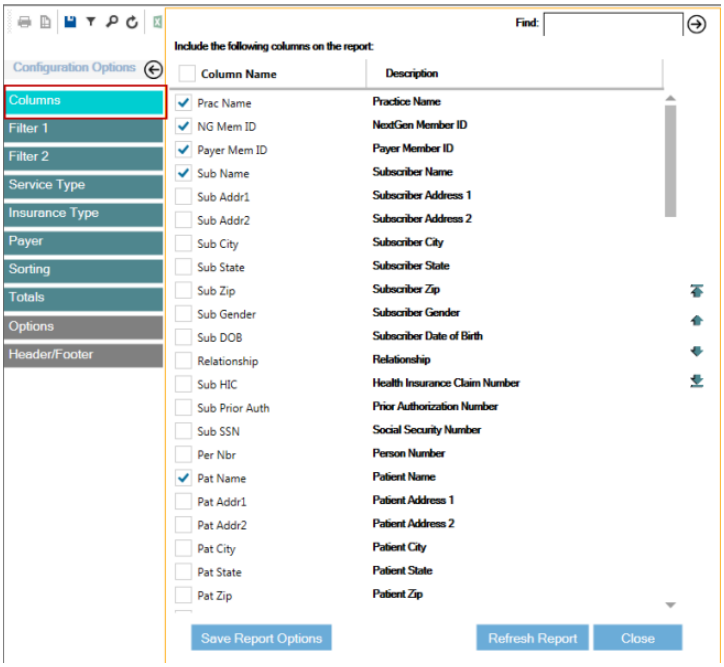
1 Click .

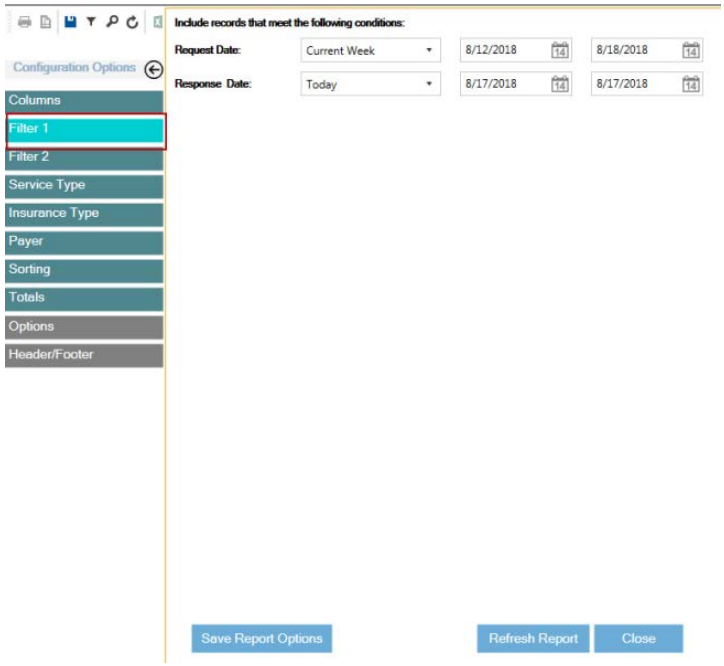
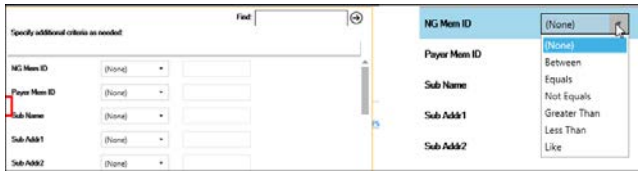
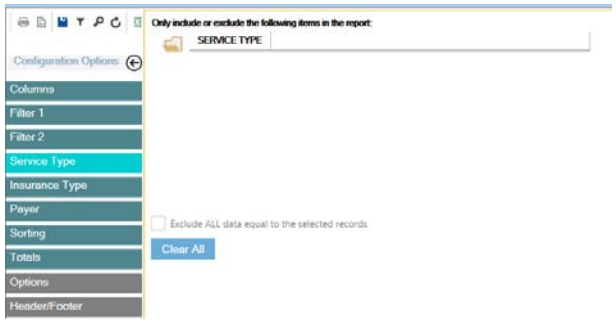
The Advanced Filters open.

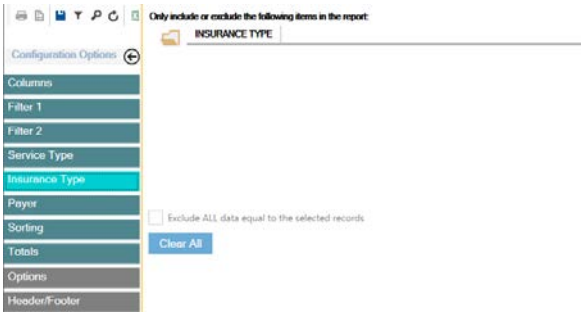
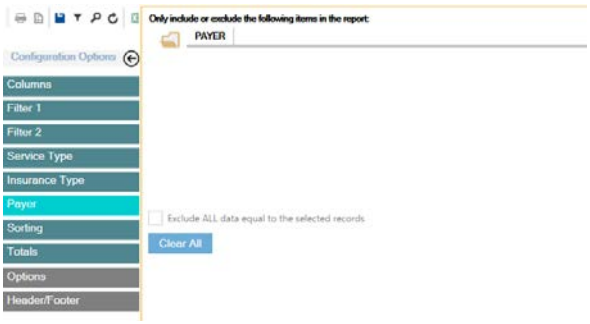
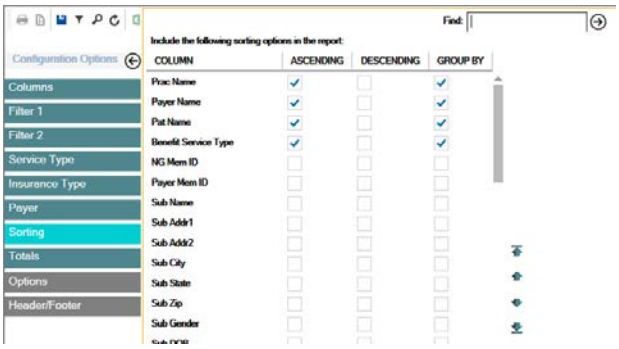


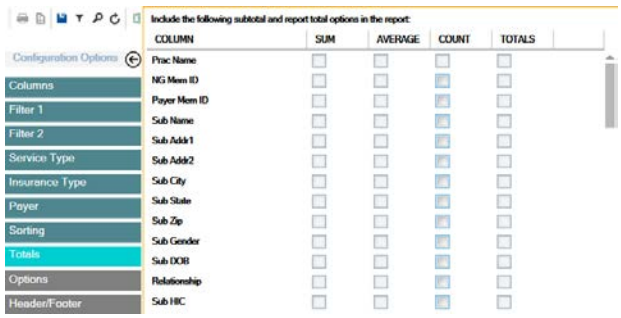
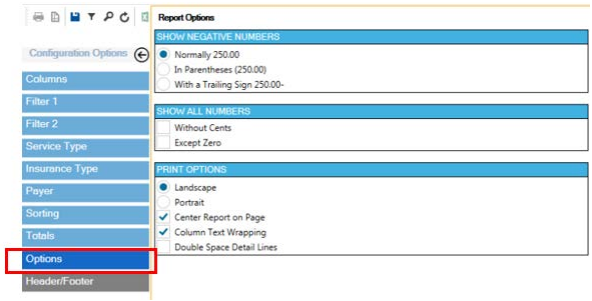
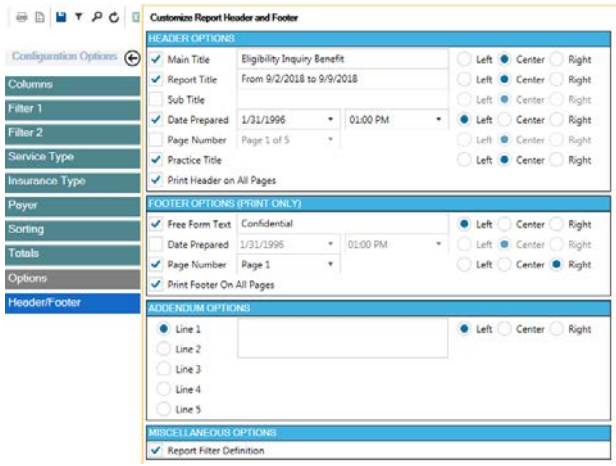
2 Select a filter from the Configuration Options menu.

Below is a description of each filter.

Filter	View	Description
Columns		Select (check) the columns to display in the report.

Filter 1		Select Date Range
Filter 2		Depending on the field, select a date, an item from a list, or type information.
Service Type		By default no service type is selected. Data displayed on the reports is based on the response received.

Insurance Type		Select Insurance Type.
Payer		By default no payer is selected. Data displayed on the reports is based on the response received.
Sorting		By default Prac Name, Payer Name, Pat Name and Benefit Service Type displays in ascending order.

Totals		By default nothing is selected.
Options		Define viewing and printing settings.
Header Footer		Define Header and Footer information.

Flag Response from Eligibility Inquiry Report

The Eligibility Inquiry Benefit Report flags a response and reports the Fiscal Intermediary (FI) or its replacement plan.

A MCO Bill Option Code only returns for Insurance Type code values (EB04 segment):

- HM – Health Maintenance Organization
- HN – HMO Medicare Risk
- IN – Indemnity
- PR – Preferred Provider Organization

PS – Point of Service MCO Bill Option Codes (MSG Segment):

MCO Bill Option Code – [code value]. Code values returned are A, B, C, 1, or 2 The following is a definition of each MCO code value and how they are processed on claims.

Medicare Beneficiary "locked in" to MCO

"A" - Fiscal intermediary should process all claims

"B" - MCO should process only in-plan Part A claims and in-area Part B claims

"C" - MCO should process all claims

Medicare Beneficiary "locked in" to MCO

"1" - Fiscal Intermediary should process all claims

"2" - MCO should process only in-plan Part A claims and in-area Part B claims

View Eligibility Inquiry Status Report

The Eligibility Inquiry Status Report allows you to view all the Eligibility Inquiry transaction status information.

This report is not available for Legacy reporting. Since it is an enhanced report there it is no asterisk '*' mark against the report name. In addition, no configurations are required in preferences to differentiate between a Legacy and Enhanced report.

To view the Eligibility Inquiry Status report:

From Enterprise® PM, click Reports > General > Eligibility Inquiry Status.

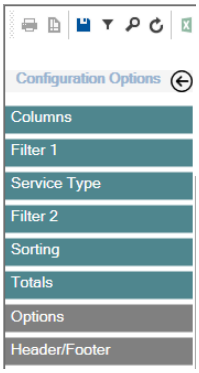
The Eligibility Inquiry Status report opens.

Set Filters for Eligibility Inquiry Status Report

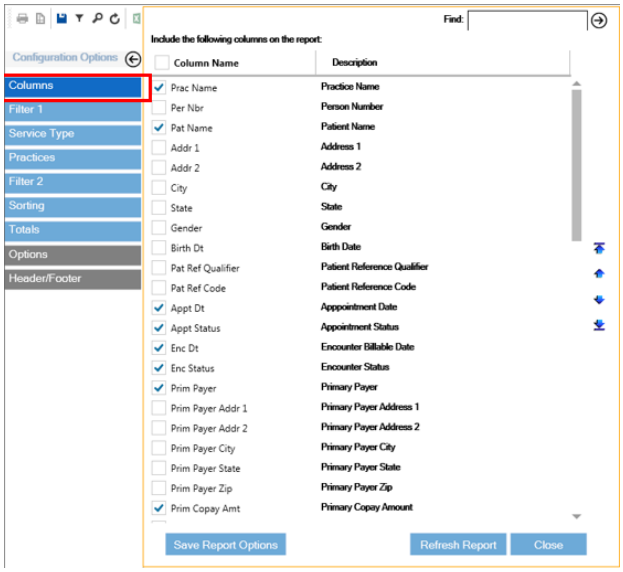
To Set filters for Eligibility Inquiry Status Report:

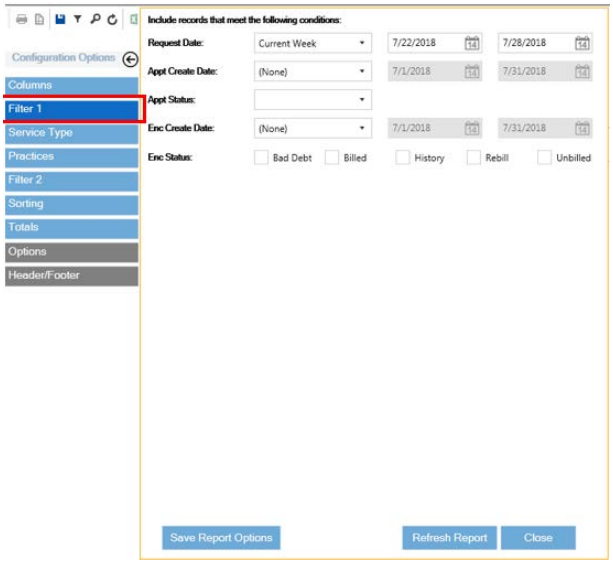
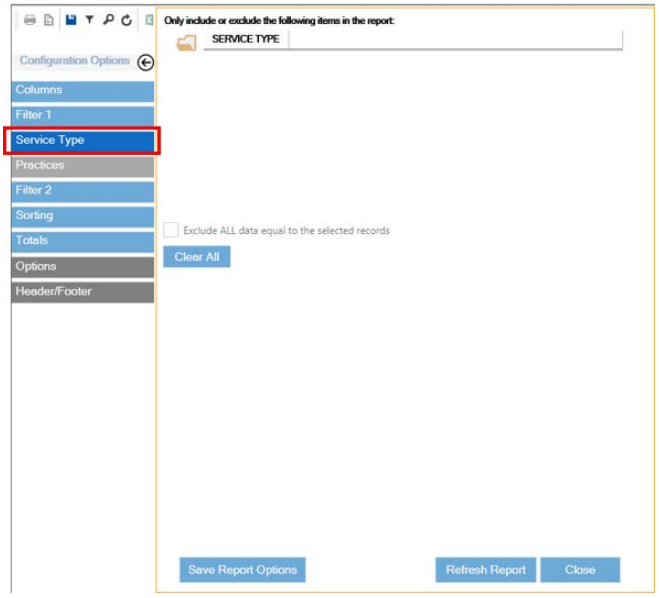
1 From the Eligibility Inquiry Status Report, click .

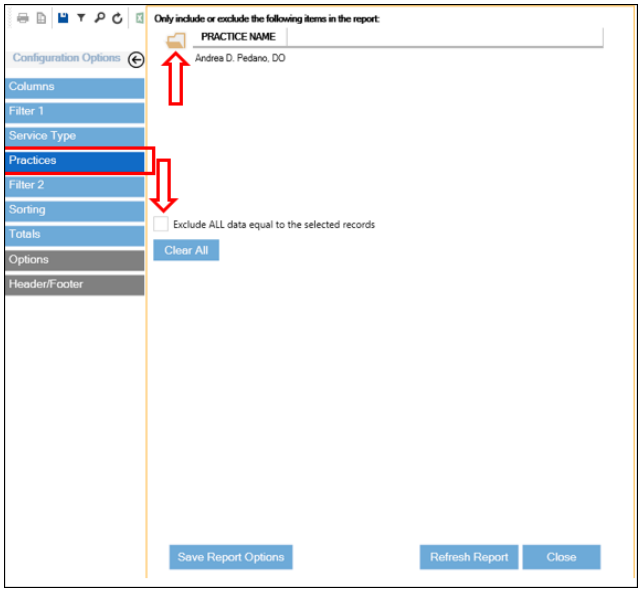
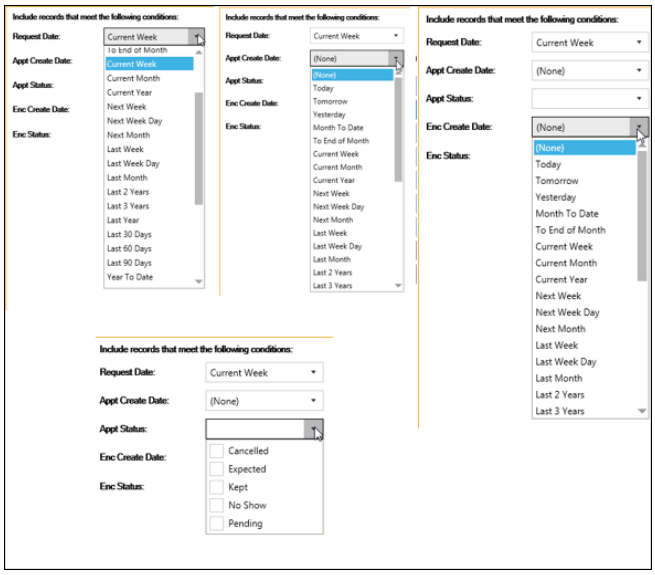
The Advanced Filters open.

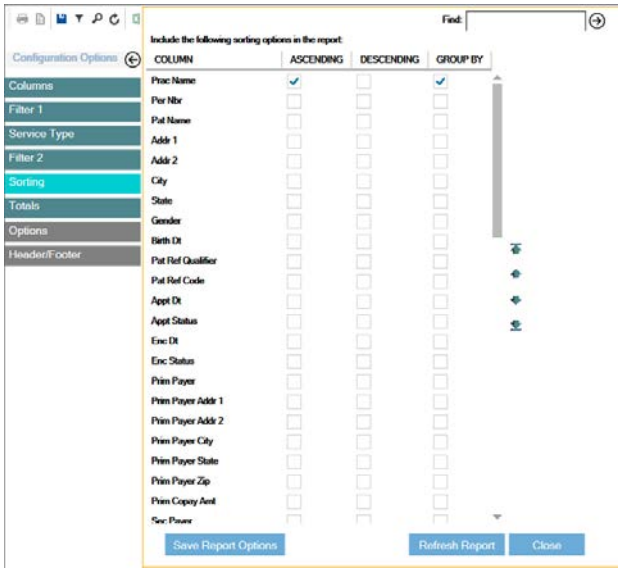
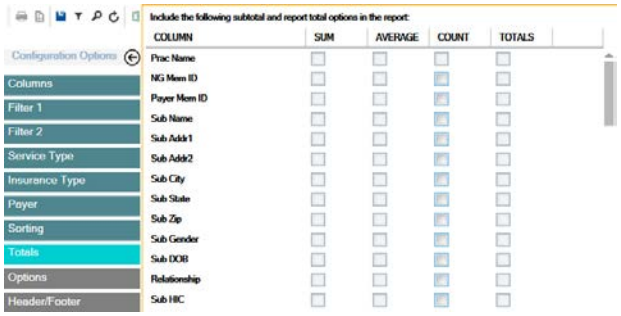
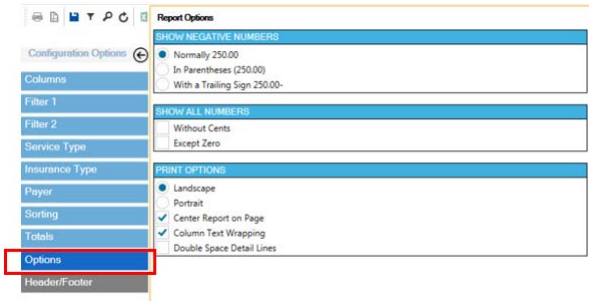


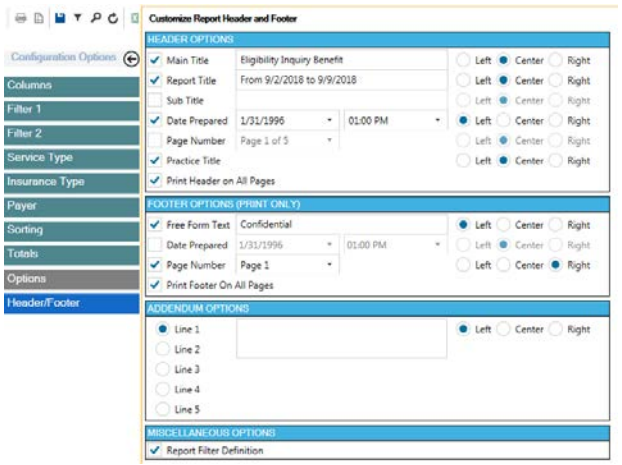
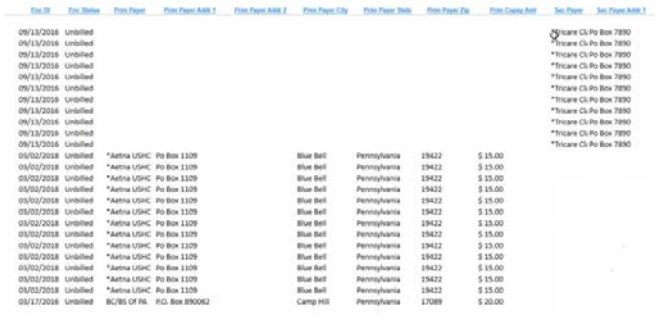
2 Select a filter from the Configuration Options menu.
Below is a description of each filter.

Filter	View	Description
Columns		Select (check) the columns to display in the report.

Filter 1		Select Date Range
Service Type		By default none of the service types are selected and the report displays the reports based on the status.

Practices		The Practices filter option is available only a user has access to multiple practices. By default the report displays information from the practice you are currently logged into. If you have the access rights, records from multiple practices can be reported.
Filter 2		Filter 2 provides user-friendly but robust search logic. The image to the left provides examples.

Sorting		By default Prac Name, Payer Name, Pat Name and Benefit Service Type displays in ascending order.
Totals		By default nothing is selected.
Options		Define viewing and printing settings.

Header Footer		Define Header and Footer information.
Special Character: Asterisk (*)		The asterisk (*) character, when prefixed along with the primary or secondary or tertiary payer, distinguishes which payer the request was being sent to.

CHAPTER 9

Referral Inquiries and Histories

This feature allows you to submit, or request, new referral inquiries and view referral histories.

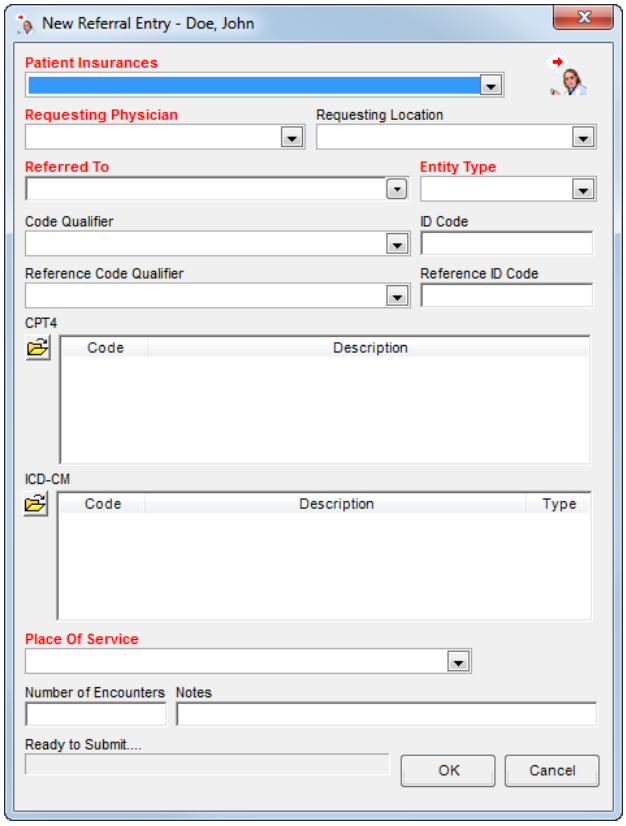
Referral requests are made to generate a referral number so that a primary care physician (PCP) can send a patient to an authorized specialist.

Referral history enables you to view a patient's history. This history lists all previous referrals made for a patient. Referral history generally documents the history of a patient treated by a specialist.

Submit New Referral Inquiry

To submit a New Referral Inquiry:

1 Right click, click New Referral... from one of the defined access paths.
The *New Referral Entry* appears.



2 Complete the required fields:

a) Patient Insurances
b) Requesting Physician
c) Referred To

d) Entity Type
e) Place of Service

3 Optional fields
a) Requesting Location (leave blank)
b) Code Qualifier (leave blank)
c) ID Code (leave blank)
d) Reference Code Qualifier (leave blank)
e) Reference ID Code (leave blank)
f) CPT4
g) ICD-CM
h) Number of Encounters
i) Notes (not sent to payer but displays on response - 255-character limit)

4 Click OK.

The inquiry is now being processed. The Progress bar appears under Ready to Submit. When the submission is complete, the system displays the response in the *Referral Result* window.

5 To print a copy of the eligibility response for your records click the Print option.

6 Click Close.

Note: Each time an inquiry is submitted and a response is received, a significant event is logged. When a response is received, a Chart Note is recorded under Referral Results with the status of the inquiry.

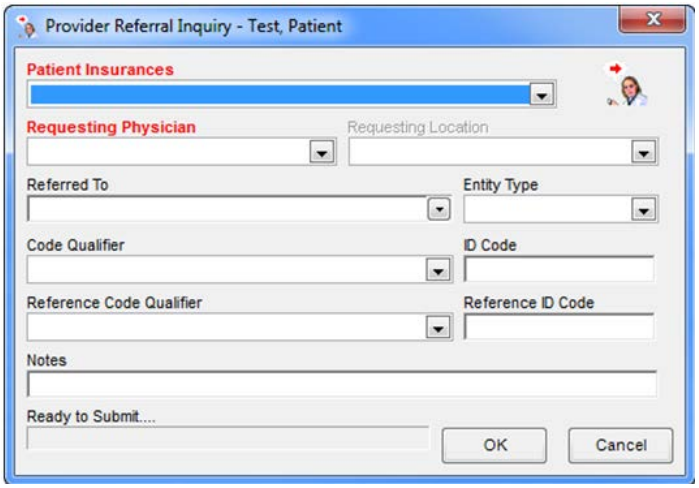
Referral History Inquiries

Referral History Inquiries enable providers to view referral submissions.

To submit a referral history inquiry:

1 Right click, click Referral History... from one of the defined access paths.

The *Provider Referral Inquiry* appears.



2 Complete the required fields:

a) Patient Insurances

b) Requesting Physician

3 Optional fields

a) Requesting Location

b) Referred To

c) Entity Type

d) Code Qualifier (leave blank)

e) ID Code (leave blank)

f) Reference Code Qualifier (leave blank)

g) Reference ID Code (leave blank)

h) Notes (not sent to payer but displays on response - 255-character limit)

4 Click OK.

The inquiry is now being processed. The Progress bar at the bottom of the dialog box displays under Ready to Submit. When the submission is complete, the system displays the response in the *Referral Result* window. View the Transaction Details, Service Provider Details, and Subscriber Details.

Note: Scroll-down and view additional information; for example, Services Detail and procedure and diagnosis codes, and benefit dates.

5 To print a copy of the eligibility response for your records click the Print option.

6 Click Close.

Note: Each time an inquiry is submitted and a response is received, a significant event is logged. When a response is received, a Chart Note is recorded under Referral Results with the status of the inquiry.

CHAPTER 10

Eligibility Inquiry Library

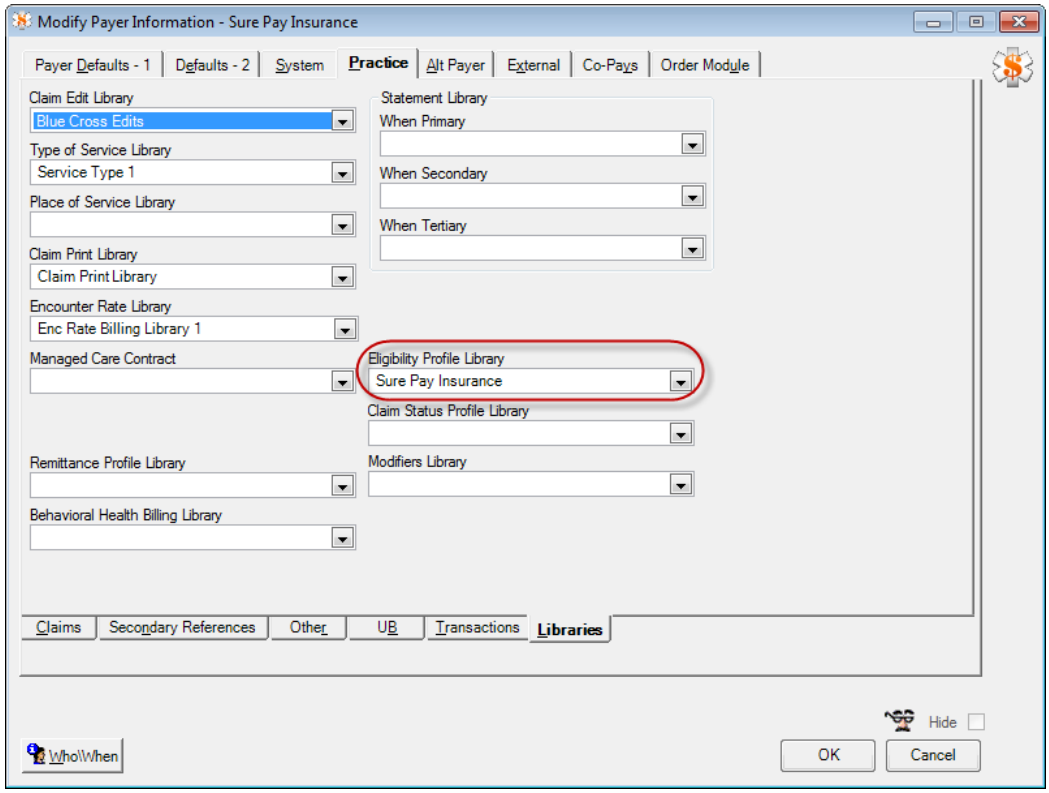
Processing inquiries in batch mode requires creating a library. Once created, Eligibility Inquiry libraries automatically complete required fields and additional data in batch mode that would otherwise require the fields to be entered manually. Two libraries are used to process inquiries in batch mode:

- Eligibility Profiles
- Claim Status Profile

Your Eligibility Inquiry Analyst assists in creating the libraries.

To attach the Eligibility Profile Library:

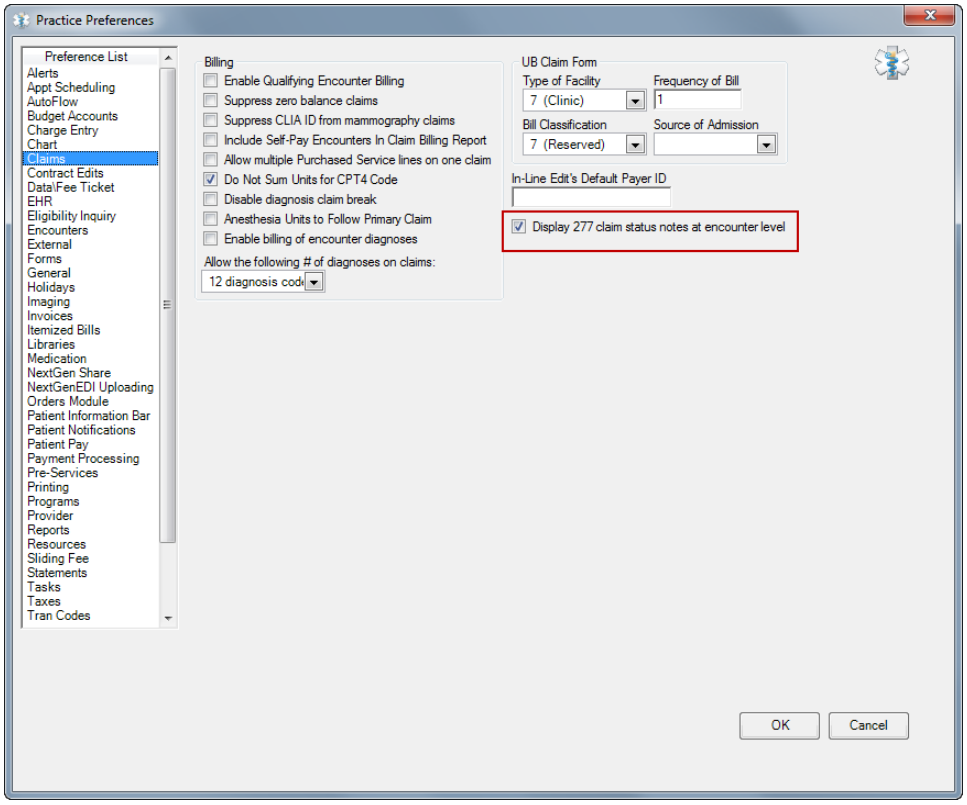
1. In BBP, create an Eligibility Responses job to receive a response.
2. In File Maintenance, set up an Eligibility Profiles library defining the rules for submitting eligibility inquiries in batch mode.
3. In File Maintenance, click Master Files - System > Payers > Practice tab > Libraries sub-tab.
   The *Modify Payer Information* opens.
4. Attach the Eligibility Profile Library to the payer and click OK.



CHAPTER 11

Attach 277 Claim Status Note to Encounter

This feature provides usability improvements to notes generated by the *Claim Status* and *Eligibility Inquiry Claim Status (277)* transactions. The claim status notes display at the encounter level instead of the chart level, allowing for greater visibility and improved workflow during follow up. To use this feature, you must enable it from Practice Preferences > Claims.



Note: If your practice upgraded from a previous version this setting displays upon upgrade to 5.9.1 or later. If you want to store claim status notes at the encounter level you must enable this setting in Practice Preferences > Claims.

Document Revision History

Application Version	Date	Document Version	Summary of Changes
Fall2018	10/22/2018	2.0	General Release
Fall 2018	09/20/2018	1.0	Initial Release

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