Electronic Data Interchange (EDI) ELIGIBILITY

Flowcast 4.0

University of Miami Clinical Enterprise Technologies
Acknowledgments

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Eligibility is the process of verifying a patient's insurance with an insurance payor. Eligibility can be performed by:
- calling the payor,
- having the system automatically send and receive the necessary patient insurance information electronically. This method is called Electronic Data Interchange (EDI) Eligibility.

**NOTE:** Eligibility does not take the place of obtaining referrals and going through the insurance verification process. These tasks must be completed also.

The University has agreements with most of the large volume insurers to perform EDI Eligibility. As of March, 2007, eligibility requests can be submitted via EDI to the following insurers:

- Aetna
- Avmed
- BC/BS
- Cigna
- Humana
- JMH Health Plan
- Neighborhood Health Partnership
- United Healthcare
- Medicare
- Medicaid

Any insurance payer not listed above has to be checked manually or as you do in your current process.

The rest of this document describes the steps to perform EDI Eligibility verification.

The system stores all the EDI eligibility requests and replies as they occur. They are available for viewing on the system for a year.

The University's policy is that if a patient's eligibility with an insurer has been verified within the last month and the patient is active with the insurer, you do not have to verify the insurance again. For example,

1. The patient has Avmed as her insurer. Someone verified her insurance on March 5th using the system's Eligibility functionality. The patient is covered by the insurer.
2. It's now March 20th and you have to verify the patient's insurance with Avmed. You do not have to send another request to Avmed because within the last month, her insurance was verified with Avmed.

*Note:* For the rest of the document, EDI Eligibility will be referred to as Eligibility because that is how it is referred to in the system.
### Eligibility Steps Overview

If the patient has an EDI Eligibility insurer, the steps to verifying EDI Eligibility are:

1. Has a request been sent within the last month to the insurer and the patient is covered?

2. If yes, then update the current appointment with the information on the Outcome of that request.

3. If no, then
   a. Send a request to the insurer
   b. If the patient is insured, use the side-by-side screen to view the variances between the insurer's patient data and our system's patient data.
   c. View the patient's benefits
   d. If the information needs to be added back to the patient's demographic or insurance data in the system, edit Registration or Insurance and make the necessary updates.
   e. File the variants and mark the request as Reviewed and assign an Outcome.

### Scenario A

An EDI eligibility request was submitted for patient Test,Yamile for her Humana insurance. Humana returned the results.

You need to review the benefits and results, update Yamile's demographic and/or insurance data in the system and enter an Outcome in the system.

### Access

Access to the Eligibility List can be done from various locations.

**NOTE:** The Eligibility List in the example below is shown through Scheduling.

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**1. Eligibility List link**

1. Select action code <E> Eligibility List

**Eligibility Request List screen displays.**

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Eligibility Request List screen displays. The Eligibility Request List contains all the Eligibility Requests that have been requested for the patient.

The columns are:
- **FSC** = FSC Number
- **Insurance** = Payor
- **Req’d** = Date request was sent
- **Status** = Response we received from the payor
- **Var** = Difference, if any, are noted with a diamond
- **Rej** = A rejection code if the request was rejected
- **Outcome** = Comment assigned to the request after it has been reviewed
- **Rev’d** = Reviewed date
- **By** = Initials of the user who reviewed the request

2. Select the request for this month.
3. Select action code <E> **Results** to view the results.

The Side-by-Side screen displays the eligibility results.

4. Select action codes <B> **Benefits** to view the benefits.

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The Eligibility Benefits screen displays.

All the benefit types the patient has under their health plan are displayed. You can scroll up or down to view the desired benefit. Please ensure that you are viewing the appropriate benefit for the services the patient is coming in for.

5. Select action code <X> Expand/Contract to view more details about the patient’s benefits.

6. Select a specific benefit.

7. Select action code <D> Detail to view more information about the specific benefit you selected.

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A Benefit Detail screen displays. This screen shot shows the Benefit Detail - Specialist copay screen.

8. Select action code <E> Edit if any of the patient information from the payor needs to be added back to the patient's account (either to the Insurance or Demographics)

9. Select the type of information that needs to be updated in the system:
   - Demographics
   - IMS
   - Pln
   - NOTE: Do not use the Insurance option

The selected Edit Registration screen will display for you to update the patient's information in the system.

10. Click the <F10> button when all the updates to the patient's demographics and insurance have been made.

The Eligibility Benefits screen redisplays.

You can continue to select different benefits, view the details and update the system if appropriate.

11. When you are done viewing the patient's benefits and updating the system, click the <F10> button until you are back at the side-by-side screen.

The Side-by-Side screen redisplays.

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There are two remaining results screens that need to be reviewed

12. Click on the Page Down button to see the Eligibility Results - Subscriber/Family screen.

The Eligibility Results - Subscriber/Family screen:

The Subscriber/Family screen is the second screen in the Eligibility Results.
This screen displays the subscriber's and dependant's information

13. Click on the Page Down button to see the Eligibility Results - Payor screen.

Continued on Next Page
14. Click the **Page Up** button twice to return to the Side-by-Side screen.

The Side-by-Side screen redisplay.

All variants should be filed. **Variants note the differences between the system and the payor.**

The variants that are selected and filed will not affect the patient's registration information.

This information is stored in special FSC Follow Up Questions prefixed with "Eligibility" within the patient's regular FSC Follow Up Questions.

15. Enter `<Y>` next to the highlighted items as the first step to filing the variants.

**NOTE**: The insurance and the FSC Follow Up Questions still need to be updated.
16. Enter a <Y> to mark the run as reviewed.
The Outcome is determined by the status received from the payor and the patient's benefits.
The Eligibility Verification Outcomes popup box displays.
17. Select the appropriate outcome. Options are:
- Covered with Limitation
- Eligible
- Hospital Benefits only
- Not Eligible
- Terminated
- Wrong FSC
18. Click the <F10> button once the outcome as been selected.
The Eligibility Request List redisplay.
The Outcome you assigned, your initials and date are displayed on the Eligibility List screen.
19. Click the <F10> button to return to the Scheduling screen.

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Scenario B

You have to verify eligibility for patient Test,Yamile for her Humana insurance.
You need to determine if any requests have been submitted for the month of the appointment.

A request has not been submitted to Humana for the month of the appointment. Therefore you have to make a new eligibility request.

Access

Access to the Eligibility List can be done from various locations.

NOTE: The Eligibility List in the example below is shown through Scheduling.

1. Select action code <E> Eligibility List.

Eligibility Request List screen displays.

2. Select action code <N> New Request.

If a request has already been sent for that calendar month, DO NOT submit a new request. Use the request that is already there for that calendar month.

You view the list of previous requests and see that a request has not been submitted for the month.

2. Select action code <N> New Request.
The Eligibility Request - Select Insurance screen displays

3. Enter a <Y> at the Send request for multiple insurances field if you are requesting new eligibility requests for multiple insurance carriers.

   Leave the Send request for multiple insurances field blank if you are requesting a new eligibility for only one insurance carrier.

   **NOTE:** Keep in mind that not all insurance carriers are available through EDI Eligibility.

4. Enter a <Y> to the left of the insurance(s) for which you want to request EDI eligibility.

This is a screen shot of the same screen with eligibility requests from two insurers.

5. Click the <F10> button to continue.

The system sends the request to the insurer(s). In a matter of seconds you are notified of the results.

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While you are waiting for the results, a message displays on the screen.

Note: If you leave this screen you will not get a notification.

Message:
Waiting 90 seconds. Press any key to stop waiting.

6. The system will let you know once the reply is

6. Click the OK button in the pop up box.

The Eligibility Results - Patient Demo/Insurance screen displays.

At this time you need to check the benefits and enter an outcome for the request.

>> Refer to Scenario A for instructions.