Eligibility Best Practices

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Purpose

NEHEN is publishing this Eligibility Best Practice guide to assist our Members in understanding the eligibility EDI transaction, the options available to NEHEN Members for implementing this transaction and the best practices for eligibility verification as provided by NEHEN Payers, Providers, and Program Management.

Introduction

Across the United States, approximately 25% of all health care claims are rejected. Of those rejected claims it is believed that 80% are rejected for reasons associated with eligibility verification. Even among NEHEN Payers, the vast majority of claims rejected prior to reaching the payers' adjudication systems are due to reasons such as "Invalid Member Id" or "Incorrect Date of Birth" which could be prevented by performing electronic eligibility verification and updating the billing system with the correct information.

NEHEN Members have been exchanging electronic eligibility transactions since 1998 and currently perform millions of eligibility verification transactions a month – more than any other region in the country. Despite the wide adoption and use of electronic eligibility, NEHEN members continue to see claim rejections for reason such as "Invalid Member Id" and denials for no referral. This document will discuss ways to improve the effectiveness of electronic eligibility as well as options for getting additional value from your processes.

Eligibility Overview

The NEHEN technology is designed to send and receive the HIPAA designated standard for eligibility verification: ASC X12N 270/271(004010X092A1).

The Health Care Coverage and Eligibility Benefit Inquiry (270) is used by health care providers to determine if the payer/information source has the subscriber/dependent on file and to determine the health care eligibility and/or benefit information about that subscriber and/or dependent(s).

The Health Care Coverage and Eligibility Benefit Information (271) is used by the payer/information source to provide data to verify an individual's eligibility/benefit information. It may also provide information about third party liability for coordination of benefits. The transaction may not be used to provide a history of benefit use.

Eligibility Search Options

Most payers support two options for searching for a patient's eligibility and benefit information. The first search option uses a **Policy Number/ Member ID** as the primary data element of the search. The second option uses the patient's **Name** as the primary data element of the search and usually requires other data such as **Date of Birth** and **Gender** to uniquely identify the patient. There are payers that allow a search to be specific to a user's needs by allowing the user to select a specific 'Service Type'. By doing this, it narrows the benefit information that is returned by the payer. You see only the information that applies to your service.

Eligibility Response Contents

The NEHEN Payers include the following information in the Eligibility Response.

- Detailed patient demographic information including name, address, date of birth and gender
- Plan information such as plan name, group name if applicable, plan type
- Primary Care Physician information including address and phone number if applicable to the patient's plan
- Co-pay or Co-insurance information for the most common services such as Office Visit, Specialist Office Visit, Emergency Room, Hospital Admission and Pharmacy as applicable to the patient's plan
- Visit Limits or Other Payer information such as third party responsibility or replacement plans

It is important that registrars and others performing eligibility checks review all response information and update the registration/billing system appropriately. The proper spelling of names and a date of birth that matches the payer's system are usually required for claim submission.

In addition, certain types of insurance products require that patients see a designated primary care provider or a physician in a defined network. If your provider is not part of the network, or is not the PCP of record, you may not be paid for the visit. The eligibility response may also identify a replacement plan such as a Medicare HMO. Registrars should note the information and perform a subsequent eligibility check on the replacement plan to ensure that a claim is directed to the proper payer the first time.

Any information that is returned from the payer that differs from the information entered by the individual performing the verification will be highlighted in pink. If any pink highlighting is shown whatsoever in Eligibility verification, the user should verify that ALL patient information is correct. Individuals performing eligibility verifications should always ensure that the patient information being displayed on screen is the same as the information on file at the provider. Payers may elect to return information that is "close enough" – information that is similar to what has been searched for, but not identical. When the pink highlighted information is displayed, extra caution should be taken to verify that the information is correct.

NEHEN Technology

The NEHEN technology allows members to send standard requests and receive eligibility information from other NEHEN members and non-NEHEN members supporting the 270/271 eligibility transaction. The following components are used to format and route eligibility transactions using NEHEN.

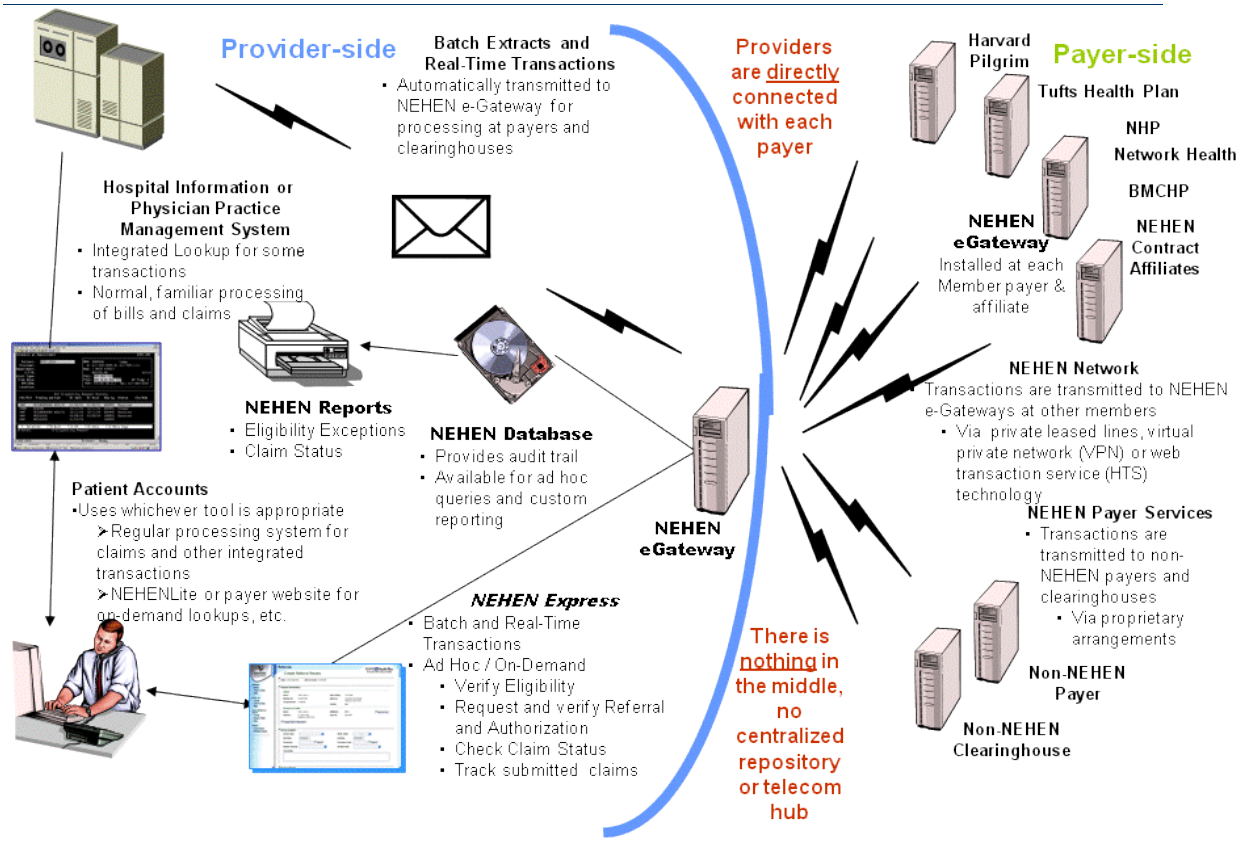
e-Gateway validates that transactions are in standard EDI format and transports transactions between a provider and a payer. The e-Gateway supports both real time transactions and batches. It is the used to route transaction to and from stand-alone applications as well as transactions generated from a member's core information systems.

NEHENExpress is a web-based application that allows NEHEN members to interactively send transactions and receive and review responses.

NEHEN "Core" is a set of programs and services that format a simple comma separated file into a standard EDI transaction. NEHEN provides the specification. This functionality is used to send batches of transactions to payers. It is also used to map non-standard transactions into standard transactions.

NEHEN Database stores inquiry and response information that is used to display information in NEHENExpress and can be accessed for customized reports.

Network Connections are necessary in order to use NEHEN technology. To send and receive transactions, a provider must have a way to connect to a payer. NEHEN supports many connectivity options including Frame Relay, Virtual Private Network (VPN) and Web Services.



NEHEN Payers

NEHEN Members may use the NEHEN technology to send HIPAA Standard EDI transactions to NEHEN Payers and Non-NEHEN Payers alike. NEHEN Payers use the NEHEN technology to route transactions back to providers and also deliver additional electronic information such as Claim Response Reports.

NEHEN Payers work together to provide a common approach to using transactions in order to simplify the process for NEHEN Providers. NEHEN Payers participate in the NEHEN planning process and decided together to develop EDI transactions well in advance of the HIPAA deadlines to allow both providers and payers to benefit from the move to EDI technology.

Nehen is adding new payers all the time, for an updated payer list go to: www.nehen.org/resources/Transaction%20Payer%20Matrix.pdf

Eligibility Options

NEHEN Members have four basic options for implementing eligibility verification: Interactive Real Time (stand-alone), Batch, Self-pay and Integrated into their core information systems. The NEHEN technology supports all four options.

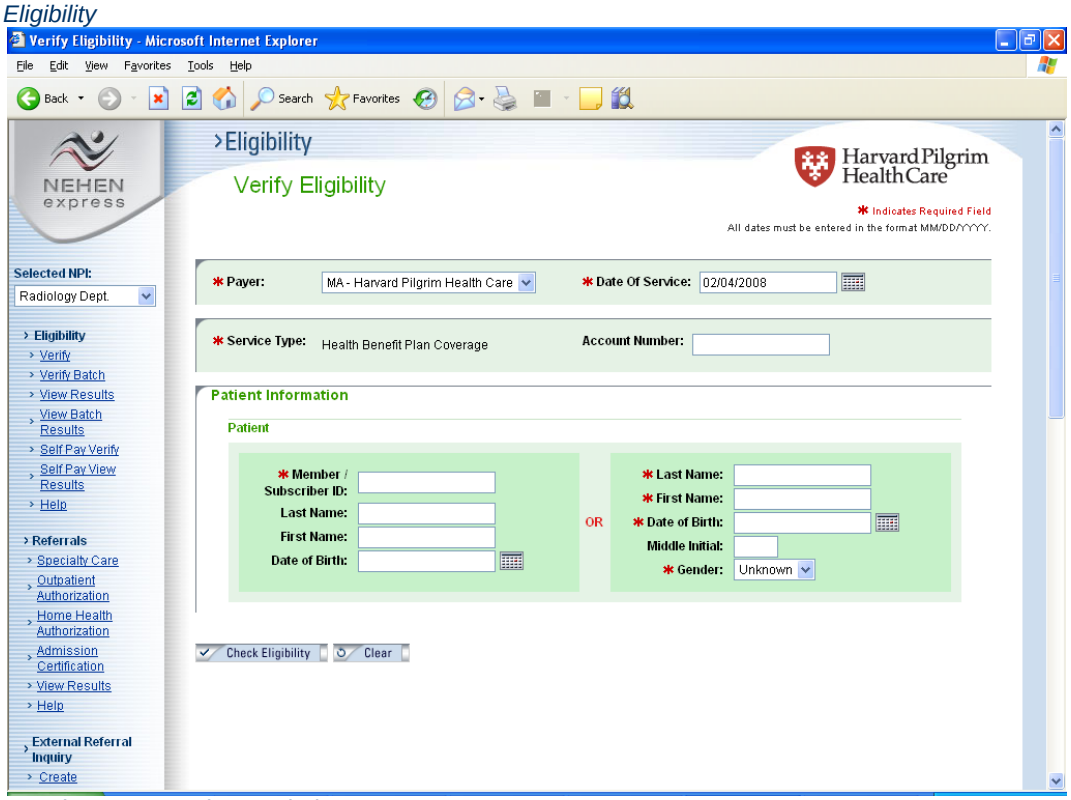
Interactive real time – Stand-alone

Using stand-alone interactive real time eligibility verification, the provider uses an application separate from the registration system to inquire on a patient's eligibility and benefits. NEHEN Members can use the intranet web application ***NEHENExpress*** to access multiple payers from a single site and do individual eligibility checks. Many providers also use individual payer websites or other commercial products to do real-time eligibility.

Stand- alone eligibility applications are an improvement over making telephone calls or not checking eligibility at all and they are relatively quick and inexpensive to implement. However, this type of application requires a user to type in each request and to log into another system to update the insurance information.

This option for checking eligibility is best for getting up and running quickly while development is completed on more automated or integrated methods. It is also useful in areas where a complete registration system is not available such as remote offices.

Eligibility



y Options: Interactive Real Time: NEHENExpress

Batch

NEHEN members use batch eligibility to inquire on multiple patients without doing the data entry. The business process takes place behind the scenes, in the background, by the computer.

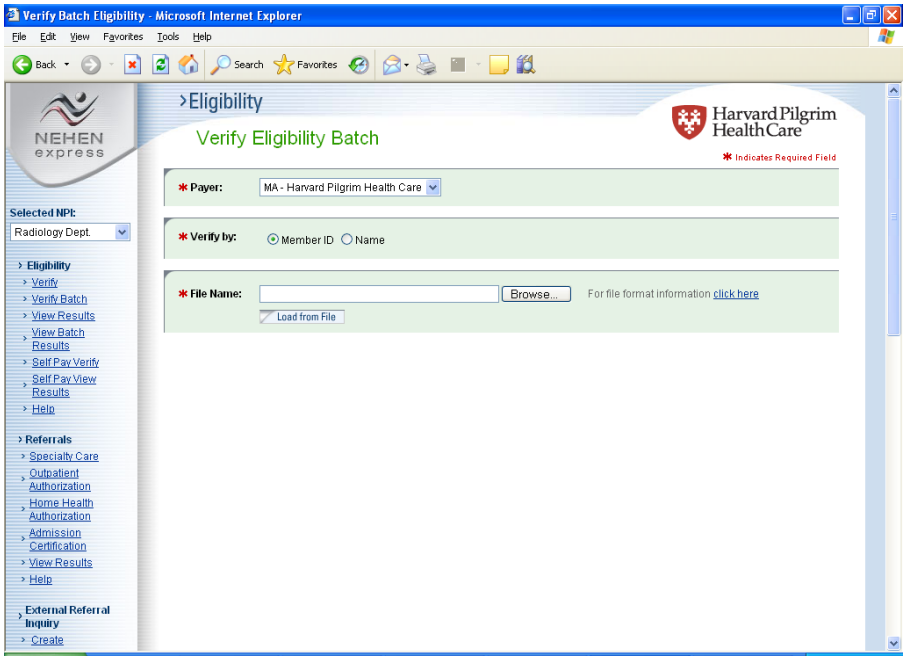
An extract of the required data for the eligibility transaction is taken from the Scheduling/Registration/Billing System. This data is formatted as individual EDI transactions and then sent to the payer. The responses are returned individually and stored for later reporting.

NEHEN supports this option for eligibility by allowing providers to format the inquiries in simple "flat file" format. The NEHEN core technology takes the file and formats the EDI transactions. Each transaction is stored in the NEHEN database and the response is matched and stored when returned by the payer. Providers may then use NEHENExpress to view the responses or develop reports out of the stored transactions in the relational database.

By using batching, providers have the ability to increase the number of eligibility inquiries performed while reducing the required time and labor. The provider may choose to only work the "exceptions" or report on data that will help ensure claims are sent cleanly to the correct payer the first time.

Implementing a batch option requires changes to existing business processes and requires the provider to invest in the development of extracts, reports, and processes to update the core registration/billing system. NEHEN provides a guide to setting up batch eligibility.

Eligibility Options: Batch Eligibility Process

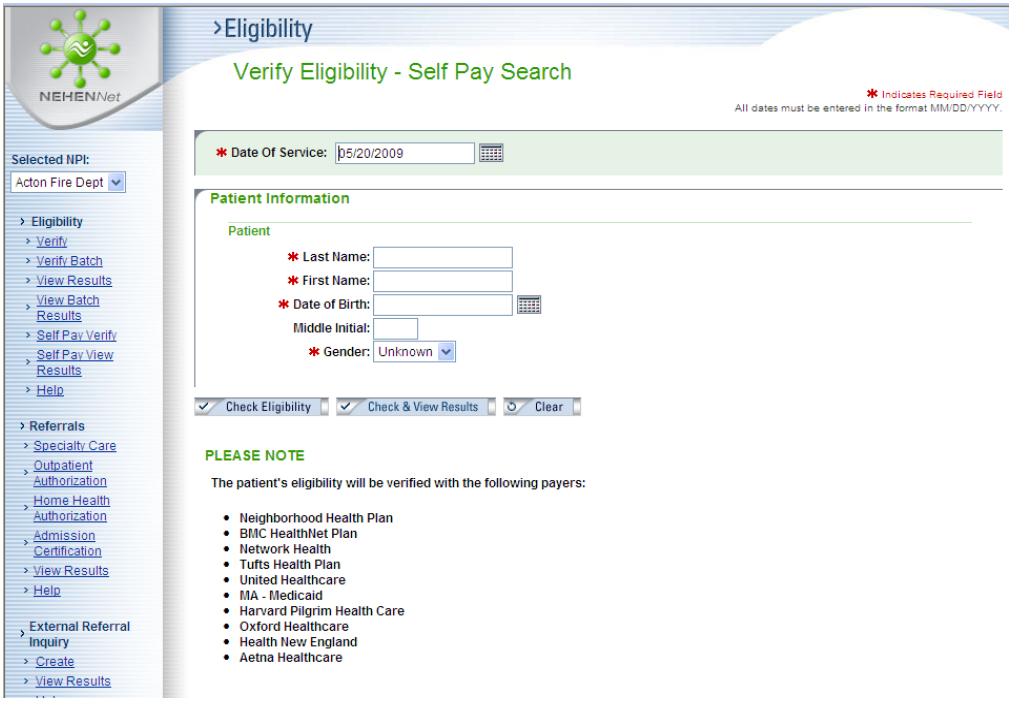


Self-Pay

This screen provides the ability to submit an online query against a set of payers. Certain payers are not eligible for Self Pay eligibility verification due to the fact that they require the Member ID or other specific data elements on all inquiries. The red indicators provided on the screen indicate those fields that are mandatory. For the Verify Eligibility Self Pay option, the mandatory fields are the minimum patient required fields needed by all payers to process eligibility verification.

The **Verify Eligibility - Self Pay Search** screen allows the user to submit an online eligibility transaction for a patient who does not know their insurance coverage. It is particularly helpful for confirming which Managed Medicaid Plan a patient has since patient's have the ability to switch plans at any time during the month. The Verify Eligibility - Self Pay Search verifies eligibility with

each participating and contracted insurance carrier based on the patient information entered by the user.



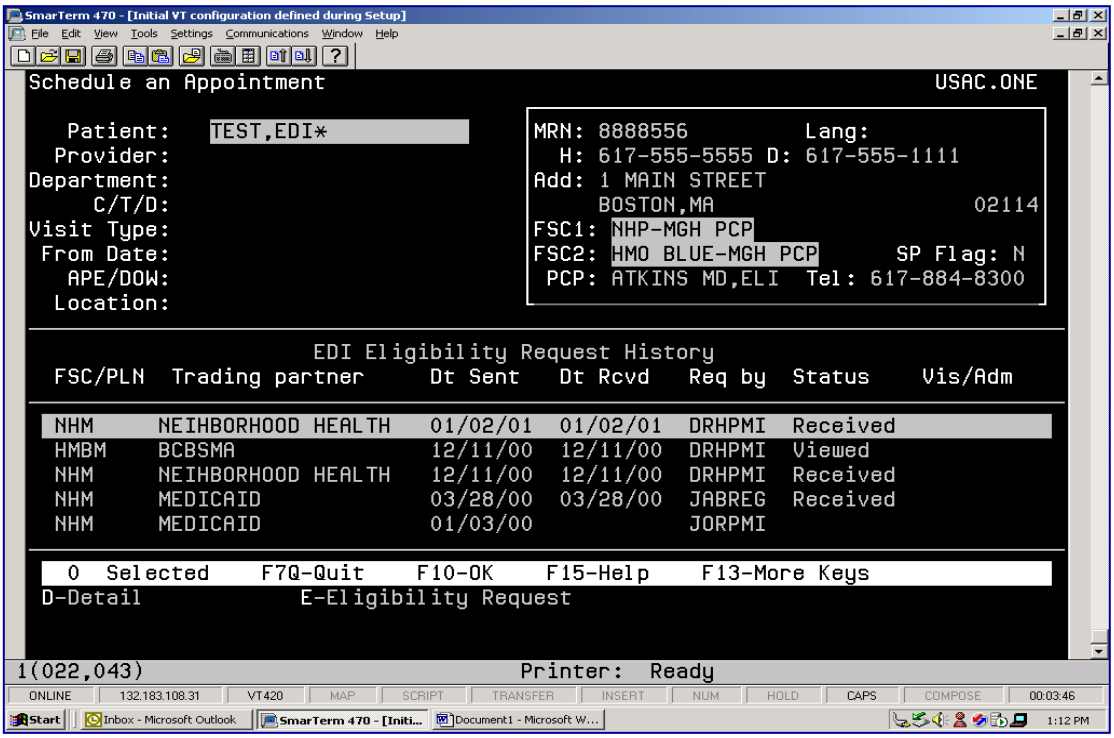
Integrated

Integrated EDI transactions are programmed into the provider's core Hospital Information System. The system allows real time inquiries as part of the normal workflow or can be automatically programmed to send batches of scheduled patients. The responses are stored along with all the patient registration/claim information. Reports are either provided with the system or are easily customizable.

Integrating EDI transactions into core systems is the ideal way to ensure that all information regarding a patient is stored in the same place. It also minimizes the training required. Although the eligibility transaction is generated from the core system, the response does not necessarily populate the registration/billing record. Therefore, a registrar must review the response information and choose to correct discrepancies from the core registration record.

In order to integrate eligibility verification into a core system, the provider must purchase or develop the additional EDI module for their core system and do customization and/or programming and testing before general use.

Eligibility Options: Integrated Eligibility Verification - Example

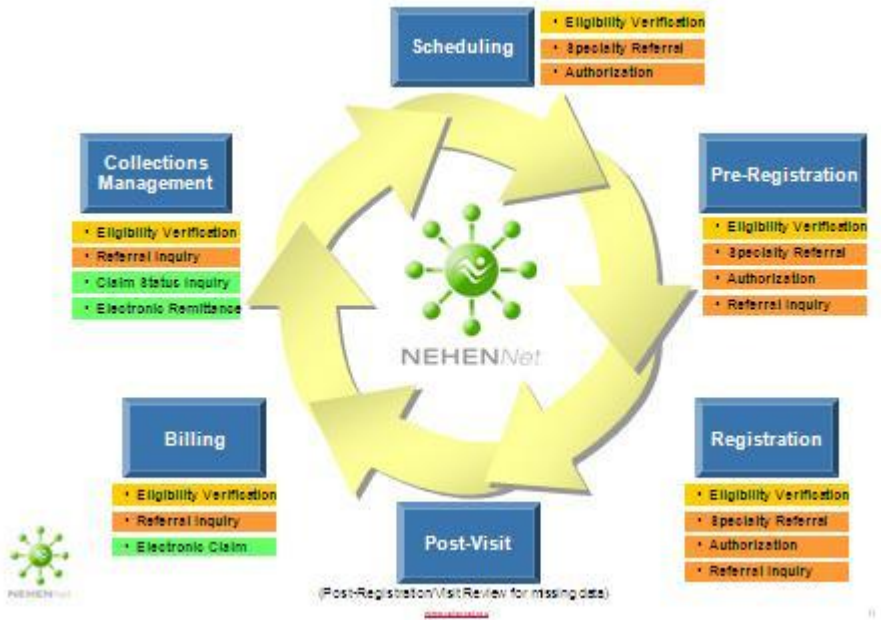


Eligibility in the Revenue Cycle – When and how often to inquire?

Eligibility verification is useful at many points in the revenue cycle from the point when a patient schedules an appointment to researching claim denials. Since the NEHEN payers do not incur transaction fees, NEHEN encourages members to utilize available transactions as often as necessary to provide information to ensure that claims are correct the first time and paid in a timely manner.

Since each organization has different business practices and system capabilities, we do not recommend a single process for verifying eligibility but identify the points in the revenue cycle where there are definite benefits to checking eligibility. We also encourage NEHEN Members to take advantage of the entire "suite" of options available for checking eligibility from integrated to payer websites and the use the best option for their business process.

Eligibility Verification in the Revenue Cycle



Scheduling

When scheduling appointments, providers have their first opportunity to obtain correct insurance information. Information provided at previous visits cannot be relied upon since insurance information can change at any time. At a minimum, schedulers should ask for and record current health insurance information.

Ideally, provider staff has the ability to record insurance information and other required data for an eligibility check and perform a real time eligibility check while on the phone with the patient. This ensures that the insurance information and other data required for billing is entered correctly in advance. Scheduling staff may also remind patients of co-pay collection policies or refer them to the financial office if they require assistance.

Checking eligibility at scheduling also allows the provider to review PCP information and inform the patient that they must call their Health Plan if they need to change the PCP information on record. The provider may also remind the patient to obtain a referral if required by the plan verified during the eligibility check.

Most payers provide the option for a name search so a patient or person making the appointment need not have an insurance card in front of them to make the appointment as long as they have name, date of birth, and gender information.

Best option at scheduling: integrated real time.

Pre-Registration

Even if eligibility is checked at scheduling, there are benefits to checking again 3-7 days prior to the appointment date. Many times appointments are scheduled months in advance and insurance information may have changed. Information recorded at scheduling may be incorrectly entered in registration systems or not updated.

Sending a batch of eligibility transactions 3-7 days prior to a visit provides enough time to contact a patient if there is an issue. At a minimum, the eligibility checks that are invalid should be worked prior to the appointment date. You may also want to look at the data for patients in managed care plans to ensure PCP information is correct and referrals are received.

Another use of a pre-visit eligibility check is to ensure critical data stored in the registration/billing system matches the payer's response. An invalid date of birth or incorrect spelling of a name may result in a claim rejection and rework at the back end.

If the payer's data is incorrect the patient or employer must contact the payer to correct the information. Beginning that process earlier will ensure a clean claim is submitted earlier.

Best option 3-7 days prior to visit: batch

Registration

Eligibility should be checked at every visit. Again, insurance information can change at any time and some Health Plans such as Medicaid and Managed Medicaid plans require that you check eligibility on the day of the appointment. Checking eligibility during registration also ensures that same day appointments are verified.

The person registering the patient should compare the results of the eligibility check with the data stored in the system and ensure that discrepancies are corrected.

To keep things moving, refer problems such as ineligible, no insurance, mismatched data, and incorrect PCP to a "specialist" to resolve. A specialist should know all the options for verifying eligibility and be willing to assist the patient in calling the health plan if information such as PCP needs to be changed.

Best option for registrations: integrated real time

Post -Visit

There are times when you may also want to verify eligibility after a visit. This is done to compensate for scheduled or unscheduled time when on-line eligibility in unavailable, to verify issues identified during registration have been resolved or to provide feedback to individual registrars or an entire department/location on performance.

Best options for post-visit: integrated real time/batch

Pre-Billing

Sometimes information is not available until after a visit has occurred. Providers can check eligibility prior to generating a bill if there are situations where the patient never registered such as emergency room visits or lab specimens submitted by a physician's office. Also, if a patient has applied for assistance such as Medicaid but a decision was not available during the visit, the provider may check prior to submitting a bill. You may also want to flag other self-pay patients for further investigations such as minors/young adults unaware of a parent's health insurance coverage. For larger claims, providers may want to again check that the information on the bill matches the payer information to ensure the claim is not rejected and payment delayed.

Best options for post-visit: integrated real time/batch

Collections Management

When providers fail to obtain correct information prior to or during registration, the collections staff must follow up upon claim rejection or denial. The goal of every provider organization should be to minimize the amount of follow-up work after a claim has been generated.

If a claim is rejected or denied due to incorrect date of birth, name, or member id, providers use a real-time eligibility option to resolve the discrepancy and resubmit the claim. Payer web sites may provide additional search options if an eligibility issue is discovered. Be sure to advise staff to update the permanent registration information if discovered after a bill is submitted to prevent the same problem from occurring again.

Providers should track the frequency and reasons for eligibility related rejections and denials. Look for patterns where eligibility is either not verified or information not updated correctly prior to billing. Communicate with registration staff and propose solutions to improve eligibility verification processes.

Best option upon claim rejection or denial: Integrated Real Time, Payer Web Sites

Payer Lessons Learned

Using NEHEN technology, providers get eligibility information directly from payer systems. Therefore, there are slight differences among payers. We have covered the differences in search criteria previously. Additional differences will be noted in this section as well as other information that will help you understand and use a payer's response. Providers should review the 270/271 Companion Guides available at payer web sites for additional payer-specific information.

All Payers

Patient Search: Most payers perform only one search per inquiry. For example, if the Member ID is provided and the search fails, the system does not search again using name and other identifying data. In general, providers should remove the Member ID/Policy number to search on name. Exceptions to this are noted in the payer-specific sections below.

Date of Service: Most payers allow you to check eligibility for a date of service in the past or in the future. Eligibility information for future dates of service is subject to change and therefore less reliable. MassHealth/Medicaid and Medicare will not accept a future date of service in an eligibility check. When a date range for dates of service is submitted, the payers generally use the first date of service provided.

Availability: Most payers keep their eligibility service up 24/7. There are some scheduled downtimes. Inform users of the procedure to be followed when electronic eligibility is unavailable.

If you are planning to submit batches of eligibility inquiries, it is usually best to schedule them for times outside of normal business hours. Please notify the payers of your plans and ask for the best time to schedule a batch. Payer contact information is included in the back of this document.

Responses: Understand the available responses to the eligibility transaction and how meanings may differ among payers. Information about responses can usually be found in Companion Guides to the 270/271 transaction available at the payer web sites.

- **Unable to Respond** - This response is most often seen when sending transactions to Medicare or MedAvant payers. If you receive this response from Medicare it means that the transactions was successfully received but the Medicare system is unavailable. You will have to send another transaction when Medicare is available to receive eligibility information. When you receive this information from a MedAvant Payer, it means that the transaction was received but the response could not be processed/read by the NEHEN Technology.

- **BCBS Response when OOS not available**

- **No Response at this time**

Harvard Pilgrim Health Care

Date of Service: Harvard Pilgrim validates eligibility for future and past (up to 13 months) dates of service.

Helpful Hints:

- Member and provider information submitted on an eligibility inquiry does not update the member and provider information stored in Harvard Pilgrim's claim processing system. If the member is found and eligible, Harvard Pilgrim will return the member and provider information that is stored in the Harvard Pilgrim claim processing system.

- If more than one member meets the search criteria, Harvard Pilgrim follows HIPAA recommendations for privacy and security and returns a "member not found" message instead of multiple records.

Neighborhood Health Plan

Date of Service: Neighborhood Health Plan does not allow eligibility checks on dates of service in the future. If you submit a future DOS you will get an error "Date of Service in Future" response. You may submit a past DOS.

Network Health

Date of Service: Network Health does not allow eligibility checks on dates of service in the future. If you submit a future DOS you will get an error "Date of Service in Future" response. You may submit a past DOS.

Tufts Health Plan

Date of Service: Tufts Health Plan will accept eligibility inquiries on any past date of service provided. Tufts Health Plan will accept future dates of service up to 90 from the transaction date. Beyond the 90 days Tufts HP will reject the transaction for "Date of Service in Future".

Responses: PCP Information – If not PCP information exists, the following messages will appear:

- HMO, POS, EPO Members – "No PCP Selected"
- PPO Members – "No PCP required"

MassHealth (Medicaid)

Date of Service: MassHealth (Medicaid) does not allow eligibility checks on dates of service in the future. If you submit a future DOS you will get an error "Date of Service in Future" response. You may submit a past DOS up to 6 months in the past. A DOS greater than 6 months in the past will give the error response "Date of Service Not Within Allowable Limits".

Helpful Hints: MassHealth (Medicaid) will provide you with the name of replacement insurers such as NHP or Network Health. Be sure to recheck eligibility with the other insurer to get correct member id, PCP, etc.

Medicare

Eligibility Process: Until a 270/271 EDI transaction is available from Medicare; NEHEN will continue to use a proprietary process to access eligibility information.

Date of Service: Medicare will not accept a future date of service in an eligibility check.

Helpful Hints: Useful Data – Medicare provides users with the name of replacement insurers such as HPHC's First Seniority, and THP's Secure Horizons. Be sure to recheck eligibility with other insurer to get correct member id, PCP, etc.

Aetna

Date of Service: Aetna will accept eligibility inquiries on past dates of service within 6 months of the transaction date. Aetna will accept future dates of service up to 30 days from the transaction date.

Helpful Hints: If the patient is a dependent, Aetna and Cigna may return Subscriber demographic information in addition to the patient information.

Cigna

Date of Service: Cigna will accept eligibility inquiries on past dates of service within 6 months of the transaction date. Cigna will accept future dates of service up to 30 from the transaction date.

Helpful Hints: Following Cigna's interpretation of the HIPAA requirements, all dependent inquiries must contain the following information:

> Subscriber Policy Number, Subscriber Last Name, Patient Last Name, Patient First Name, Patient Date of Birth, Patient's Relationship to the Subscriber.

If this information is not present for a dependent inquiry, Cigna will return a "Patient Not Found" response. A dependent Cigna patient policy number contains 11 digits; a subscriber policy number contains 9 digits. Therefore, for all Cigna patients that have an 11-digit policy number, the inquiry must contain a subscriber and dependent loop with all of the aforementioned data elements present.

If the patient is a dependent, Aetna and Cigna may return Subscriber demographic information in addition to the patient information.

Other Payers through MedAvant

Other payers such as Oxford and Anthem are available through MedAvant. The full list of MedAvant Payers is available at their web site www.MedAvant.com. Contact your NEHEN Administrator if you would like to add these payers to your processes.

Blue Cross Blue Shield of MA

Some members access BCBSMA eligibility information through Emdeon. To the end user, the eligibility verification process works exactly the same as with the NEHEN payers. They use NEHENExpress, NEHEN Batch or core systems integration to format the 270 request and send it over a connection to WebMD and the response comes back as though it was from a NEHEN payer.

Provider Best Practices

NEHEN Members have been using the 270/271 EDI transaction to check eligibility since 1998. This section contains helpful hints and lessons learned from the experience of NEHEN Providers and NEHEN Program Management.

Plan for Unscheduled Downtime

NEHEN Payers are available for eligibility verification 7 days a week and nearly 24 hours a day. On occasion there is a problem in the network that causes a delay in the eligibility response or an "Unable to Respond" response. The problems can occur in the payer's system, the network connection between the payer and provider, the provider's core system or the e-Gateway.

Notify the NEHEN Administrator at the provider site to troubleshoot the problem. End users are the first to notice a problem and should report them as soon as possible. The NEHEN Administrator will contact NEHEN Technical Support or the Payer Technical Support if he/she cannot resolve the problem.

Registrars and other end users should have a process for scheduled and unscheduled downtime. They may use the phone, the Internet or identify patients that should be verified later when the systems are available.

NEHEN Queues Transactions

The NEHEN e-Gateway routes transactions between payers and providers. It maintains a queue of requests to each payer and processes the transactions based on when they were received in the queue. Most of the time, the end user is unaware of the queue because responses are returned within seconds of the inquiry.

Occasionally, the queue backs up due to a payer's gateway being down or another technical issue. If the NEHEN e-Gateway is unable to deliver the transaction, it holds the transaction in the queue and checks constantly to see if it is able to deliver the transactions. Once the payer can receive the transactions and generate a response, the queued transactions are sent and the queue is cleared.

The end user only knows that no response has been received. Re-sending the transaction adds additional transactions to the queue and will delay the time that it takes to return to normal operation.

End users should follow their organizations procedure for contacting the on-site NEHEN Administrator to notify him/her of possible issues.

For cases where the end user receives an "Unable to Respond" response, the NEHEN e-Gateway successfully delivered the transaction and it is not longer in the queue. In this case, the payer has received the transaction but the back-end process that processes the transaction may be unavailable as is the case when Medicare is down. The end user must therefore resend the transaction when the payer system is available.

If end users receive the "Unable to Respond" transaction outside of the known Medicare downtime, they should contact he on-site NEHEN Administrator.

Patient Not Found – When to keep trying

In addition to reviewing data when an eligibility response is successfully returned, registrars should be trained to double check information on the inquiry when the first response results in "Patient not Found". Train the registrars to double check the Member ID, to remove the ID and do a name search, check spelling of the last name and date of birth.

Often Patient Accounts Analysts know all the options for discovering a patient's eligibility and are excellent resources to the people training the Patient Access staff.

Understand how your system is programmed

NEHEN Program Management has programmed NEHENExpress and the NEHEN Batch process to account for the variations in NEHEN Payer and other supported payer processing. It is important that someone in your organization understand how your core system has been programmed to send an eligibility inquiry and receive a response. You may have to train end users to account for the variations in payer requirements/responses if your system is not programmed to take into consideration these variations. Some questions to consider include:

Does it do a Member Id search first? A name search automatically?

Does eligibility response information update the registration information?

If you update information for the visit does is update the permanent record?

Is the patient always the subscriber in the Eligibility Search?

How does your system create the 270?

Use your claim results to measure how well the Eligibility processes are working

Have you implemented on-line eligibility yet still experiencing large numbers of rejections for invalid Member id/date of birth/invalid name?

Do you have denials for no referral or not your patient?

Keep track of the rejections and denials received in order to pinpoint where eligibility processes may be improved.

Communicate your findings

Follow up with departments/areas where improved processes could produce fewer claim rejections and denials.

Share results with NEHEN Members. Inform NEHEN Payers of discrepancies or issues and remember to keep NEHEN Program Management in the loop.

Claims of Discrepancies of data

Sometime providers claim they get a different response if they use a payer web site vs. their NEHEN connected system. If you encounter a discrepancy between systems, print the screens from each system and highlight the inconsistent data. Document the problem and contact your NEHEN Administrator, NEHEN Technical Support and the Payer Technical Support.

Revenue Cycle e-Transaction Specialist

There are many details to learn in order for organizations to use their NEHEN and other e-transactions effectively. We recommend making it someone's job to understand the business processes and rules surrounding the e-transactions such as eligibility verification and also understand enough of the technical requirements to make recommendations to the organization.

The Revenue Cycle e-Transaction Specialist would have the following responsibilities:

- **Educate:** Train others on the options and best practices for utilizing the electronic transactions.

- **Automate**: Use knowledge of the e-transaction technology, options and best practices to automate existing business processes or design new processes to improve results.

- **Evaluate**: Review the results of existing business processes and make recommendations for improvement.

- **Communicate**: Assist members of the organization by being the aggregator of lessons learned and best practices. Communicate information internally and externally to payers and NEHEN Members.

Contact and Support Information

NEHEN Members can contact NEHEN technical support or program management if they have questions. Remember that you are connecting directly to payer systems so if you have problems you may want to contact the payer directly.

NEHEN Contact Information

NEHEN Support

NEHEN_Support@csc.com

781-290-1490

NEHEN Website: www.NEHEN.org

The NEHEN website is where NEHEN Members can find useful information for technical support and best practices. These items are found in section titled "Support and Resources". Here are some of the documents relating to eligibility that can be found on the website:

- Batch Eligibility Verification Setup Document
- NEHENExpress Eligibility Training Guide
- Eligibility Best Practices (this document)

Eligibility FAQ

Eligibility is the most commonly used feature of NEHEN. Because it is so important, there are many questions about it. Please read below to find some explanations for common questions.

Why, or Why Not?

1. ***Why do responses frequently time out or come back as "Cannot respond at this time"? Is NEHEN Down?***

NEHEN is not down because you see "Cannot respond at this time". One explanation may be due to system downtime at specific payer– it is not likely that all of the payers will be unresponsive at the same time.
You should try one or two other payers to quickly determine if there's a issue at your organization or at the individual payer. Most often, it's an individual payer, you should contact your own Help Desk or System Administrator to report the problem and continue your work with the other payers.

2. ***Why is my eligibility response "patient not found'?***

In some cases, the patient may not have coverage with a certain payer. However, if you believe the patient does have coverage, verify that the information entered is correct. Confirm the payer info – who are you asking for the verification? Reconfirm that the information is actually correct, that you have the correct dates, numbers and correct spelling of names. Especially when you are doing many entries at once, it is easy to mistype without realizing it.

3. ***Why do the responses from payers on* NEHEN *often differ from what is on their website?***

NEHEN obtains the information displayed on the Eligibility Response page directly from the payer. Sometimes NEHEN is restricted in what we can display due to either (a) the limitations of the HIPAA standard transaction or (b) what the payer includes in their transaction. If there are specific examples of data elements which are either different or missing altogether, please forward as much information as possible (screen shots are helpful if possible) to Rebekah McLear (rmclear@csc.com) and we will research the issue with the payers.

4. ***Why do we always need the subscriber info, when we don't always have it?***

NEHEN's inquiry screens are developed based on the requirements of the payer's individual systems. Some payers may require certain Submitter information to be included when you are looking for a dependent to better ensure a unique match on the first try. NEHEN users have noticed however that sometimes if they submit all the patient information correctly as the submitter (even if the patient is a dependent) the payers **MAY** return an accurate response including the subscriber's information. This is something you may wish to try however NEHEN cannot guarantee it will work in every situation.

5. ***Why is different information required for some payers?***

NEHEN's screens are based upon what can be supported by the individual payer. We are in the process of revisiting the required fields with the payers to see if we can bring payers more in sync and therefore limit the variation among the payers.

How do I…

6. ***How do I enter dates more easily? Do I need the slashes?***

You do not need the slashes to enter a date in NEHEN. You must use one of two date formats if you type dates in. You may use either the MMDDCCYY format without slashes, or

the MM/DD/CCYY format with slashes (e.g. 08312009 or 08/31/2009). Alternatively, next to each field with a date, there is a Calendar Icon which can be clicked on to choose a specific date simply by clicking on it.

7. How do I print the information on the screen?

There are two simple ways to print the information that is returned with an Eligibility Response. They both involve the print buttons located in the upper right side of the NEHEN screen. Using the "Print Summary" button will print the summary information of the Eligibility verification, or the top portion of the screen. "Print Details" will print the entire screen. The advantage to using these buttons is that you will eliminate the chance that your browser will cut off or lose information on the screen. These buttons create new windows or tabs with a simplified, easier to print, view.

Payer Specific

8. *Can I check Eligibility of an Out-of-State BCBS* patient?*

You can, as long as you have the patient's Member ID. With the Member ID you are able to submit an Eligibility Verification via NEHEN. If you do not have the Member ID you will not be able to obtain Eligibility Information for an Out-of-State BCBS patient.

9. Why aren't all of the payers I need available?

NEHEN adds new payers and transactions with every release, always keep up to date with what payers are available. Also, NEHEN is working to increase the payers available. If there are other payers you are interested in, please contact NEHEN Program Management to have them added to the list of priority payers.

10. Can I get Medicare Eligibility through NEHEN?

Medicare eligibility verification is available either with direct connectivity to Medicare or via NEHEN Hub. Please contact your System Administrator if you are interested.

11. Why is Medicare not available in Self-pay Search?

Due to strict auditing limits in place with CMS, NEHEN does not allow sending self-pay searches to Medicare. Basically CMS monitors the number of 'Patient Not Found' responses as compared to the total number of Eligibility checks submitted by an organization. If the 'Patient Not Found' rate exceeds a set limit (approximately 30%), your organization will be put on probation and if it happens again you may risk losing the ability to submit Electronic Eligibility Checks to Medicare.

* Regarding BCBS Downtime:

A BCBS 'Home Plan' "must support the … core hours of operation, which at a minimum must be Monday thru Saturday from 6am to 12am Central Time, excluding holidays".

If you are experiencing frequent 'Cannot respond at this time' error message from BCBS plans, please send specific examples with the Member ID, date and time of the transaction to BCBSMA EDI Support (EDI_Support@bcsbsma.com) and copy NEHEN Support (NEHEN_Support@csc.com) so that the issue may be researched.

CSC's Role as the common NEHEN Program Manager
CSC is the coordinator and facilitator for NEHEN, in particular:

- Creating strategy & direction
- Organizing and supporting participant meetings and discussions
- Developing and piloting core technologies
- Coordinating implementation plans
- Resolving implementation issues
- Recruiting new members
- Providing impetus and momentum - keeping the ball rolling

As Program Manager, CSC provides support and guidance to Managers in carrying-out and implementing NEHEN's goals and priorities. CSC is also the Technical Architect responsible for the design, implementation and the technical support of NEHEN's core technologies.

About CSC
Computer Sciences Corporation helps clients achieve strategic goals and profit from the use of information technology.

With the broadest range of capabilities, CSC offers clients the solutions they need to manage complexity, focus on core businesses, collaborate with partners and clients, and improve operations.

CSC makes a special point of understanding its clients and provides experts with real-world experience to work with them. CSC is vendor-independent, delivering solutions that best meet each client's unique requirements.

For more than 40 years, clients in industries and governments worldwide have trusted CSC with their business process and information systems outsourcing, systems integration and consulting needs.

The company trades on the New York Stock Exchange under the symbol "CSC."

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