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Determine Eligibility via Clinical

Since the checking of client Eligibility via the Clinical workflow occurs prior to Services being rendered, it is considered a pre-determination of coverage. This method for eligibility checking is frequently used by non-residential/outpatient facilities, as it determines if a payer will consider reimbursement for Services provided on a per-client basis.

Eligibility via NSS Clinical is assessed via a **Realtime Eligibility** field (which can be set up on Notes/Forms during implementation). Agencies must be contracted with Trizetto in order to utilize this feature.

Add a Realtime Eligibility Check Field to a Form or Note

1. Navigate to Form Builder or Note Builder: **Admin Tools > Form Builder or Note Builder**.
2. From the **Select Form** or **Select Note Type** drop-down menus, select the Form or Note you want to add the field to.
3. Click the **Add New Field** button.
4. From the **Type** drop-down menu, select **Realtime Eligibility**.
5. Enter a **Field Name**. This is what will be displayed on the Form or Note.
6. *(Optional)* Add an **Alias Field Name**.
7. *(Optional)* Enter a **Prompt** that you want to be displayed on the Form or Note for users.
8. *(Optional)* For a Form, select the **Print Prompt** checkbox if you want the prompt to be printed when printing the Form.
9. *(Optional)* Select the **Disable Print** checkbox if you don't want the Realtime Eligibility field to print when printing the Form.
10. From the **Payer List** select the Payers that should be displayed in the Payer Name drop-down menu for selection.
11. From the **Provider List** select the Providers to be displayed in the Provider Name drop-down menu for selection.
12. Click the **Add Field** button.

Run Insurance Eligibility Verification in Clinical

- Navigate to the Note or Form that the Realtime Eligibility field is added to for your Agency.
Note: If this field is added to a Clinical Form, the client must be admitted for you to access the Form.
- Search for and select the client.
- In the Form or Note, scroll to the **Realtime Eligibility** field.
Note: This field may be named something different depending on how your Agency named it.
- Select a **Payer Name** from the drop-down menu.
- Select a **Provider Name** from the drop-down menu.
- Enter the **Subscriber Number**.
- Select a **State** from the drop-down menu.
- Click the **Check Eligibility** button. Any potential client eligibility based on the search criteria will appear in an itemized list of Services, organized by both In and Out Of Plan Networks.
Note: You can click the **Clear Eligibility** button to reset the fields.

| Eligibility | | | |
|---------------------|-----------------|--------------|---------|
| Mental Health | | | |
| In Plan Network | | | |
| ID | Description | Amount | Details |
| 1 | Active Coverage | | |
| Out of Plan Network | | | |
| ID | Description | Amount | Details |
| 1 | Active Coverage | | |
| Messages | | | |
| Benefit I... | Message Name | Message Text | |
| No data | | | |

- Complete the Form or Note as you normally would with the client's eligibility confirmed.

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Determine Eligibility via Billing

Determination of eligibility via **Billing** differs from Clinical, as it is performed after a Service has been rendered and processed so that a billable Line Item exists in the Billing Engine. Payers must have their **Elig Payer ID/Name** fields completed on Page 2 of the Master Insurance Form in order to check eligibility.

A 270 Batch Form is used to generate a file of multiple clients and Service data that you will manually upload to your clearinghouse. The clearinghouse then generates a 271 (Inbound) response file determining client eligibility. This type of eligibility check is commonly used in residential programs, as the clientele is typically known in advance, and in neighborhood/call centers operating as a crisis service.

Run Insurance Eligibility Verification in the Billing Engine (270 Transfer Form)

1. Navigate to the HIPAA 270 Transfer Form in the Billing Engine: **File > Claims Processing > Eligibility > 270 (Outbound)**.
2. Set filters around which clients to run eligibility for.

Notes:

- Event Date is the Date of Service and Control Date is the last time the Line Item was changed.
 - If your Agency is using the VPO Billing Engine, you can filter by Program if necessary.
3. Click the **Start** button.
 4. Select the location you want to save your file to.
 5. Enter a file name, and click the **Save** button.
 6. A verification prompt is displayed, listing the number of client eligibility requests that have been created. Click the **OK** button.
 7. Navigate to your clearinghouse website and manually upload the 270 file.

Import 271 Eligibility Response File

1. Navigate to your clearinghouse and download the 271 eligibility response file.
2. Within the Billing Engine, navigate to the HIPAA 271 Report: Claims the 271 Inbound: **File > Claims Processing > Eligibility > 271 (Inbound)**.
3. Select the **Report No Change** checkbox if you want to show all eligibility responses in the file or keep it unchecked if you only want to view eligibility for clients whose coverage has changed from what exists currently in the Billing Engine.
4. Click the **Print** button.
5. In the Report Output Options window, select the **Report to Printer** radio button if you want to print the report or select the **Display Report On-Screen** radio button to review the report on-screen.
6. Click the **Continue** button.
7. Locate the 271 file that you've downloaded to your computer from the clearinghouse and select the file.
8. Click the **OK** button. The report will either be displayed on-screen or sent to the printer based on your previous Report Output Options selection.

9. Manually update any discrepancies in coverage in the Billing Engine.

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Determine Eligibility via Scheduler

Eligibility determination via the **Scheduler** is the least used option. **Note:** You'll need to have access to your Agency's Scheduler RDP to perform the workflow.

Determine Eligibility via Scheduler

1. From within the Scheduler RDP, click on the client's appointment.
 2. Click the **Edit Patient** button.
 3. Click the **Add Ins** button to add the client's insurance information, if not already there.
- Note:** Click the **Copy information from the patient** button to bring over the patient's demographics.
4. Enter the client's primary insurance information.
 5. Click the **Save** button.
 6. Right click on the appointment listed on the Scheduler, and select **Check Eligibility**.
 7. The client's verification of benefits and eligibility appears in the **Benefit Details** window.

Note: If the payer has made it available, this will include copay amounts and descriptions.

| Benefit Details | | |
|---|------------------------------|---------------------|
| Drag a column header here to group by that column | | |
| Amount | Service Type | Benefit Information |
| \$500.00 | Health Benefit Plan Coverage | Deductible |
| \$50.00 | Health Benefit Plan Coverage | Co-Payment |

8. Click **Print** to print the report, or **OK** to return to the Scheduler.
9. Once verified, the appointment will be updated.
 - If the client is eligible for services, the appointment will display a green **E**.
 - If the client is deemed ineligible, the appointment will display a red **E**.

| | |
|-------------------------------------|---|
| - Individual Therapy | |
| | BLUE CROSS BLUE SHIELD (\$30.00 / \$0.00) |
| | SELECT HEALTH (\$0.00 / \$0.00) |
| There are no outstanding invoices. | |
| Balance: \$0.00 | |
| - Individual Therapy (Client Phone) | |
| | Prim. Clinician: |
| | Copay: 0.0000 |
| | BLUE CROSS BLUE SHIELD (\$0.00 / \$0.00) |
| | HEALTHY BLUE (\$0.00 / \$0.00) |

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