



+*first*CONNECT

HEALTHCARE
+*first*
patients before paperwork

firstConnect Users Guide, September 2014 Edition

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Table of Contents

About This Guide	4
Internet Settings	5
Logging In	7
Logging In.....	7
Reset Password	9
Menu Bar Options	10
Home.....	10
Settings	10
Logout	12
DDE	14
DDE Screen Captures.....	16
File Transfer	17
File Manager	18
Reconciliation Manager.....	21
Downloading Response Files	22
Eligibility	23
Viewing Previous Eligibility Reports.....	27
Retrigger Report Request	27
Status Types	27
Printing Eligibility	28
Saving Eligibility	28
Viewing Eligibility Responses.....	28

About *first*CONNECT

Preface

HEALTHCARE *first* is providing connectivity to the Medicare Administrative Contractor (PGBA, CGS, NHIC, NGS). Once in the CMS system if you have questions on how to use DDE, you should refer to the CMS Direct Data Entry Manual. If you don't already have a copy of the DDE manual it is located at:

<http://www.palmettogba.com/palmetto/providers.nsf/DocsCat/Providers~Jurisdiction%2011%20Part%20A~EDI~Software%20Manuals~7GLSDQ7740?open&navmenu=EDI%7C%7C%7C%7C>

A copy of the CMS HETS User Guide can be located at:

<http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp/downloads//HETSUIUserGuide.pdf>

A copy of the Palmetto GBA OPS User Manual can be located at:

[http://www.palmettogba.com/Palmetto/Providers.nsf/files/OPS_UserManual.pdf/\\$File/OPS_UserManual.pdf](http://www.palmettogba.com/Palmetto/Providers.nsf/files/OPS_UserManual.pdf/$File/OPS_UserManual.pdf)

The HETS 271 transaction only provides HEALTHCARE *first* with the NPI number. We use the tool below to convert to the Provider Name/Number. If for any reason your Provider Name or Number is not available your NPI number will be listed under the Provider Number columns.

http://www.hipaaspace.com/Medical_Billing/Coding/National_Provider_Identifier/NPI_Number_Lookup.aspx

After the contract is finalized, Implementation will create your account and provide you with the login credentials as well as walk you through how to use *first*CONNECT.

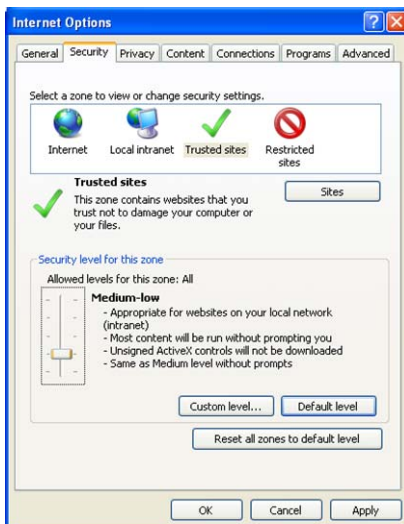
Internet Settings

Chapter 1

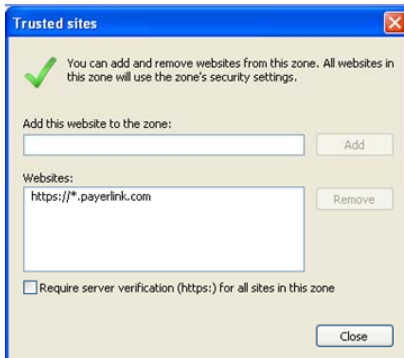
Settings may differ for certain browsers. Below are the instructions for Internet Explorer settings. The settings must be configured before accessing *firstCONNECT*.

To configure settings for *firstCONNECT* DDE access:

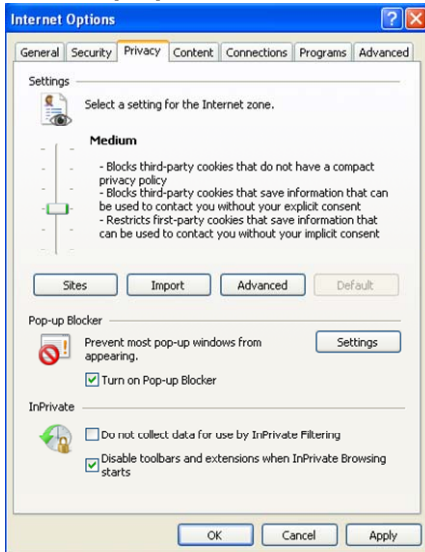
- 1 From the internet browser go to **Tools | Internet options.**
- 2 Click the **Security** tab.



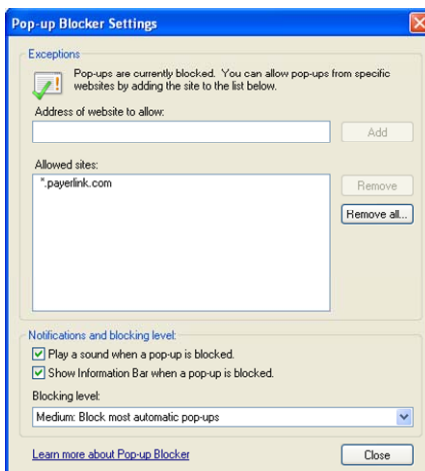
- 3 Click **Trusted Sites** (a green check mark should appear).
- 4 Click the **Default level** button.
- 5 Slide the slider bar on the left to Medium-low.
- 6 Click the **Sites** button. The following window will appear.



- 7 Type https://*.payerlink.com in the **Add this website to the zone:** box.
- 8 Click **Add** to add the site to the Trusted sites list. Make sure that the **Require server verification** checkbox is **unchecked**.
- 9 Click **Close**.
- 10 Click the **Privacy** tab in the **Internet Options** window.
- 11 In the **Pop-up Blocker** section click on the **Settings** button if it is enabled.



- 12 In the **Pop-up Blocker Settings** window type *.payerlink.com in the **Address of website to allow:** box.



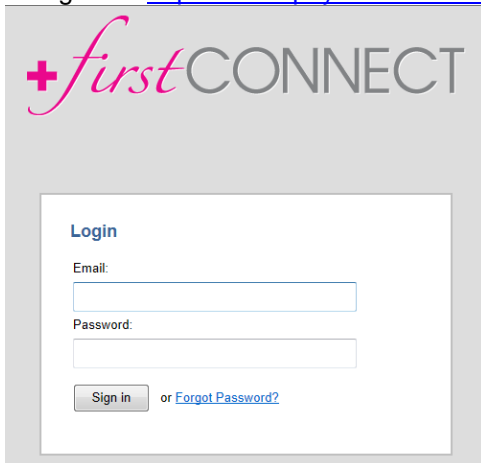
- 13 Click **Add**.
- 14 Click **Close**.
- 15 In the Internet Options window click **Apply**.
- 16 Click **OK** to save all settings.
- 17 You may proceed to login.

Once you have contracted *first*CONNECT services, HEALTHCARE*first* Implementation will create your agency account and login information. A default password, 1Connect, and a default security question, What is your favorite sports team? Answer: Cardinals, will be set up and emailed to each user at your agency. When a user logs in for the first time both the default password and security question will need to be changed. Until your account is activated you will not have access to the program. Once your account is activated you will receive verification from Implementation.

Logging In

To login to *first*CONNECT by navigating your browser to the web page:

- 1 Navigate to <https://www.payerlink.com/PL/PTLogin.aspx?type=logout>.



The screenshot shows the firstCONNECT login interface. At the top, the logo consists of a pink plus sign followed by the word 'first' in a script font and 'CONNECT' in a bold, sans-serif font. Below the logo is a white box with a grey border containing the 'Login' section. This section includes two text input fields: one for 'Email:' and one for 'Password:'. Below the password field is a 'Sign in' button and a link for 'Forgot Password?'.

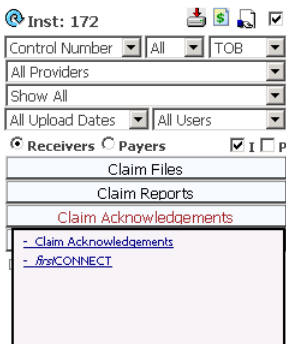
- 2 Enter the **Email** and **Password**.
- 3 Click **Sign in**.
- 4 The *first*CONNECT main menu screen will appear.



Enterprise Edition Users

To login to *firstCONNECT* within Enterprise Edition:

- 1 On the Enterprise Edition main menu click **Accounts | Billing | Download Claims**.
- 2 The Account Management screen will appear.
- 3 Click Claim Acknowledgements in the Account Management screen.
- 4 A link to *firstCONNECT* will appear on this screen. Click the *firstCONNECT* link.



- 5 *firstCONNECT* will open a new window in your browser.
- 6 Once you logout and close the *firstCONNECT* window, or click on the Enterprise Edition window, you will return to the Enterprise Edition product.

Reset Password

If you forget your password you can request to have the password reset.

To request a password reset:

- 1 From the login page at <https://www.payerlink.com/PL/PTLogin.aspx?type=logout> click the **Forgot Password?** link.



- 2 Type your **Email** address.
- 3 Click **Submit**.
- 4 A screen will appear requesting you to **Answer Security Question**.



- 5 Select the **Security Question** from the drop-down menu.
- 6 Enter your **Security Answer**.
- 7 Click **Reset**.

You will receive an email similar to the message below notifying you that your password has been reset. You will need to change the password after you login.

From: <noreply@payerlink.com>
Date: Mon, Mar 26, 2012 at 4:53 PM
Subject: PayerLink: Forgot Password Notification
To: dloftus73@gmail.com

Jane Doe,
Your password has been updated.
The temporary password is :

Wtsifd2QQJ

You will be asked to update this password once you log in


Menu Bar Options

Chapter 3

The Menu bar exists at the top of every screen in *firstCONNECT* and appears as follows:

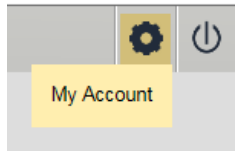


Home

The Home button  displays in the menu bar at the top left of the screen throughout *firstCONNECT*. To return to the Home screen from any location in *firstCONNECT*, click the button. You will return to the Home page which contains options for the three functions of *firstCONNECT*.

Settings

Account options are accessed by clicking  then selecting **My Account**.



Security

After logging in with the default password for the first time the password and security question will need to be changed:

- 1 On the main *firstCONNECT* screen click  at the top right of the screen then select **My Account**.
- 2 A new window will display and will default to **Security**.

- 3 Enter the **Old Password**.
- 4 Enter a **New Password**. (The password must be 6 characters minimum and must contain 1 letter, 1 number and is case sensitive.)
- 5 Enter the New Password again in the **Confirm** field.
- 6 Select a new **Security Question**.
- 7 Enter a new **Security Answer**.
- 8 Click **Update**. A window will appear notifying you that the information has been updated.
- 9 Click **Back to Home**.

Settings

The **My Account** option **Settings** includes default settings that can be changed per user preference for file transfers.



Set Default File Transfer Page

The setting selected determines which screen will open when you access File Transfer from the Home page in *firstCONNECT*. Two options are available:

- **File Manager Page** – When selected **File Transfer** will open to the **File Manager** page giving you quick access to download new 835 files.
- **Claim File Reconciliation Page** – When selected **File Transfer** will open to the **Claim File Reconciliation** page displaying information for all claims that have been filed.

firstCONNECT is automatically set for **File Transfer** to default to open to the **File Manager** page. However, the first time that you access the **Claim File Reconciliation** page, a dialog will appear asking if you wish to make the **Claim File Reconciliation** page your default view. If you click Yes in the dialog, going forward the **Claim File Reconciliation** page will be the default view when accessing **File Manager**.

To change the default setting for your user login:

- 1 On the main *firstCONNECT* screen click  at the top right of the screen then select **My Account**.
- 2 Click .
- 3 The **Settings** window will display.




- 4 Click the arrow to the right of **Set Default File Transfer Page**.
- 5 Select the desired option, **File Manager Page** or **Claim File Reconciliation Page**.
- 6 Click [Update](#). A window will appear notifying you that the information has been updated.
- 7 Click **Back to Home**.

835 Notifications

When selected, a check will display in the box to the right and will trigger an email to be sent when a new 835 file is available for download. *firstCONNECT* is automatically set to default this option to NOT be selected.

To change the default setting for your user login:

- 1 On the main *firstCONNECT* screen click  at the top right of the screen then select **My Account**.
- 2 Click the box to the right of **835 Notifications** to select or deselect the option.
- 3 Click [Update](#). A window will appear notifying you that the information has been updated.
- 4 Click **Back to Home**.

When an 835 file is available for download, you will receive an email similar to the following:

From: noreply@payerlink.com [<mailto:noreply@payerlink.com>]
 Sent: Saturday, July 12, 2014 10:00 PM
 To: [User Name]
 Subject: ERA notification for [Submitter ID]

A new 835 is now available in your Reconciliation Manager.

Filename: [835 file name]
 Received from: [Receiver Name]
 Sent to submitter: [Submitter ID]

You can turn off these notifications within the 'Settings' menu.

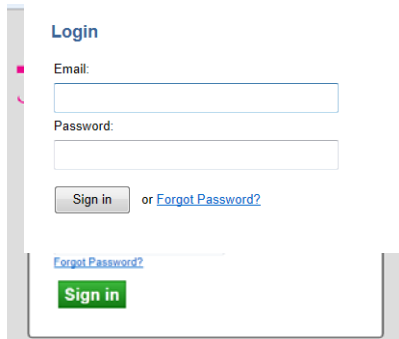
Logout

Logging Out from *firstCONNECT*

To log out from *firstCONNECT*:

- 1 Click  at the top right of the screen.

After you logout the following window will appear notifying you that you have successfully logged out.



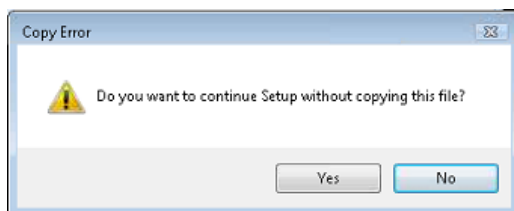
The screenshot shows a web form titled "Login". It contains two input fields: "Email:" and "Password:". Below the "Password:" field is a "Sign in" button. To the right of the "Sign in" button is a link that says "or [Forgot Password?](#)". Below this is a separate box containing a link that says "[Forgot Password?](#)" and a green "Sign in" button.

Logging Out from CMS

To log out from the CMS system:

- 1 Click **File** then select **Exit**.

In order to install the DDE software on your computer you must be an administrator for the computer, or have an administrator log in and install the software for you. If you do not have administrative rights to install software, you will receive the following error message.

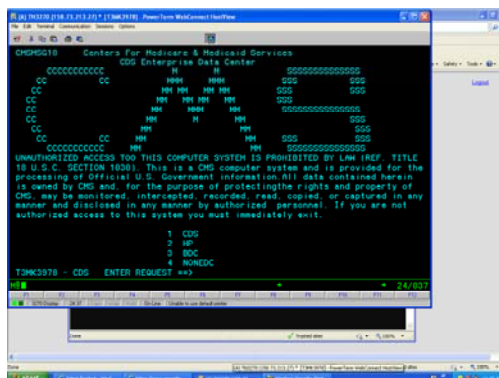


To access and install DDE:

- 1 On the main *first*CONNECT screen click **DDE**.
- 2 A pop-up security warning about installing software will appear. Click **Install** to continue access to DDE. This message will only appear one time on the PC.



- 3 Wait as components are downloaded and installed. (This could take several minutes depending on the Internet connection speed.)
- 4 Access to the CMS DDE system should now be available.



- 5 Select 1 for PGBA or 2 for all other Medicare Administrative Contractors.

The DDE system will only allow one user to be logged in at a time. If you attempt to login when another user is already logged in you will receive an error message.



If Windows Firewall is enabled, the Ericom terminal program for access will need to be enabled if notified by Windows. Click the **Windows Security Alert** button in the taskbar at the bottom of the screen and click **Unblock** in the window. This will remove any Windows Firewall notifications from popping up in the future.

DDE Screen Captures

DDE allows for the ability to capture screen shots which are stored in a single file and can be printed or saved to your computer. Screen captures are available until the DDE session ends, make sure to save screen captures before ending your session.

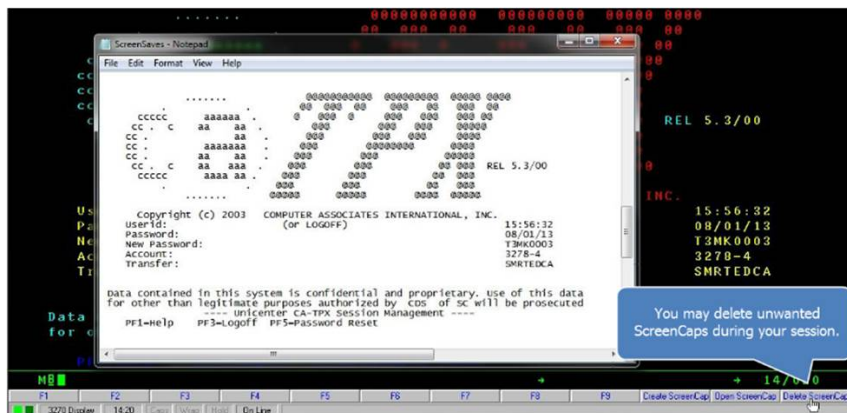
To create a screen capture click **Create ScreenCap** on the bottom right hand side of the screen, as shown below. Screen captures will all be stored in a file.



To view, Print, or Save the screen capture from the stored file click **Open ScreenCap**, as shown below.



To delete the screen capture during the session, click **Delete ScreenCap**, as shown below.



File Transfer

Chapter 5

File Transfer is a component included in *first*CONNECT and can take the place of the additional cost of using another vendor to upload billing claims to the Medicare Administrative Contractor (MAC).

As soon as claims are processed they are automatically sent to a File Transfer Queue. Files are transferred to and picked up from MACs in *first*CONNECT every thirty minutes. After claims are sent to the File Transfer Queue, they will be transferred to the MAC on the next scheduled transfer. Likewise, inbound files (response files) will be received on the next scheduled system refresh. See below for a sample schedule outlining the timing of file transfers for various intermediaries. Files will be transferred or refreshed every thirty minutes based on this schedule.

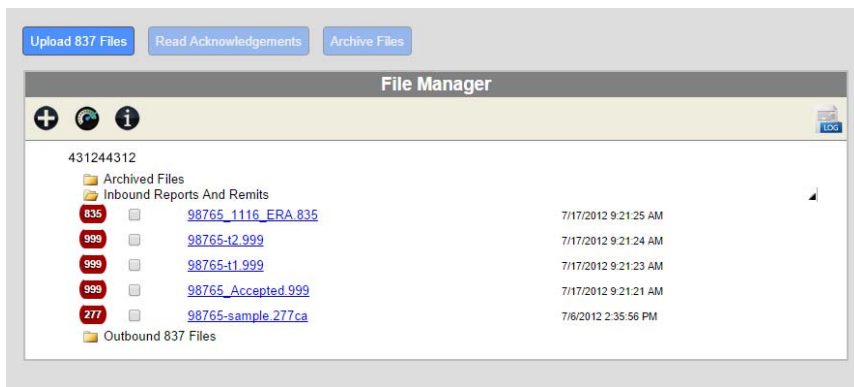
Transfer Schedule	PGBA/CGS	NGS/NHIC
06:00:00 (on the hour), 06:30:00, (on the half hour)	Send files	
06:10:00 (ten minutes after the hour), 06:40:00 (forty minutes after the hour)	Receive response files	
06:15:00 (15 minutes after the hour), 06:45:00 (45 minutes after the hour)		Send files
06:30:00 (thirty minutes after the hour), 07:00:00 (on the hour)		Receive response files


File Manager

The File Manager gives you access to manage all files including the ability to:

- Upload 837 Files
- Read Acknowledgements
- Archive Files
- Add Submitter
- Access Reconciliation Manager
- Access messages from Receivers

When the File Transfer default is set to File Manager Page (see page 11 for further details on File Transfer default) and the File Transfer button is clicked on the Home page, the File Manager screen will display.



If the File Transfer default is set to Claim File Reconciliation Page (see page 11 for further details on File Transfer default) you will need to click  at the top left of the screen to access the **File Manager** screen.

Upload 837 Files

Enterprise Edition Auto-Upload Users

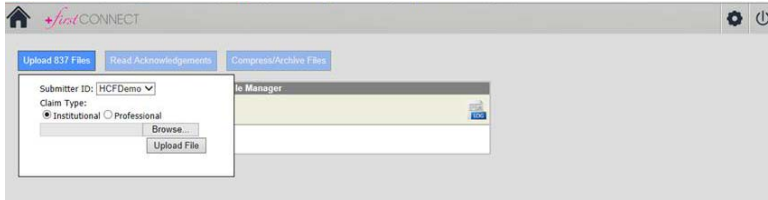
As an Enterprise Edition client, all RAP/EOE claims that are generated after File Transfer has been activated will be automatically uploaded after claims are processed in the grid within Enterprise Edition. You will no longer need to save 837 files to your desktop if you were using another transfer vendor prior to *firstCONNECT*.

Manual Upload Users

For agencies not exclusively utilizing Enterprise Edition to generate claims, it is necessary to manually upload files from your prior software program until all admissions/patients are in Enterprise Edition. After claims are processed, 837 files will need to be uploaded to *firstCONNECT*.

To upload 837 files:

- 1 On the main *firstCONNECT* screen click the **File Transfer** button.
- 2 On the File Transfer screen click **Upload 837 Files**.
- 3 A window will appear containing filters to browse for the applicable files.

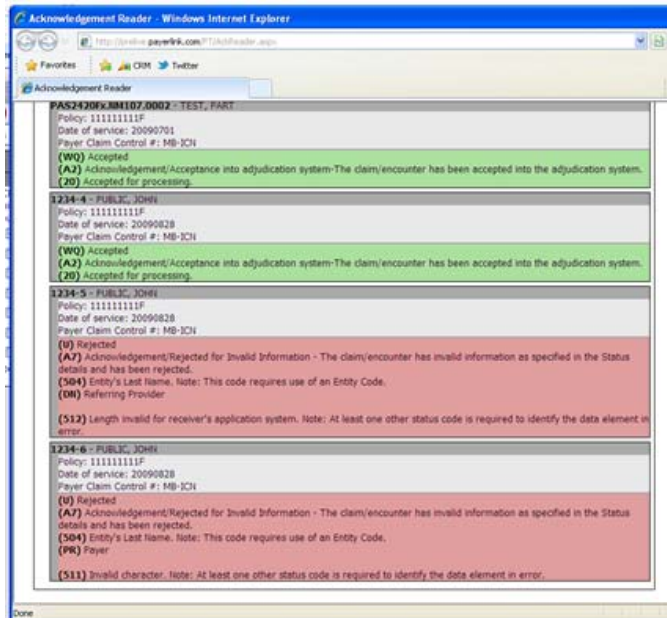


- 4 Select the applicable **Submitter ID** and **Claim Type**.
- 5 Click **Browse**.
- 6 Select the applicable file.
- 7 Click **Upload File**.

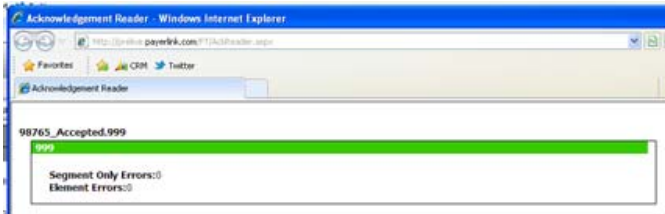
Read Acknowledgements

You will have the ability to retrieve and view the response files from *firstCONNECT*. To view files:

- 1 Expand the inbound folder to see a list of all response files.
- 2 Check the box next to each file that needs to be viewed. Only 277 and 999 files will automatically be available for viewing, 835 files must first be downloaded. (See steps above for downloading 835 files.)
- 3 Click **Read Acknowledgements** to view the response files.
- 4 The 277 Claim Status file will appear for review as seen below. Rejected claims will appear in red shading, accepted response files will appear in green shading.



- 5 The 999 Claim Status accepted files will appear as shown below.




The 999 Claim Status rejected files will appear as shown below.



If you double click the inbound file itself from the File Manager screen without clicking the **Read Acknowledgements** button, the response file will open, however the format will not be readable. In order to read the response file you must click the **Read Acknowledgements** button.

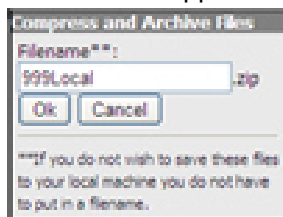
Archive Files

Response files are never deleted from *firstCONNECT*. They will remain as visible current files in the inbound folder for 10 days following the receipt of the response file. After 10 days the response files will automatically be archived and will be available for viewing in the archived files. To access archived files from the Transaction Log:

- 1 Click  to the right of Transaction Log.
- 2 A calendar will appear. Select the log date to view.
- 3 A list of transactions will appear.

Additionally, response files can manually be archived by the user at any time during the 10 day period. To manually archive response files:

- 1 Check the box to the left of the file to archive.
- 2 Click **Archive Files**.
- 3 A window will appear. If you do not want to compress the file, leave the filename blank. Click **OK**.







If you want to compress the file enter a filename and click **OK**.

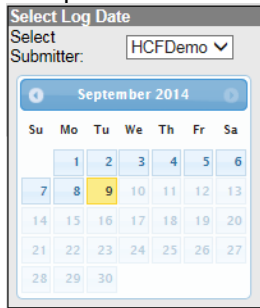
Archived response files will be available for viewing for all files that have been received through *first*CONNECT after service is implemented.

File Manager Menu Buttons

Three buttons will display on the top left of the screen:

-  – Add Submitter. When clicked a dialog will display in which you can enter new Submitter information to request activation for.
-  – Check on the status of your claim files. When clicked the **Claim File Reconciliation** page will display.
-  – Medicare System Messages. When clicked a window will display with any messages from Receivers.

At the top right of the screen  will display. When clicked, a calendar will appear, allowing you to select the specific **Submitter** and **Log Date** to display data for.





Reconciliation Manager



The Reconciliation Manager will display information for claims that have been submitted, allowing you to quickly see the status of submitted claims.

When the File Transfer default is set to Claim File Reconciliation Page (see page 11 for further details on File Transfer default) and the File Transfer button is clicked on the Home page, the Claim File Reconciliation screen will display.

Claim File Reconciliation									
Receiver	837 Sent	Claims	Billed	999	277	Accepted	Rejected		
Payment recieved for 431244312 on date 7/15/2014 3:28:43 PM									
Payment recieved for 431244312 on date 7/15/2014 3:28:43 PM									
WPS	6/23/2014 1:08:59 PM	10	\$500.00	6/26/2014 4:32:19 PM	6/26/2014 4:31:54 PM	65	18	999 277	
WPS	6/23/2014 1:08:59 PM	10	\$500.00	6/26/2014 4:40:35 PM				999	
WPS	6/23/2014 1:08:59 PM	10	\$500.00						
Payment recieved for 431244312 on date 6/23/2014 1:08:59 PM									
Payment recieved for 98765 on date 6/23/2014 1:08:59 PM									
Highmark	6/22/2014 12:06:45 PM								
Payment recieved for 431244312 on date 6/21/2014 1:05:59 PM									
Previous 1 Next									

If the **File Transfer** default is set to **File Manager Page** (see page 11 for further details on File Transfer default) you will need to click  at the top left of the screen to access the **Claim File Reconciliation** screen.

A file folder will display in the top left corner of the screen. When  is clicked, you will return to the **File Manager** page.

The top right corner of the screen will contain the option to **Show** or **Hide** details for each batch of files that was transferred. Additionally, the option to show or hide each individual batch of files is available by clicking  or  to expand or hide details.

The **Claim File Reconciliation** screen will contain information regarding each batch of files that have been transferred.

Hidden batch files will display information regarding if the payment was received including the batch number, and date and time the payment was received.

Expanded batch files will contain the following:

- Receiver name
- Date and time the 837 file was transferred
- Number of claims included in the file that was transferred
- The amount that was billed
- The date and time the 999 file was transferred
- The date and time the 277 file was transferred
- Number of claims accepted
- Number of claims rejected
- Links to view the files

Files that were late will display with yellow shading in the applicable box. Files that were rejected will display with red shading in the applicable box.

Downloading Response Files

Response files are automatically stored and auto archived in *firstCONNECT*. 999 and 277CA files will not need to be downloaded unless you want to store a copy of the files on your hard drive. ERN/835 files will not be able to be viewed in *firstCONNECT*. In **Settings** you can select the option to receive an email notification when 835 files are ready for download (See page 11 for further details). If you use Enterprise Edition and have ERA activated, you can import the file into Enterprise Edition. Follow the steps below to download files, then follow the normal steps to import the ERN/835 files into Enterprise Edition.

To download 835 files (or 999 and 277CA files if you wish to store them on your hard drive):

- 1 Expand the inbound folder to see a list of all response files.
- 2 Click the blue hyperlink for the file to be downloaded.
- 3 A File Download window will appear. Click **Open** or **Save**.
- 4 If you click **Open**, downloaded files will appear as shown below.

```
http://prelive.payorlink.com/TFT_main.asp?download-MTRHCITestInbox98765-sample.277ca - Windows Internet Explorer
http://prelive.payorlink.com/TFT_main.asp?download-MTRHCITestInbox98765-sample.277ca
I38*00* *00* *27*99999 *27*88888 *091006*1250**00901*00000001*1*9*~
G3*H0*88888*99999*20091006*1250*1234*X*009010K214~
ST*27*999000002*009010K214~
BNT*0088*08*BATCH0001*20091006*1250*TH~
HL*~20~1~
INI*FR*2*TEST 5010 PAST B****92*99999~
TRM*1*0001~
DTF*030*DE*20091006~
DTF*039*DE*20091006~
HL*2*1*21*1~
INI*41*2*GASTERS CLINIC*****XX*9999999999~
TRM*2*00003~
STC*A3*3*20091006*WQ*6489~
QTY*90*12~
QTY*AA*2~
ANT*YU*4888~
ANT*YU*1900~
HL*3*2*18*1~
INI*85*2*GASTERS CLINIC*****XX*9999999999~
HL*4*3*9T~
INI*QC*1*PUBLIC*0088*Q**HI*111111111F~
TRM*2*1234~1~
STC*A2*20*20091006*WQ*990~
REF*1H*MB*ICD~
DTF*472*DE*20090828~
HL*3*3*9T~
INI*QC*1*PUBLIC*0088*Q**HI*111111111F~
TRM*2*1234~2~
STC*A2*20*20091006*WQ*990~
REF*1H*MB*ICD~
DTF*472*DE*20090828~
HL*4*3*9T~
INI*QC*1*TEST*PAST*B**JK*HI*111111111F~
TRM*2*PAST242DFX.UN103.0001~
STC*A2*20*20091006*WQ*99.50~
REF*1H*MB*ICD~
DTF*472*DE*20090703~
TRM*2*PAST242DFX.UN104.0001~
STC*A2*20*20091006*WQ*99.50~
Done
```

Eligibility

Chapter 6


firstCONNECT generates a 270 eligibility transaction request based off of the patient information entered in the Eligibility Inquiry screen. *firstCONNECT* then accesses CMS' HIPPA Eligibility Transaction System (HETS) which is available 24 hours a day, 7 days a week. CMS sends back a 271 Eligibility response file that *firstCONNECT* translates into an Eligibility report.

To access Eligibility:

- 1 On the main *firstCONNECT* screen click the **Eligibility** module icon.
- 2 The **Eligibility Inquiry** screen will appear as shown below.


The screenshot shows the 'Eligibility Inquiry' web interface. At the top, there's a header with 'Name - Your Facility' and 'NPI - 9999999999'. Below that, a field for 'HICN/Member Id' contains '132456789'. The main form has three columns: 'Last Name' (Doe), 'First Name' (John), and 'Date of Birth' (06/24/1971). Below these are 'Date Type' (Plan Date), 'From' (3/27/2011), and 'Thru' (10/27/2013). A 'Get Eligibility' button is at the bottom. A mouse cursor is hovering over a 'Add/Remove active code sets' button in the top right.

- 3 Type the **HICN/Member Id** (required field).
- 4 Type the **Last Name**, **First Name**, and **Date of Birth** (two of these three fields are required).
- 5 The **Date Type**, **From**, **Thru**, **Code 1**, **Code 2**, and **Code 3** fields are automatically set so that the maximum values/data are retrieved in the Eligibility response.
- 6 Click **Get Eligibility**.
- 7 The Eligibility response will appear in a new browser tab.

The *first*CONNECT Eligibility module will give the user control over which Preventive Care code filters are used when requesting benefit information for selected services. These code sets can be accessed from the **Eligibility Inquiry** page by clicking on the pencil icon  at the top right of the screen. The following screen will appear.

Eligibility Inquiry

Name - Family Home Care NPI - 1871599571

Preventive Care Codes 

Initial Preventive Physical Examination (IPPE)
G0402: Initial Preventive Physical Examination(IPPE)
G0403: EKG for IPPE
G0404: EKG tracing for IPPE
G0405: EKG interpret & report for IPPE

Annual Wellness Visit (AWV)
G0438: Initial visit
G0439: Subsequent visit


UltraSound Screening for Abdominal Aortic Aneurysm (AAA)
G0389: Ultrasound exam AAA screening

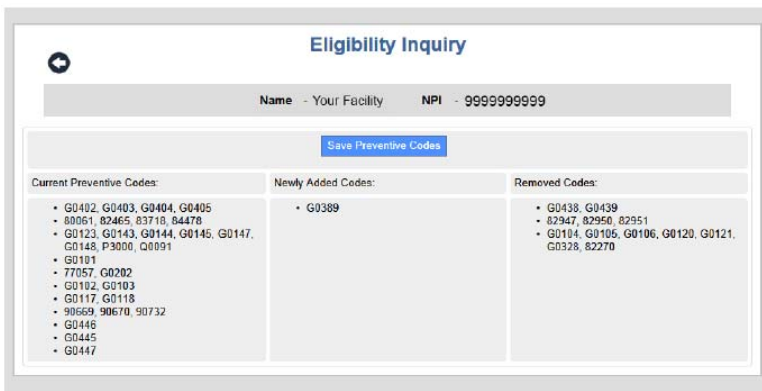
Cardiovascular Screening Blood Tests
80061: Lipid panels
82465: Cholesterol
83718: Lipoprotein
84478: Triglycerides

Diabetes Screening Tests
82947: Glucose, quantitative, blood (except reagent strip)
82950: Glucose, post-glucose dose (includes glucose)
82951: Glucose, tolerance test (GTT), 3 specimens (includes glucose)

All Eligibility Inquiries will be set with default Preventive Care codes available in the 270 and 271 files. Only codes being used in the inquiry will appear in the file. Preventive Care codes can be customized as well, changing the default codes for the selected customer.

To edit Preventive Care codes:

- 1 Click  at the top right of the Eligibility Inquiry screen.
- 2 To add codes to the inquiry, simply check the box next to the heading of the section of applicable codes to be added. To remove codes from the inquiry, simply uncheck the box next to the heading of the section of applicable codes to be removed.
- 1 After adjustments are completed, click **Save Preventive Codes** to continue.
- 2 Codes selected and saved will now be the default codes for the selected customer for all future Eligibility requests.
- 3 A screen will appear allowing the user to review the changes made on the previous screen, as shown below.



The screenshot shows the 'Eligibility Inquiry' interface. At the top, there is a header with a back arrow icon and the title 'Eligibility Inquiry'. Below the header, there is a form with two fields: 'Name - Your Facility' and 'NPI - 999999999'. A blue button labeled 'Save Preventive Codes' is positioned below the form. The main content area is a table with three columns: 'Current Preventive Codes', 'Newly Added Codes', and 'Removed Codes'. Each column contains a list of codes with a bullet point next to each code.

Current Preventive Codes:	Newly Added Codes:	Removed Codes:
<ul style="list-style-type: none">• G0402, G0403, G0404, G0405• 80061, 82465, 83718, 84478• G0123, G0143, G0144, G0145, G0147, G0148, P3000, Q0091• G0101• 77057, G0202• G0102, G0103• G0117, G0118• 90669, 90670, 90732• G0446• C0445• G0447	<ul style="list-style-type: none">• G0389	<ul style="list-style-type: none">• G0438, G0439• 82947, 82950, 82951• G0104, G0105, G0106, G0120, G0121, G0328, 82270

- 4 After reviewing the updated information, click **Save Preventive Codes**.
- 5 You will be returned to the Eligibility home page.

Viewing Previous Eligibility Reports

All Eligibility responses that have previously been pulled can be viewed.


To view previous Eligibility responses:



- 1 On the Eligibility Inquiry screen click .
- 2 The Eligibility Manager screen will appear with a list of previous responses.

Eligibility Manager



Search by Member ID Select by Status: CMS Report Success ▾

Name	Date of Birth	Member ID	Timestamp		
Baker	8/12/1935	156973596D	7/9/2013 9:56:34 AM		
Callaway	4/18/1940	639875698A	7/9/2013 9:56:16 AM		
Johns	4/25/1950	369785423D	6/6/2013 3:37:16 PM		
Lake	11/30/1932	968765238A	5/8/2013 1:13:58 PM		
Little	11/30/1943	369857215B	5/5/2013 2:22:13 PM		

- 3 Click  on the row of the response file that you wish to view.
- 4 If the Previous Responses list is long, you can click the **Select by Status** drop-down menu to filter the list to display only the status types that you wish to view. (See below for further information on Status Types.)
- 5 To go back to the Eligibility Inquiry screen click .

Retrigger Report Request

All Eligibility Requests can be triggered from a previous request to generate a new Eligibility Report without re-entering all of the patient information.

To re-generate an Eligibility Report:

- 1 On the Eligibility Manager screen click  on the row of the response file that you wish to re-generate.
- 2 The re-generated report will appear on a new browser tab on your screen. The report can be saved or printed from the screen that appears.

Status Types

Eligibility includes four response status types. These status types explain the type of response received, and allow you to filter previous responses by status.

The four status types include:


- CMS Report Success — Your Eligibility request was processed and successfully converted to a report.
- Eligibility Entry Error — One of the pieces of data you entered about the patient does not match what CMS has in the Common Working File.

- Failed CMS Report — Your Eligibility request was received, but there was an error converting it to a readable report.
- Failed CMS Response — Your Eligibility request was received from CMS, but there was an error retrieving the 271 response and no report was generated.
- Eligibility Transaction Error — No Eligibility 271 response was received due to an error from CMS.

Printing Eligibility

After you click **Get Eligibility** and the response appears on the screen, you will have the ability to print the response.



To print the Eligibility response:

- 1 After the response appears two icons will appear on the top right of the screen.
- 2 Click .
- 3 A Print window will appear. Click **Print**.

Saving Eligibility

After you click **Get Eligibility** and the response appears on the screen, you will have the ability to save the response.

To save the Eligibility response:

- 1 After the response appears two icons will appear on the top right of the screen.
- 2 Click .
- 3 Different browser versions will pop up various windows. You may need to click Save and/or Open for the response to appear in a new tab.
- 4 The response will appear in a new browser tab.
- 5 Click  on the browser toolbar to print the report.

Viewing Eligibility Responses

Eligibility responses that do not contain errors will contain several categories of information if they are entered, including the following:

Agency/User

The Agency/User section appears as follows:

Agency/User		Provider:	
Agency:	ABC Home HEALTHCAREfirst	111111	
firstCONNECT User:	Jane Doe	Date/Time Requested:	5/31/2012 1:55 PM

Subscriber

The Subscriber section appears as follows:

Subscriber			
Name:	Johns, Elizabeth	Date of Birth:	7/29/1921
Gender:	F	HICN/Member Id:	496093871A

Eligibility

The Eligibility section appears as follows:

Eligibility			
Part A Effective Date:	7/1/1986	Part A Termination Date:	
Part B Effective Date:	7/1/1986	Part B Termination Date:	
Inactive Period Effective Date:		Inactive Period Effective Date:	
Beneficiary Address Line 1:	1234 West Ozark Avenue	ESRD Benefit Desc. Svc Type Code:	
Beneficiary Address Line 2:		ESRD Transplant DC Date:	
Beneficiary City:	Ozark	ESRD Effective Date:	
Beneficiary State:	MO		

Report Item	Description
Part A Effective Date	A date that indicates the start of eligibility for Medicare Part A benefits.
Part A Termination Date	A date that indicates the termination of eligibility for Medicare Part A Benefits. No date in this field means Medicare Part A eligibility has not terminated.
Part B Effective Date	A date that indicates the start of eligibility for Medicare Part B benefits.
Part B Termination Date	A date that indicates the termination of eligibility for Medicare Part B benefits. No date in this field means Medicare Part B eligibility has not terminated.
Inactive Period Effective Date	A date that indicates the start of an inactive period due to unlawful, deported, or incarcerated reasons.
Inactive Period Termination Date	A date that indicates the end of an inactive period due to unlawful, deported, or incarcerated reasons.
Beneficiary Address Line 1, Line 2	The address line of the subscriber (beneficiary), if available.
Beneficiary City	The city of the subscriber (beneficiary), if available.
Beneficiary State	The state of the subscriber (beneficiary), if available.
Beneficiary Zip	The zip code of the subscriber (beneficiary), if available.
ESRD Effective Date	The date that indicates the start of eligibility for ESRD services.
ESRD Benefit Desc. Svc Type Code	The Type of Dialysis (14 or 15) services that are being rendered.
ESRD Transplant DC Date	The Date the Transplant services were discharged.

-3436trdDeductible

The Deductible section appears as follows:

Deductible			
Part B Deductible Year:	1/1/2012 – 12/31/2012	Part B Remaining Deductible Amount:	\$0
Blood Calendar year:	1/1/2012 – 12/31/2012	Blood Number of Units Remaining:	3
OT Cap Calendar year:	1/1/2012 – 12/31/2012	OT Cap Remaining Amount:	\$1880
PT & ST Cap Calendar year:	1/1/2012 – 12/31/2012	PT & ST Cap Remaining Amount:	\$1880
Pulmonary Rehab. Sessions Remaining (T):	72	Pulmonary Rehab. Sessions Remaining (P):	72
Cardiac Rehab. Sessions Remaining (T):	0	Cardiac Rehab. Sessions Remaining (P):	0
Int. Cardiac Rehab. Sessions Remaining (T):	0	Int. Cardiac Rehab. Sessions Remaining (P):	0

Report Item	Description
Part B Deductible Year	The calendar year associated with the remaining deductible amount.
Part B Remaining Deductible Amount	Medicare Part B remaining deductible amount associated with the calendar year indicated.
Blood Calendar Year	The calendar year associated with the remaining deductible amount.
Blood Number of Units Remaining	The Blood Deductible units remaining associated with the calendar year indicated.
OT Cap Calendar Year	The calendar year associated with the remaining capitation amount.
OT Cap Remaining Amount	Occupational Therapy remaining amount associated with the calendar year indicated.
PT & ST Cap Calendar Year	The calendar year associated with the remaining capitation amount.
PT & ST Cap Remaining Amount	Physical and Speech Therapy remaining amount associated with the calendar year indicated.
Pulmonary Rehab. Sessions Remaining (T)	The number of Pulmonary Rehabilitation sessions remaining for the Technical Component.
Pulmonary Rehab. Sessions Remaining (P)	The number of Pulmonary Rehabilitation sessions remaining for the Professional Component.
Cardiac Rehab. Sessions Remaining (T)	The number of Cardiac Rehabilitation sessions remaining for the Technical Component.
Cardiac Rehab. Session Remaining (P)	The number of Cardiac Rehabilitation sessions remaining for the Professional Component.
Int. Cardiac Rehab. Sessions Remaining (T)	The number of Intensive Cardiac Rehabilitation sessions remaining for the Technical Component.
Int. Cardiac Rehab. Sessions Remaining (P)	The number of Intensive Cardiac Rehabilitation sessions remaining for the Professional Component.

Part A Hospital/SNF

The Part A section contains all information for Medicare Part A plans and appears as follows:

Part A Hospital/SNF										
<i>Plans:</i>	Hospital					SNF				
	Full Days	\$per	Coin Days	\$per		Full Days	\$per	Coin Days	\$per	
2014	60	\$0.00	30	\$304.00		20	\$0.00	80	\$152.00	
2013	60	\$0.00	30	\$296.00		20	\$0.00	80	\$148.00	
2012	60	\$0.00	30	\$289.00		20	\$0.00	80	\$144.50	

<i>Spells:</i>	DOEBA	DOLBA	Full Rem.	Coin Rem.	Amount	DOEBA	DOLBA	Full Rem.	Coin Rem.	Amount
5/17/2013	5/18/2013		59 of 60	30 of 30	\$0.00	5/17/2013	5/18/2013	20 of 20	80 of 80	\$0.00

Report Item	Description
Hospital Full Days	Number of full days spent in the hospital YTD under a Medicare Part A plan.
Hospital \$per	Dollar amount spent per full day spent in the hospital YTD under a Medicare Part A plan.
Hospital Coin Days	Number of Hospital days assessed coinsurance per benefit period under a Medicare Part A plan.
Hospital \$per	Dollar amount applied to Hospital coinsurance per benefit period under a Medicare Part A plan.
SNF Full Days	Number of full days spent in a skilled nursing facility under a Medicare Part A plan.
SNF \$per	Dollar amount spent per full day spent in a skilled nursing facility under a Medicare Part A plan.
SNF Coin Days	Number of SNF days assessed coinsurance per benefit period under a Medicare Part A plan.
SNF \$per	Dollar amount applied to SNF coinsurance per benefit period under a Medicare Part A plan.
DOEBA	The date of the earliest billing activity for the spell of illness.
DOLBA	The date of the latest billing activity for the spell of illness.
Full Rem.	Number of full days reimbursement was received for.
Coin Rem.	Number of days assessed coinsurance.
Amount	Full dollar amount of reimbursement.

Preventative

The Preventative section contains all preventative care and appears as follows:

Preventative		
Smoking Cessation Sessions Remaining: 8	Smoking Cessation Next Session Date:	
Prev. HCPCS Code	Prev. Next Professional Date	Prev. Next Technical Date
G0439-Annual Wellness Visit (AWV)	1/1/2011	1/1/2011
G0438-Annual Wellness Visit (AWV)	1/1/2011	1/1/2011

Report Item	Description
Smoking Cessation Sessions Remaining	Number of Smoking/Tobacco Cessation Counseling Sessions remaining for a subscriber.
Smoking Cessation Next Session Date	The next available begin date for Smoking/Tobacco Cessation Counseling Session program if there are no sessions in their current period.
Prev. HCPCS Code	A Healthcare Common Procedure Coding System (HCPCS) code.
Prev. Next Professional Date	The date a subscriber is next eligible for professional services associated with the indicated HCPCS code.
Prev. Next Technical Date	The date a subscriber is next eligible for technical services associated with the indicated HCPCS code.

Plan Coverage

The Plan Coverage section appears as follows:

Plan Coverage			
Enrollment Date :	1/1/2012	Term Date:	
Type:	Preferred Provider Organization (PPO)	Option:	MCO Bill Option Code C
Name	Humana Insurance Company	ID:	H0939 879
Address Line 1	1100 Insurance Blvd.	Telephone:	2120C, N402, (Hower 148)
Address Line 2:		Zip:	697586384
City:	St. Louis	Website	www.humana-medicare.com
State:	MO		

Report Item	Description
Enrollment Date	The date that indicates the start of enrollment to the coverage plan.
Type	A full plan description followed by Plan Type Code: HM — Health Maintenance Organization Medicare Non Risk HN — Health Maintenance Organization Medicare Risk IN — Indemnity PR — Preferred Provider Organization

	PS — Point of Service Part D — Pharmacy
Name	A descriptive name of the beneficiary's insurance coverage organization.
Address Line 1, 2	The Coverage Plan's Address lines.
City	The Coverage Plan's City Address.
State	The Coverage Plan's State Address.
Term Date	The date that indicates the termination of enrollment to the coverage. No date in this field means the plan enrollment has not terminated.
Option	The bill option code of the Plan Type. This field only applies to plan types HM, HN, IN, PPO, and PS. This field will not be displayed for Part D plan type.
ID	The contract number followed by the plan number (if on file).
Telephone	The Coverage Plan's Contract Telephone Number (if on file) displayed as XXX-XXX-XXXX.
Zip	The Coverage Plan's Zip Code.
Website	Contract Plan's website address that will provide information on the subscriber's insurance.

Medicare Secondary Payer

The Medicare Secondary Payer section will contain Secondary Payer information if there is any entered and appears as follows:

Medicare Secondary Payer	
Effective Date:	Address Line 1:
Termination Date :	Address Line 2:
Insurer Name:	City:
Policy Number:	State:
Type of Primary Insur:	Zip:

Report Item	Description
Effective Date	The date that indicates the start of the primary insurer's coverage.
Termination Date	The date that indicates the termination of the primary insurer's coverage. No date in this field means primary insurance coverage has not terminated.
Insurer Name	The name of the insurance company.
Policy Number	The primary insuring organization's policy number for the Medicare beneficiary.
Type of Primary Insur	The type code and description of the Primary Insurance Plan: 12 — Medicare Secondary Working Aged Beneficiary or spouse with Employer group health plan

	13 — Medicare Secondary End Stage Renal Disease Beneficiary in the 12 month coordination period with and Employer group health plan 14 — Medicare Secondary No-Fault insurance including auto is primary 15 — Medicare Secondary Workers Compensation 16 — Medicare Secondary Public Health Service or other Federal Agency 41 — Medicare Secondary Black Lung 42 — Medicare Secondary Veteran’s Administration 43 — Medicare Secondary Disabled Beneficiary under age 65 with Large Group Health Plan 47 — Medicare Secondary other liability insurance is primary WC — Workers Compensation Medicare Set aside arrangement.
Address Lines 1, 2	The address Line of the insurance company.
City	The city of the insurance company.
State	The state of the insurance company.
Zip	The Zip Code of the insurance company.

Home Health Certification

The Home Health Certification section appears as follows:

Home Health Certification			
Certification:	G0180	Certification Date:	1/4/2011
Re-Certification:	G0179	Re-Certification Date:	2/28/2012

Report Item	Description
Certification	The HCPCS code used when the subscriber became certified for home health care services.
Certification Date	The date the subscriber was certified to receive home health care services.
Re-Certification	The HCPCS code used when the Beneficiary became recertified for home health care services.
Re-Certification Date	The date the beneficiary was recertified to receive home health care services.

Home Health

The Home Health section appears as follows:

Home Health							
<u>Start Date</u>	<u>End Date</u>	<u>DOEBA Date</u>	<u>DOLBA Date</u>	<u>Provider #</u>	<u>Provider Name</u>	<u>Contractor #</u>	<u>Contractor Name</u>
2/28/2012	4/27/2012			135968456	other	44697	PGBA
12/30/2011	2/27/2012	12/31/2011	2/27/2012	135968456	other	44697	PGBA

Report Item	Description
Start Date	The date the 60-day Home Health episode period started.
End Date	The date that the Home Health episode terminated.
DOEBA Date	The date of earliest billing activity for spell of illness.
DOLBA Date	The date of latest billing activity for spell of illness.
Provider #	Provider name and number, will show only the NPI if the Provider name is not available.
Contractor #	A display of the Contractor number.
Contractor Name	A display of the Contractor name.



If DOEBA and DOLBA dates are not available in the 271 Eligibility file retrieved, they will not be listed on the report. It is possible to have PPS period information with no DOEBA and DOLBA information.

Hospice

The Hospice section appears as follows:

Hospice					
<u>Benefit Period</u>	<u>F2F</u>	<u>Start Date</u>	<u>Term Date</u>	<u>Provider</u>	<u>Revocation Code</u>
2		2/29/2012	5/28/2012	807590700	0 Not revoked, open spell
1		12/1/2011	2/28/2012	807590700	0 Not revoked, open spell

Report Item	Description
Benefit Period	The number of the Benefit Period.
F2F	For future enhancement, currently does not display any data.
Start Date	The start date of a subscriber's elected period of Hospice coverage.
Term Date	The termination date of a beneficiary's elected Hospice coverage. No date in this filed means the beneficiary's elected

	period of Hospice coverage has not terminated.
Provider #	Provider name and number, will show only the NPI if the Provider name is not available.
Revocation Code	Code indicating whether hospice coverage was terminated or not. "0" indicates continuing hospice coverage. "1", "2", or "3" indicates the hospice coverage was terminated (revoked).

Pharmacy (Part D)

The Pharmacy (Part D) section appears as follows and will only appear if the patient has a Pharmacy Part D plan:

Pharmacy (Part D)	
Enrollment Date: 8/1/2013	Disenrollment Date: 12/31/2013
Contract Number: H4590	Plan Number: 012
Plan Name: AETNA HEALTH, INC. (TX)	Plan Website: www.aetnamedicare.com
Plan Address: 2777 Stemmons Freeway Suite 300 Dallas, TX 753569440	Plan Phone: 8004451796

Report Item	Description
Enrollment Date	The date that indicates the start of enrollment to the coverage plan.
Disenrollment Date	The date that indicates the end of enrollment to the coverage plan.
Contract Number	The insurance company's Part D contract number.
Plan Number	The number of the beneficiary's Part D insurance plan.
Plan Name	A descriptive name of the beneficiary's insurance coverage organization.
Plan Website	The coverage plan's website address.
Plan Address	The coverage plan's mailing address.
Plan Phone	The coverage plan's telephone number.

No Data Available

If no data is available for a section, the section will appear as follows:

Medicare Secondary Payer
<i>No Medicare Secondary Payer data available</i>