

Guide to PC-Based Transactions

Montana Medicaid Eligibility

v2.1

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Overview	1	Responses	4
About the Transaction	1	About Your Responses	4
Customer Support	1	Status	4
		Indicators	5
Requests	2	Input and Response Information	5
Search Types	2	Transaction Information	5
Cascade Sequence	2	Information Source	6
Input Prompts	2	Information Receiver	6
		Subscriber	6
		Eligibility/Benefit	7
		Error Messages	8

Overview

About the Transaction

This transaction allows you to verify a patient's eligibility status and benefits for Montana Medicaid for a single date of service.

Disclaimer: Verification of eligibility does not guarantee payment for service.

Date of Service Restrictions

- Up to one year in the past.
- Future dates not allowed.

National Provider Identifiers

In order for you to use a National Provider Identifier (NPI) as the provider ID, the following conditions must exist:

- The payer must be ready to accept NPI. Consult our payer lists at www.emdeon.com/PayerLists/payerlists.php for this payer's NPI-readiness status.
- The inquiring provider must have fulfilled all of the payer's NPI registration requirements.

Customer Support

Emdeon Customer Support

800.333.0263

customer.service@emdeon.com

Requests

Search Types

ID

- The **provider ID** of the inquiring provider.
- The Montana Medicaid **recipient ID**.
- The **date of service**.

ID Card

- The **provider ID** of the inquiring provider.
- The Montana Medicaid **card number**.
- The **date of service**.

Cascade Sequence

1. Recipient ID
2. ID Card

What is Cascading?

Cascading refers to the capability of the software to execute multiple searches automatically when a single search does not find the patient's record, or receives an error with a **Retry** status.

To enable cascading in a transaction, you must enter data for more than one search type. In this case, the software will continue to cascade until one of the following occurs:

- The patient's record is found, or a valid non-error response is received (**Closed** status)
- All available search types have been exhausted
- An error is received with an **Error** status

Input Prompts

Prompts are listed in alphabetical order.

Account

Requirement: *Optional; not sent to the payer.*

The account number you have assigned to this account, for your internal use only.

Amount

Requirement: *Optional; not sent to the payer.*

The amount applicable to this inquiry, for your internal use only.

Date of Service

Requirement: *Required.*

The date of service, in MMDDYY or MMDDCCYY format.

Note: The date of service must be within the past year and cannot be in the future.

ID Card #

Requirement: *Required for ID card searches.*

The identification number from the patient's card. This information is read automatically when you swipe the patient's card.

Provider ID

Requirement: *Required.*

The provider ID of the inquiring provider.

In order for you to use the National Provider Identifier (NPI), the payer must be ready to accept NPI. Additionally, the payer's NPI registration requirements must be fulfilled.

Recipient ID

Requirement: *Required for ID searches.*

The patient's Montana Medicaid recipient identification number.

Responses

About Your Responses

All of the items described in the following response explanation may not appear in every response. Payers typically return only the information that is applicable to your query.

If the payer does not return a particular piece or section of information in a specific response, the headings for that information will not print. Items will shift position to fill the vacancy.

Your username appears in the upper left corner of the response. See your product **User's Guide** for information about creating usernames.

Additional Reference Documents

More information about your response can be found in the following documents:

- **PC-Standard-Eligibility-Response-Dictionary.pdf** - gives a more detailed description of data fields returned in the standard Emdeon response.
- **Dictionary-of-Transaction-Error-Messages.pdf** – a complete dictionary of error messages.
- **Common Response Abbreviations.pdf** – common abbreviations used in the standard Emdeon response, along with their full description.

These documents are available on your installation CD, and on the Web at:

http://www.emdeon.com/support/document_library.php

Note: The above documents are in Portable Document Format (.pdf). You must have the Adobe® Acrobat® Reader to view this document. If you do not have the Reader, you can download it for free at www.adobe.com.

Status

Closed

The patient is eligible or is on file. Read the response for clarification.

Retry

The patient is ineligible or is not on file, or you entered invalid information, or Emdeon did not receive a valid standard response. Read the message in the response for clarification.

Error

A communications-related error or error of greater severity occurred. Read the message in the response for clarification.

Indicators

This information appears on the top of the report. The indicators show the following:

Benefit

Indicates the presence or type of benefit information in the response.

Y = Benefit information exists

N = No benefit information exists

P = Pending

Q = QMB

S = Spenddown

Other Payer

Indicates the patient's Other Payer coverage.

Y = Patient has Other Payer coverage.

NA = Unable to determine if Other/Additional Payer information is present in the response from the payer.

Medicare

Indicates the patient's Medicare coverage.

A = Patient has Medicare Part A coverage.

B = Patient has Medicare Part B coverage.

A&B = Patient has Medicare Parts A and B coverage.

NA = Unable to determine if Medicare information is present in the response from the payer.

Input and Response Information

The input area shows the data you sent in the request. For some of the input fields, the response area displays what the payer actually has on file. This arrangement enables you to verify what you entered against what is on file.

Depending on your software product and report settings, response information fields can appear in one of two locations:

- They can appear in a column to the right of the input fields.
- They can appear beneath the input fields, with the heading (On File).

An asterisk to the left of an input field indicates that the mirrored response data did not match your input data.

The following response fields are displayed:

- The patient's Montana Medicaid recipient ID.

Transaction Information

The Transaction Information section returns reference information for this particular transaction, such as:

- The Submit ID used for tracking.
- The date and time when the transaction was created.

- Benefit Indicator:
 - Y** = Benefit information exists.
 - N** = No benefit information exists.
 - P** = Pending.
 - Q** = QMB.
 - S** = Spenddown.
- Medicare Indicator:
 - A** = Patient has Medicare Part A coverage.
 - B** = Patient has Medicare Part B coverage.
 - A&B** = Patient has Medicare Parts A and B coverage.
 - NA** = Unable to determine Medicare coverage.
- Other Payer Indicator:
 - Y** = Patient has other payer coverage.
 - NA** = Unable to determine other payer coverage.

Information Source

Information about the payer, such as primary ID and name.

Information Receiver

Information about the requesting provider, such as primary ID and name.

Subscriber

Information about the subscriber, or the patient, when the patient is the subscriber. Includes:

- The transaction audit (**trace**) numbers and origins.
- The subscriber's primary ID.
- Demographic information, such as:
 - Last, first, middle name
 - Prefix and suffix
 - Date of birth
 - Gender
 - Address
 - Student status
 - Handicap indicator
 - Birth sequence
- Whether any identifying elements for the subscriber have changed from those submitted in the request (**Change**).
- Additional identification numbers other than the primary ID.
- Eligibility or benefit dates. Dates can also appear in the Eligibility/Benefit section.

Eligibility/Benefit

Each Eligibility/Benefit section gives details about the patient's eligibility status and other types of benefits. There can be several Eligibility/Benefit sections. Information includes:

- Eligibility Type: Identifies the type of information to which this section applies. The following types can appear:
 - Actv Cvg
 - Inactv
 - Co-Pay
 - Other/Addl Payer
- Coverage type.
- Service types. The following types can appear:
 - Health Bene Plan Cvg (Health Benefit Plan Coverage)
 - LTC (Long Term Care)
- Applicable dollar amount or percentage.
- Insurance type. The following types can appear:
 - LTC (Long Term Care)
 - Mcare A (Medicare Part A)
 - Mcare B (Medicare Part B)
 - Mcaid (Medicaid)
 - QMB (Qualified Medicare Beneficiary)
- Plan coverage information.
- Benefit period.
- Benefit quantity.
- Authorization or certification required.
- In-network indicator.
- Product or service ID.
- Procedure Modifiers.
- Health care service delivery details.
- Additional identifiers.
- Benefit-specific eligibility dates.
- Limitations.
- Information used to determine eligibility.
- Benefit-related entity and entity contact information.

For a complete description of the abbreviations appearing in this section, see **Common Response Abbreviations.pdf** on your installation CD and on the Web at

http://www.emdeon.com/support/document_library.php

Error Messages

Transaction-related error messages begin with CL, HT, RH, or another alphabetic prefix, followed by a number and a line or so of text.

For a comprehensive description of all error messages, see the document **Dictionary of Transaction Error Messages**.

This document is available on your installation CD, and on the Web at:

http://www.emdeon.com/support/document_library.php