Ability Interface

Netsmart

www.ntst.com
1550 East Republic Road
Springfield, MO 65804

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Ability Interface

The Ability interface provides agencies with the ability to send files to and receive files from their Medicare Administrative Contractor (MAC) from within myUnity Essentials. **270/271 Eligibility requests, 837 electronic claim files, 999 and 277 claim response files** and **835 electronic remittance files** can be sent or received through the interface.

IMPORTANT NOTE: The login information for your Medicare intermediary must be reported to Ability prior to Netsmart activating the interface. If your agency currently uses dial-up to transmit claims to Medicare, it's very important that once you are active with Ability you stop using dial-up to send claims. Doing so will cause Medicare to automatically suspend your submitter ID. If you are not able to immediately start using the interface, you should log into Ability's website to transmit claims in the interim.

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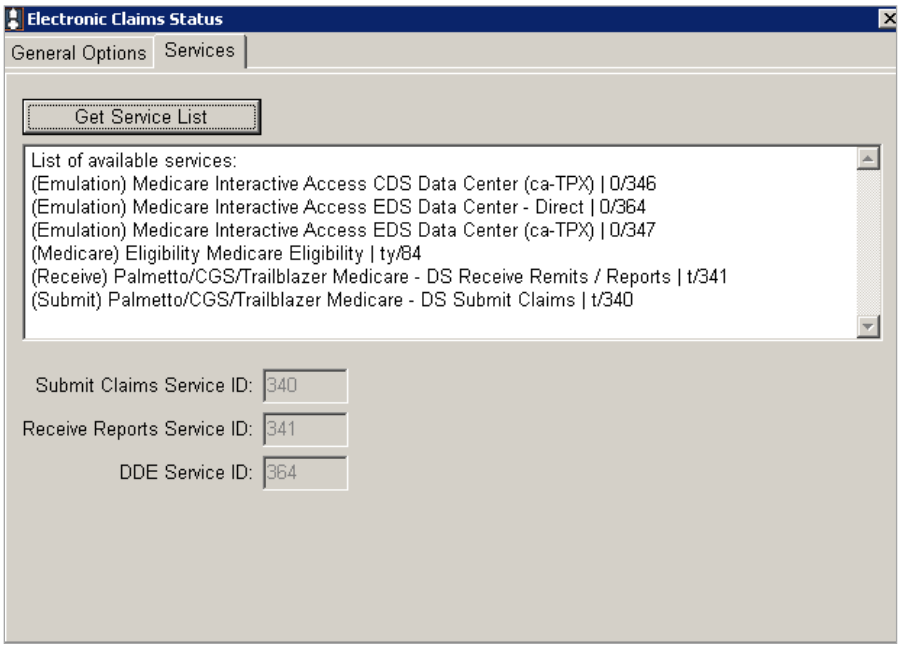
Set-up:

1. Click on **FILE>FILE MAINTENANCE>ENTITY** and select **Insurance type**.
    a. On the **'Insurance'** tab, select **Oasis Type "1–Medicare (Fee for Service)"** or **"2-Medicare (HMO/Managed)"** for each Medicare and Medicare Advantage plan for which real time eligibility will be run.
2. Click on **BILLING>CLAIMS STATUS** and select the **Services** tab.
    a. Click **"Get Service List"** to confirm the interface is active.
    b. Ensure no **Service ID** numbers are blank.
        i. For example:



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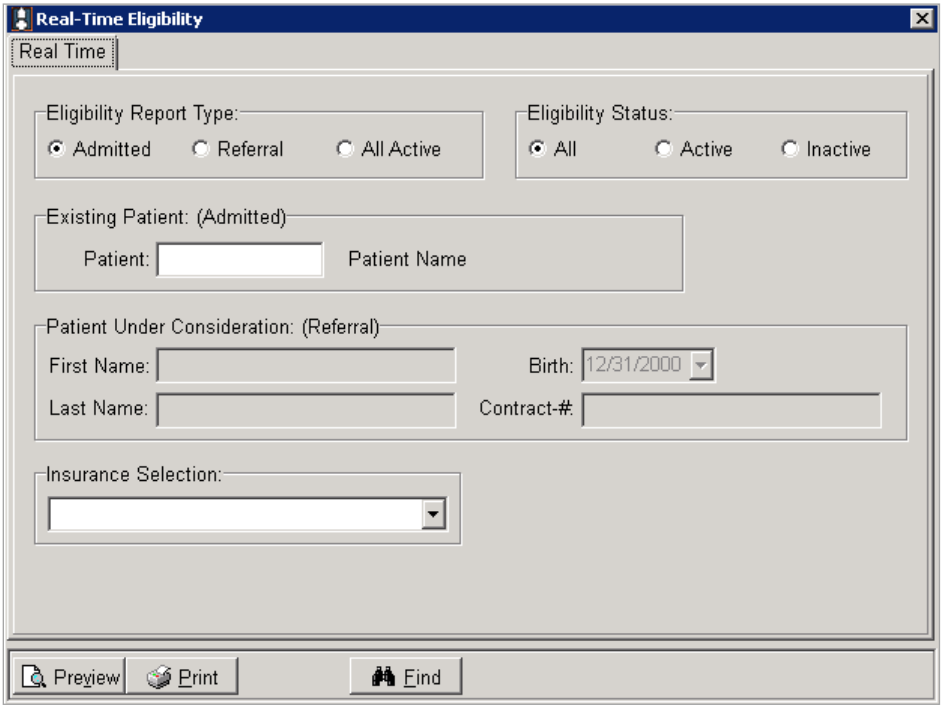
Real-Time Eligibility Process:

1. Click on **BILLING>ELIGIBILITY>REAL-TIME ELIGIBILITY**

Note: If this menu is not available, it needs to be enabled in File>File Maintenance>User Security. This option should not be grayed out if the Ability Interface is active.



Eligibility Report Type:

- If '**Admitted'** is selected, enter a patient number in the "**Existing Patient**" field or click '**Find**' to do a patient search.
- If '**Referral**' is selected, enter the name, birth-date and contract # for patients that have not yet been entered into the software to check their eligibility status.
    - **Medicare Beneficiary Matching Rules** must be followed:

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7.3 Medicare Beneficiary Matching Rules

The HETS 270/271 application applies search logic that uses a combination of the following data elements: Health Insurance Claim Number (HICN), Medicare Beneficiary's Date of Birth (DOB), Medicare Beneficiary's Full Last Name, and Medicare Beneficiary's Full First Name. Table 9 describes the necessary data elements for the required primary and alternate search options supported by the HETS 270/271 application.

Table 9 – HETS 270/271 Search Options

Search Option	HICN	Last Name	First Name	DOB
Primary	X	X	X	X
Alternate 1	X	X		X
Alternate 2	X	X	X	

- If the Medicare Beneficiary's submitted HICN is found but is not the Medicare Beneficiary's active number, the HETS 270/271 application will cross-reference the submitted HICN to the active HICN. The 271 response will include in the 2100C Loop the inactive HICN within a REF segment, the active HICN within NM109, and a AAA error with a reject reason code of AAA03 = "72". The Trading Partner may then send a new 270 request with the active HICN.
- If the search criteria do not produce a match to a Medicare Beneficiary, the HETS 270/271 application will generate the appropriate AAA03 error code in the 271 response. Refer to Section 8.3 of this Companion Guide for additional information.

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- If '**All Active**' is selected, use the **Preview** or **Print** button to view the eligibility response report for patients based on **Eligibility Status** selection.
- **Eligibility Status:** Choose to report only Active patients, only Inactive patients or All.
- **Insurance Selection:** Select an insurance from the dropdown. Insurances marked as **Oasis Type "1–Medicare (Fee for Service)"** or "**2-Medicare (HMO/Managed)**" in the Insurance tab of **File>File Maintenance>Entity>Insurance** are available for selection.
- Click **Preview** to view the report:

5/29/2013 9:41:32 AM **Patient Eligibility Report** Page 1

Payor: Submit Date: 05/29/2013
Real-Time Eligibility

Patient	Code	Admit	Disch	Contract	Eligibility	Effective
					Active	06/01/2012

1 Active: Medicare Part A
Service Types: Home-Health, Hospice, Hospital-Inpatient, Hospital-Room/Board, Skilled-Nursing, Blood, Dialysys
Entitlement date: 06/01/2012
Deductible: 1184
Benefit dates: 01/01/2013 - 12/31/2013
Deductible: 1156
Benefit dates: 01/01/2012 - 12/31/2012
Deductible: 0
Benefit dates: 04/18/2013 - 05/01/2013

1 Active: Medicare Part B
Service Types: Home-Health, Physical-Therapy, Speech-Therapy, Occupational, Blood, Urgent-Care, DME, Cardiac, Pulmonary, Dial ysys, Renal
Entitlement date: 06/01/2012
Deductible: 0
Benefit dates: 01/01/2013 - 12/31/2013
Deductible: 0
Benefit dates: 01/01/2012 - 12/31/2012

R Other-Payor: Other Insurance
Benefit dates: 02/01/2013
Pharmacy Plan: FIRST HEALTH LIFE & HEALTH INSURANCE COMPANY

R Other-Payor: Other Insurance
Benefit dates: 06/01/2012 - 01/31/2013
Pharmacy Plan: PACIFICARE OF COLORADO INC

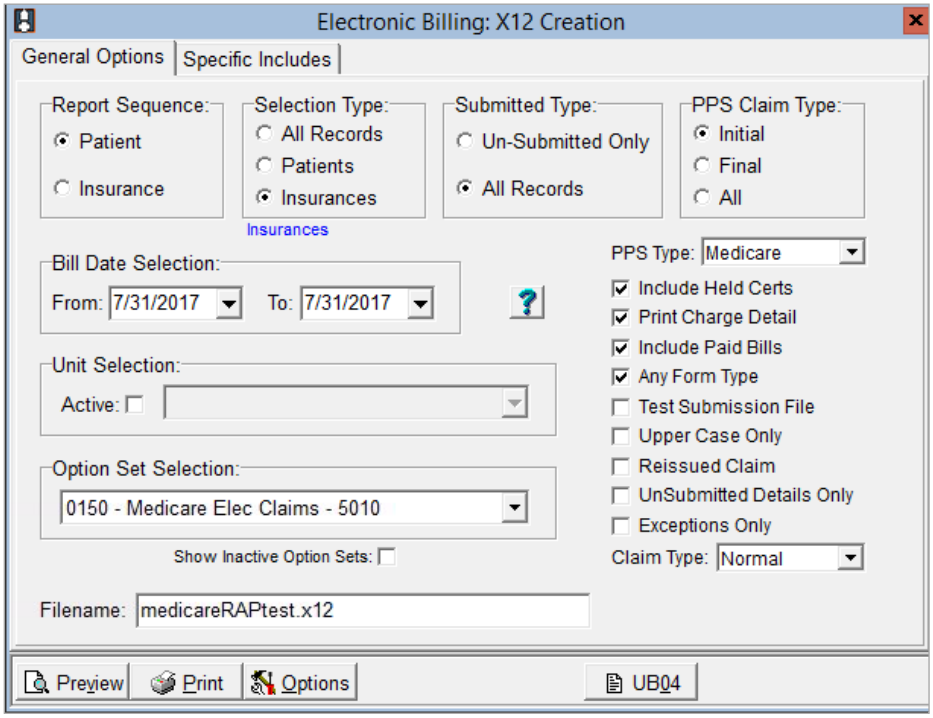
R Other-Payor: Benefit dates:
Benefit dates: 06/01/2012 - 01/31/2013
Message: MCO Bill Option Code - C
Payor Name: PACIFICARE OF COLORADO INC

Total records: 1

Electronic Claims Process:

Electronic Claims gives the user the ability to create claims in ANSI X12 institutional formats for transmission to your MAC via Ability.

1. Go to **BILLING>ELECTRONIC CLAIMS**



2. Set **Selection Type** to **Insurances and/or Patients** and select specific insurances/patients on the '**Specific Includes**' tab.
3. **Submitted Bills** should be set to '**Un-Submitted Only'** unless claims are being re-submitted in which case '**All Bills'** should be chosen.
4. **PPS Claim Type (HH only)** should be set to **Initial** or **Final** according to the claim type being billed.
5. In the '**Bill Date Selection'**, enter the **Bill Date** from the **Billing Audit** run as the **From and To Date**.
6. PPS Type should be set to **'Medicare.' (HH only)**
7. For agencies with multiple units, check the '**Active**' box under **Unit Selection** and select the unit for which the claim file is being created.
8. Select the appropriate **Medicare Option Set** in the '**Option Set Selection'** dropdown
9. For the **Filename**, assign a unique filename with a **.X12** extension.
10. Click on the ? on screen for additional information regarding selection criteria options or refer to **Help > Help, Billing > Electronic Claims**.
11. Click '**Preview**' after selections have been made.
    a. Review the **Electronic Claim Submission** report for accuracy.
    b. Claims with an "**EXCEPTIONS FOUND**" message (see below) will not be exported until corrections are made and the file re-created.

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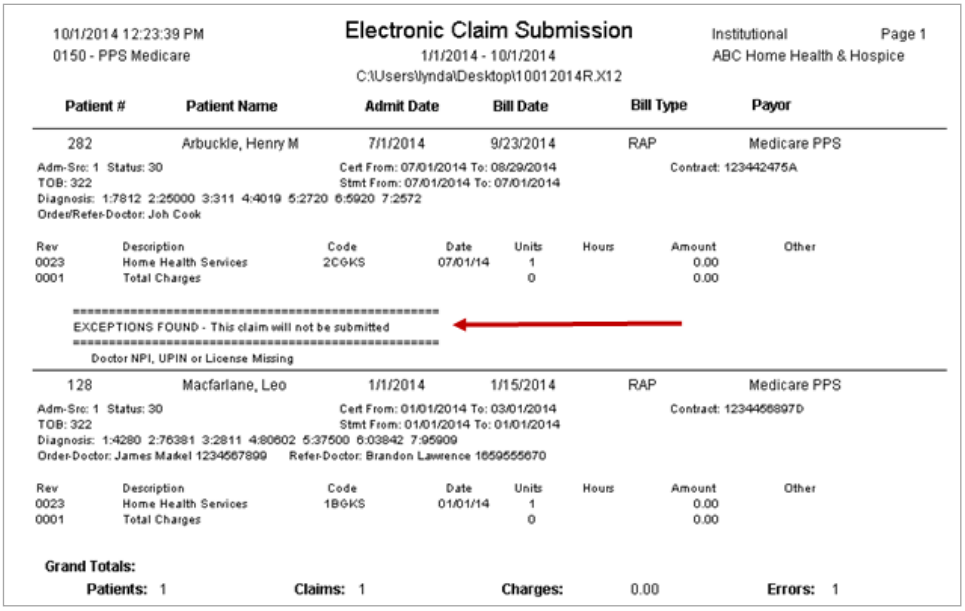
c. After the exceptions have been corrected the electronic claim file is ready for transmission to Ability.

Sample Electronic Claim Submission Report:



10/1/2014 12:23:39 PM
0150 - PPS Medicare

Electronic Claim Submission
1/1/2014 - 10/1/2014
C:\Users\lynda\Desktop\10012014R.X12

Institutional Page 1
ABC Home Health & Hospice

Patient #	Patient Name	Admit Date	Bill Date	Bill Type	Payor
282	Arbuckle, Henry M	7/1/2014	9/23/2014	RAP	Medicare PPS

Adm-Src: 1 Status: 30 Cert From: 07/01/2014 To: 08/29/2014 Contract: 123442475A
TOB: 322 Stmt From: 07/01/2014 To: 07/01/2014
Diagnosis: 1:7812 2:25000 3:311 4:4019 5:2720 6:5920 7:2572
Order/Refer-Doctor: Joh Cook

Rev	Description	Code	Date	Units	Hours	Amount	Other
0023	Home Health Services	2CGKS	07/01/14	1		0.00	
0001	Total Charges			0		0.00	

==========
EXCEPTIONS FOUND - This claim will not be submitted
==========
Doctor NPI, UPIN or License Missing

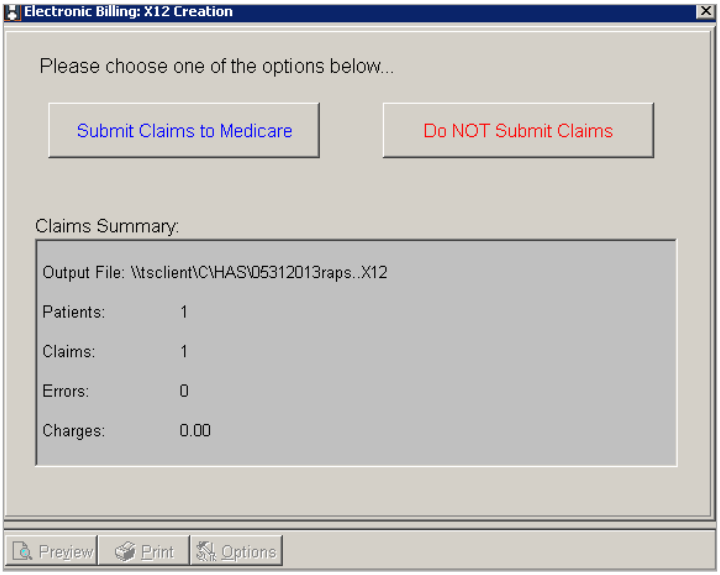
Patient #	Patient Name	Admit Date	Bill Date	Bill Type	Payor
128	Macfarlane, Leo	1/1/2014	1/15/2014	RAP	Medicare PPS

Adm-Src: 1 Status: 30 Cert From: 01/01/2014 To: 03/01/2014 Contract: 1234456897D
TOB: 322 Stmt From: 01/01/2014 To: 01/01/2014
Diagnosis: 1:4280 2:76381 3:2811 4:80602 5:37500 6:03842 7:95909
Order-Doctor: James Makel 1234567899 Refer-Doctor: Brandon Lawrence 1659555670

Rev	Description	Code	Date	Units	Hours	Amount	Other
0023	Home Health Services	1BGKS	01/01/14	1		0.00	
0001	Total Charges			0		0.00	

Grand Totals:
Patients: 1 Claims: 1 Charges: 0.00 Errors: 1

12. After previewing the **Electronic Submission Report**, click '**Submit Claims to Medicare'** if ready for transmission or click '**Do NOT Submit Claims'** if corrections are still needed.



a. After submitting claims, access **Claims Status** to confirm the files were accepted.

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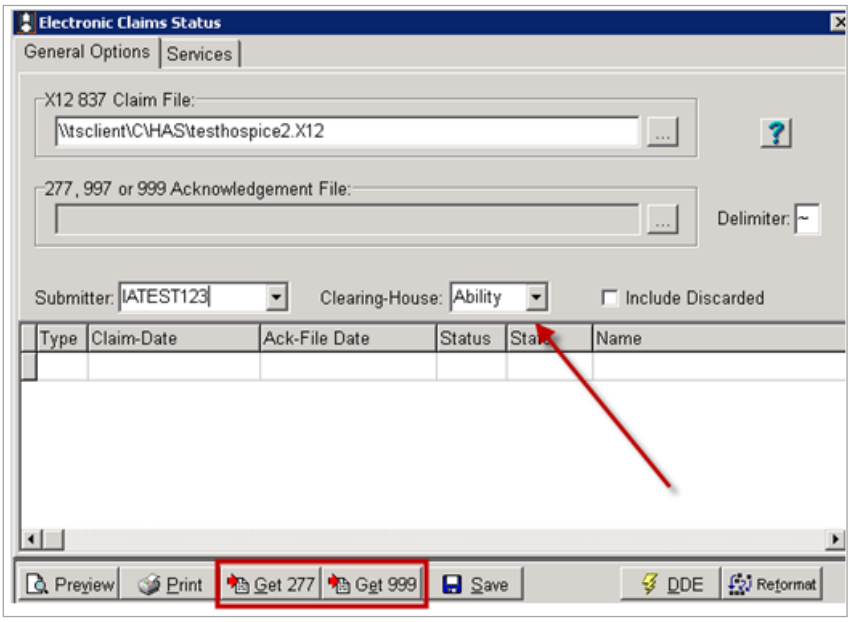
Claims Status Process:

The Claims Status menu provides access to the 999 and 277 response reports to determine if claim were accepted or rejected by Ability.

1. Click on BILLING>CLAIMS STATUS

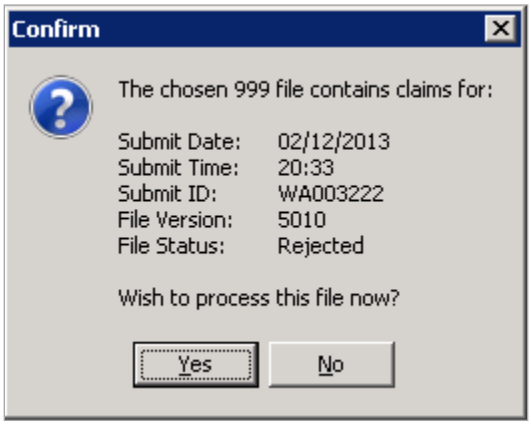
Note: If this menu is not available this menu option needs to be enabled in File>File Maintenance>User Security.

2. Set the '**Clearing-House'** to **Ability**.
3. Click '**Get 277'** or '**Get 999'** to retrieve response files.



Note: If you have multiple submitter IDs, select the appropriate one from the drop-down.

4. Highlight a file from the grid and click '**Preview**' or double-click to view the response report.



5. Click '**Yes**' to view the **Electronic X12 File Report** if the File Status is **Rejected**.

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   a. Rejections will appear in bold on the report.

6. Click '**No**' if the File Status is **Accepted**.
   a. Click in the '**State**' column to manually mark accepted files as **Discarded**.
7. After the **277** or **999** report is previewed or printed you will be prompted to mark the file as '**Discarded**'.
   a. Files should be marked '**Discarded**' if they are no longer needed for reference.
   b. Discarded files can be viewed by checking the '**Include Discarded**' box.
8. Click the '**Save**' button to save the **999/277** file to your local drive (optional).

- **DDE option:** This link to **Direct Data Entry** is functional for non-Cloud based clients but requires installation of the **Ability Certificate**.
  - If the certificate is not installed you will get this message:

- **Non-Cloud clients** who wish to access **DDE** via this link or via the Ability website must install the **Ability Certificate** on their PC (Internet Explorer or Edge are required for the install).
  - Contact Netsmart Support for assistance.
- **Cloud-based clients** hosted by Netsmart should contact **Netsmart IT Support** to install the certificate for that user.
  - Once the certificate is loaded, you can access **DDE** via Internet Explorer or Edge at this web address: https://myability.abilitynetwork.com/Pages/myWorkspace.aspx

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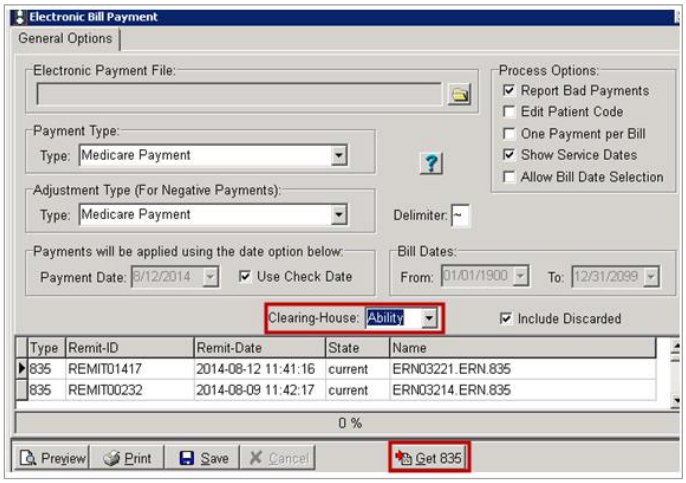
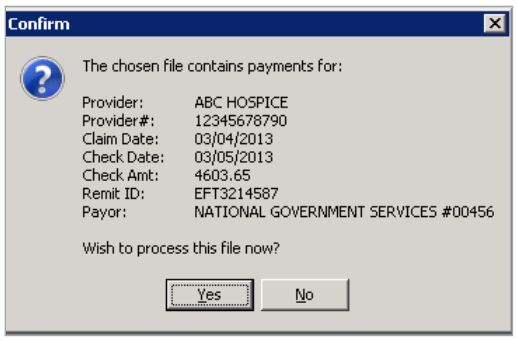
Electronic Payment Process:

Electronic Payments allows the user to post ERA/835 payment files.

1. Click on **A/R>ELECTRONIC PAYMENTS**
2. Set '**Clearing-House**' to **Ability**.
3. Click '**Get 835'**.
4. Set the **Payment Type and Adjustment Types** to ensure the Payment and Adjustment Types are set correctly and a Payment Date or '**Use Check Date'** is specified.
5. **Report Bad Payments:** This should be checked to include payments that will **NOT** be posted.
    a. Bad Payments may occur if processing a remit file that includes payments for claims that were not generated from myUnity Essentials.
6. **Include Discarded:** After a payment file has been posted you will be prompted to mark it as '**Discarded**'.
    a. Check this option if you still wish to have discarded files listed in the grid.
7. **Payment Date:** Defaults to Today's Date.
    a. Can be changed to a different date.
    b. Check '**Use Check Date'** to default the payment date to the check date from the ERA file.



8. Double-click the remit to be processed and click '**Yes**' to process the file now.



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Sample Electronic Payment Report:

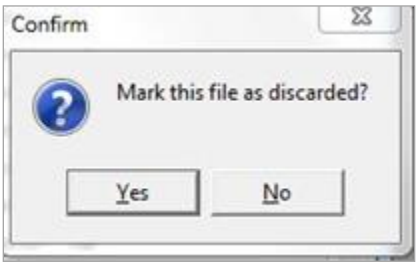
9/15/2014 9:38:08 AM **Electronic Payment Report** Page 1

Claim-Date: 03/04/2013 Check-Date: 03/05/2013 Check-Amt: 4603.65 ABC Home Health & Hospice
Payment File: C:\Users\lynda\Desktop\835.txt
Payments added will have Paid-date: 9/15/2014 and Pay-Type: Commerical Payment Remit-No: EFT3214587
Provider-Name: ABC HOSPICE Provider-#: 12345678790 Payor: NATIONAL GOVERNMENT SERVICES #00456

Bill-Date	Billed-Amt	Amount-Due	Charge-Amount	Paid-Amount	Claim-Adj	Reference/DCN
Patient:			Admit:	Disch:		LblCertPeriod
From: 12/28/2012 To: 12/28/2012 Recvd: 02/07/2013			0.00	0.00	CO*97	21303800116107IDR
NOT posted: Patient: BAAS, PAT Master-ID: 24303 Pat-Code: B110982 Paid: -1294.93 -> Bill master not found!						
From: 12/28/2012 To: 01/30/2013 Recvd: 02/07/2013			2,650.00	0.00	CO*97	21303800108107IDR
NOT posted: Patient: BASS, PAT Master-ID: 24303 Pat-Code: B110982 Paid: 2088.9 -> Bill master not found!						
		Bill Totals:	2,650.00	0.00		
		Patient Totals:	2,650.00	0.00		
Patient:			Admit:	Disch:		LblCertPeriod
From: 01/01/2013 To: 01/31/2013 Recvd: 02/19/2013			7,613.00	0.00	CO*45	21303800497607IDR
NOT posted: Patient: NOKER, LUCILLE Master-ID: 24538 Pat-Code: B104575 Paid: 4603.65 -> Bill master not found!						
		Bill Totals:	7,613.00	0.00		
		Patient Totals:	7,613.00	0.00		

Note: The 'Bill Master not found!' message will appear if there is no bill record to post the payment to. This will occur when the claim was billed out of different software or if the claim was un-billed and the A/R record deleted.

9. Once previewed or printed you will be prompted to Post the file.
    a. Previously posted records will **NOT** be double-posted – these records will be listed as "**bad**" payments.
10. Once payments are posted the '**State**' field changes to '**discarded**' and the file will not appear in the grid unless the 'Include discarded' checkbox is marked.
    a. You can also click in the '**State**' field to mark the ERA as '**Discarded**' and click **Yes** at the confirmation prompt:



11. Click the '**Save**' button to save the 835 file to your local drive (optional).

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