8.08 OPERATING POLICY & PROCEDURE

Subject: **Customer Plan Coverage/Eligibility Determination**		Application: **All Departments**
First Effective 8/28/17	Revised 11/20/2023	Reviewed 02/26/2025

PURPOSE

To verify patient plan eligibility.

POLICY

Pivotal will utilize the appropriate management information services and benefit enrollment files to properly associate clients with the correct benefit and coverage plan.

PROCEDURE

1. Pivotal will ensure that JOE-E (Electronic Health Record) will have the following minimal capabilities:
   a. Monthly downloads of Medicaid eligible information: Via JOE-E, batches are sent automatically to CHAMPS at the beginning of each month for every active client; then batches are sent weekly for new/updated clients. Information is changed by the system and will enter Medicaid information and update retroactively. If someone has a third-party payor in CHAMPS that we do not have in the system, then this will show on a report “Demographic (BH-TEDS) Data Quality Issues and On-line Clean Up”, which is monitored by financial staff monthly.
   b. Individual registration and demographic information: With JOE-E, there is an access intake workflow where all information is required, or the workflow will not be complete. This alert will stay on the clinician’s desktop or be a menu option, under Access Center Tab, that is reviewed ongoing by Access Staff.
   c. Third-party liability: Pivotal staff will request any third-party liability insurance at time of intake and enter into JOE-E, where the information is in “Awaiting Verification”. This information is then in a report “View Pending Insurance Policies”, which is reviewed weekly by the contracted biller who will verify insurance and then change the verification status to “Verified”.
   d. All staff are to ask clients if they have any insurance changes when they are seen. Support staff are to ask all clients at each appointment if there is any change in name, address, phone, or insurance and update accordingly.
2. Pivotal will determine if the patient on claim is eligible by reviewing the Benefit Enrollment and Maintenance (834) and Payment Order Remittance Advise (820) reconciliation files as the primary source for eligibility determination for Prepaid Inpatient Health Plan (PIHP) functions. The following information will be checked/verified:
   a. Client/Enrollee coverage type.
   b. Date the Client/Enrollee’s coverage begins.