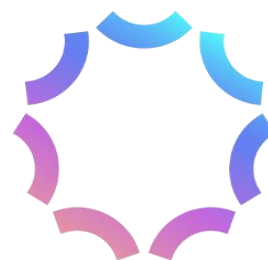


nphies



SITE ELIGIBILITY

Version 1.2

Table of Contents

Case..... 3

Solution: siteEligibility..... 3

Handling 4

BRVR..... 6

Version Control:

Version	Change	Section
1.1	<ul style="list-style-type: none"> - Added error codes (1680,1681 and 1682) - Added BRVR section - Newly Added Rules 	<ul style="list-style-type: none"> - Error codes - BRVR - Newly Added Rules
1.2	<ul style="list-style-type: none"> - Changed the description of the following codes (1680,1681 and 1682) - Added the following error codes (1665 & 1666) 	<ul style="list-style-type: none"> - Error codes

Case

The current eligibility solution in nphies gives the providers the policy and benefit information, such as Network, so that the provider can determine whether the patient is eligible to have their services paid for by the insurance. This puts the burden of determining eligibility on the provider and this will not always be accurate when the patient insurance includes some special providers in addition to their network. Therefore, a new field (siteEligibility) described below, is being added to the eligibility response from the insurer which will tell the provider whether the patient is eligible to have their services paid for by the insurance.

Solution: siteEligibility

The Payer will add the siteEligibility extension to the eligibility response. A value of “**eligible**” will indicate the patient is eligible, while a series of other codes will indicate the patient is not eligible. If the CoverageEligibilityResponse.outcome is “complete” then the siteEligibility extension is required to be provided.

Field	Description	Min	Max	Data Type
CoverageEligibilityResponse.extension.siteEligibility	Code to indicate whether the patient is eligible or not eligible and why	1	1	Codeable concept
CoverageEligibilityResponse.insurance.extension.siteEligibility	Code to indicate whether the patient is eligible or not eligible and why	0	1	Codeable concept

The “**siteEligibility**” field will be added on **CoverageEligibilityResponse** and on **CoverageEligibilityResponse.insurance**, so if a patient has 2 active policies on the service date, one of

the policies is in-network and the other is not in-network, then the payer is expected to respond back with 2 policies information as follows:

- **“siteEligibility”** on **CoverageEligibilityResponse** which will be communicated through **CoverageEligibilityResponse.extension.siteEligibility** = “eligible”.
- **“siteEligibility”** on **CoverageEligibilityResponse.insurance** level which will be communicated through **CoverageEligibilityResponse.insurance.extension.siteEligibility** for the not in-network policy will be one of the “not eligible” codes, and for the in-network policy will be “eligible”.

```
{
  "extension": {
    "url": "http://nphies.sa/fhir/ksa/nphies-fs/StructureDefinition/extension-siteEligibility",
    "valueCodeableConcept": {
      "Coding": [{
        "system": "http://nphies.sa/Terminology/CodeSystem/siteEligibility",
        "code": "eligible"
      }]
    }
  }
}
```

Handling

If the payer has successfully received an eligibility request, then they will include siteEligibility which uses the following code set:

#	Site eligibility Code	Site eligibility Code description	Business scenarios
1	eligible	Eligible	Code to be used when the patient is eligible
2	not-active	Member's insurance policy is not active	When HCP sends an eligibility request for an expired or canceled member's policy on the eligibility service date.
3	not-covered	Policy does not cover the requested services	When HCP sends an eligibility request mentioning a department that offers services out of patient policy coverage.
4	not-direct billing	Patient is not covered on direct billing basis	When HCP sends an eligibility request for insured member who is covered on patient reimbursement basis, so even the member has an active policy, but he/she will pay the

			medical fees out of his/her pocket and reimburse the claims. (e.g.: members covered under visit visa insurance policy)
5	out-network	Provider outside member Network	Facility is outside the member covered policy network.
6	limit-exhausted	Patient policy/benefit limit is exhausted	When member consumed the annual or benefit limit, benefit limit can be indicated from the department in the eligibility request or from the provider type, e.g. request from received from optical shop for a member consumed the optical benefit.
7	coverage-suspended	Patient coverage is suspended	Insurance coverage can be suspended for any reason (regulation, financial, legal, etc.)
8	provider-contract-suspended	Provider contract is suspended	Provider can be suspended for any reason (regulation, contractual, legal... etc.)

When the eligibility request contains errors then the eligibility response will have = “Error” and the error will contain one of the codes from the adjudication errors code system.

The following codes are examples of the type of errors which may occur for eligibility request:

#	Error Code	Error Code description	Business scenarios
1	1658	No member found with the supplied patient credentials	When HCP sends an eligibility request using a structurally correct Membership/Document ID number, but it does not exist among the payer’s member record.
2	1659	Provider license is not a contracted provider as of the date of service	When the eligibility request received from un-contracted provider (unknown) or the provider contract with the payer expired.
3	1660	TPA doesn’t provide adjudication services for this insurer	When HCP sends an eligibility request to a TPA mentioning an insurer which is not served by this TPA (sending transaction to wrong TPA).
4	1665	Newborn exceeds 30 days of age	When the newborn baby has his/her own separate insurance membership, no longer covered under the mother’s insurance membership
5	1666	Provider not licensed during the date of service	When the provider is blocked/suspended on the date of service

6	1680	Document ID number does not follow the correct structure	When the patient document ID number sent in the eligibility request does not follow the standards.
7	1681	Membership number does not follow the correct structure	When the patient Membership number sent in the eligibility request does not follow the standards.
8	1682	The patient information does not match the insurance member details	When there is a mismatch between the reported patient information with the insurance member information.

- Fields to report the Error eligibility response:

#	Path	Value	Status
1	CoverageEligibilityResponse.outcome	error	Exist in the profile
2	CoverageEligibilityResponse.error	This section will be used by the payer to express the reason of the error response.	Exist in the profile
3	CoverageEligibilityResponse.error.extension		Exist in the profile
4	CoverageEligibilityResponse.error.extension.expression		Exist in the profile
5	CoverageEligibilityResponse.error.code		Exist in the profile

- Note:** When **CoverageEligibilityResponse.outcome= "error"** then the payer SHALL include the error code in the intended field **CoverageEligibilityResponse.error** and the payer can elaborate more on the reason by using the **CoverageEligibilityResponse.disposition**.

BRVR

Rule ID	Rule Type	Rule Type Description	Rule Related Message/Resource /Element	Description	Display
BV-00503	BV	Business and Validation Rule	CoverageEligibilityResponse.extension.siteEligibility	CoverageEligibilityResponse.extension.siteEligibility SHALL be provided when CoverageEligibilityResponse.outcome="complete"	The siteEligibility is required when outcome is "complete"

BV-00535	BV	Business and Validation Rule	CoverageEligibilityResponse.extension.siteEligibility	The CoverageEligibilityResponse.extension.siteEligibility value SHALL not be "eligible" if for every array entry of CoverageEligibilityResponse.insurance the related CoverageEligibilityResponse.insurance.inforce value is "false"	The siteEligibility field cannot have a value "eligible" if all provided insurance are not in force
BV-00558	BV	Business and Validation Rule	The CoverageEligibilityResponse.extension.siteEligibility	The CoverageEligibilityResponse.extension.siteEligibility value SHALL not be "eligible" if no insurance element is provided or for every array entry of CoverageEligibilityResponse.insurance the related CoverageEligibilityResponse.insurance.siteEligibility is not "eligible"	The siteEligibility field cannot have a value "eligible" when either no insurance is provided or none of the related insurance(s) is eligible
BV-00559	BV	Business and Validation Rule	The CoverageEligibilityResponse.extension.siteEligibility	The CoverageEligibilityResponse.extension.siteEligibility value SHALL be "eligible" if at least in one array entry of CoverageEligibilityResponse.insurance the related CoverageEligibilityResponse.insurance.siteEligibility is "eligible"	The siteEligibility field must have a value "eligible" when at least one of the related insurance(s) is eligible
BV-00560	BV	Business and Validation Rule	The CoverageEligibilityResponse.extension.siteEligibility	The CoverageEligibilityResponse.insurance.extension.siteEligibility SHALL not be "eligible" if the related CoverageEligibilityResponse.insurance.inforce value is "false"	The insurance siteEligibility field cannot have a value "eligible" if related insurance is not in force

- If the member is eligible, then the Site eligibility value = “eligible” and the inforce=“ True”.
- If the member is not eligible, then the site eligibility should not be equal to “eligible”, the payer will use one of the above ineligible reasons.
- If the **CoverageEligibilityResponse.outcome= “error”**, then the “**siteEligibility**” is not required.

- If the **CoverageEligibilityResponse.outcome**= “complete”, then the “**siteEligibility**” SHALL be provided at the header and insurance level.
- If all the **CoverageEligibilityResponse.insurance.inforce** within eligibility response = “false”, then “**siteEligibility**” cannot be equal to “eligible”. Not inforce will be equal to false only when “Member's insurance policy is not active”, for the other reasons, it will be inforce but the “siteEligibility” will be ineligible.

Newly added rules:

- The **CoverageEligibilityResponse.error** SHALL be provided when **CoverageEligibilityResponse.outcome**= “error” (including the error code to justify the error reason).
- Remove **CoverageEligibilityResponse.extension.notInForceReason** and **CoverageEligibilityResponse.insurance.extension.notInForceReason** as it is not required in the eligibility response if the patient was not eligible.
- The **CoverageEligibilityResponse.extension.siteEligibility** value SHALL not be “eligible” if for every array entry of **CoverageEligibilityResponse.insurance** the related **CoverageEligibilityResponse.insurance.inforce** value is “false”
- **Referral:**
 - In case of referral cases when HCP sends eligibility request for referred member whose policy is non-network; so **CoverageEligibilityRequest.extension.transfer**=“true”. The HIC should respond with “**siteEligibility**” = “eligible” given the fact that the patient is referred by the payer to this facility and the facility received the referral letter offline. In both cases the payer should include the TOB (if requested purpose contains “benefits”) and the coverage information in the eligibility responses as long as the policy is inforce.