



Medicaid Management Information Systems
Maine Integrated Health Management Solution
HealthPAS Online: Eligibility Verification User Guide

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Usage Information

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HIPAA Notice

This Maine Health PAS Online Portal is for the use of authorized users only. Users of the Maine Health PAS Online Portal may have access to protected and personally identifiable health data. As such, the Maine Health PAS Online Portal and its data are subject to the privacy and security regulations within the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 (HIPAA).

By accessing the Maine Health PAS Online Portal, all users agree to protect the privacy and security of the data contained within as required by law. Access to information on this site is only allowed for necessary business reasons, and is restricted to those persons with a valid user name and password.

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1. Introduction

The Maine Integrated Health Management Solution (MIHMS) Health PAS Online Portal (online portal) enables healthcare providers to quickly and efficiently verify a MaineCare member's current eligibility status. Providers must verify an individual's eligibility for MaineCare prior to providing services. Verification of eligibility does not ensure reimbursement if requirements for medical eligibility and prior authorization have not been met. Providers must sign into their Trading Partner Account to verify a MaineCare member's eligibility.

2. System Requirements

To successfully use all features of the online portal, ensure that computer systems meets the following minimum requirements:

- Reliable online connection
- Web browser - The online portal supports the following browser types and versions:
 - Microsoft Internet Explorer versions 8, 9, and 10
 - Mozilla Firefox versions 33 and 34
 - Google Chrome version 39
- The latest version of Adobe Acrobat Reader

3. Preparation for Eligibility Verification Process

When completing and submitting member eligibility verification via the online portal, the user will need to gather the following information:

- MaineCare Member ID
- Member Name
- Member Date of Birth
- Member Social Security Number (SSN)

4. Trading Partner

To access the secure section of the online portal to submit member eligibility verification via Direct Data Entry (DDE), the user must first be a registered Trading Partner. To log into the Trading Partner Account (TPA):

1. From the online portal home page, click the **Provider** tab at the top of the screen.
2. On the Provider tab, enter the user name and password, which was created when the user registered the TPA, into the **Trading Partner Sign In**- see [Figure 4-1](#) below.
3. Click the **Sign In** button.



Figure 4-1: Trading Partner Sign In

NOTE: If the user is not already a registered Trading Partner, click this link to the [Trading Partner User Guides](#) for more information.

There are three ways a user can submit a member eligibility verification using the online portal, as shown in [Figure 4-2](#) below.

- Eligibility Verification. See [Section 4.1: Member Eligibility Verification](#) for more information.
- Primary Care Roster. See [Section 4.2: Primary Care Roster or Patient Roster](#) for more information.

NOTE: This Roster is only available to Trading Partners that register as a Provider or a Billing Agent.

- Patient Roster. See [Section 4.2: Primary Care Roster or Patient Roster](#) for more information.

NOTE: This Roster is only available to Trading Partners that register as a Provider or a Billing Agent.

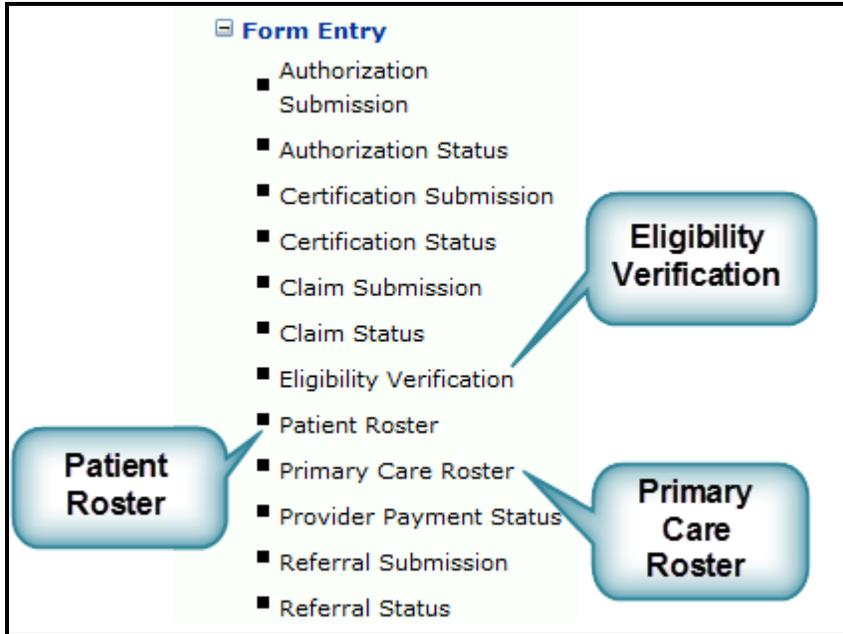


Figure 4-2: Form Entry - Eligibility Verification

4.1 Member Eligibility Verification

1. Once the user has logged in as a Trading Partner, click on the Eligibility Verification link. The Eligibility Verification – Find Member screen will populate. Verify the **Select Billing Provider** information (above the Find Member tab) is correct. If there is more than one Billing Provider associated with the Trading Partner ID, click the drop-down menu to select the proper Billing Provider from the pre-determined list- see [Figure 4-3](#) below.



Figure 4-3: Billing Provider

2. Once the Billing Provider has been selected, the Member must be identified. To search for a member, at least two of the four available member search criteria fields must be filled for a successful member search:
 - Member ID (e.g. 00000000A)
 - Name (Last and First).
 - The Last Name and First Name count as one search criterion.
 - On the search screen, enter the Last Name in the first field provided and the First Name in the second field, as shown in [Figure 4-4](#) below.
 - Names must match exactly for the first five letters of the last name and the first three letters of the first name.

HINT: For example, Jane Example-Member could be entered as Examp for the last name and Jan as the first name.

- Date of Birth, (e.g. MM/DD/YYYY)
 - Social Security Number (SSN) should be entered without any dashes.

To search for a member, enter search criteria in any two rows. For example (Last Name and first) and the Date of Birth.

Member ID:

Name (Last and First): *And*

Date of Birth:

Social Security Number:

Callouts: Last Name, First Name

Figure 4-4: Member Search

3. Select the **Submit** button to perform the search.

NOTE: If no match is found, try fewer criterions. For example, use the MaineCare ID and member Date of Birth. If no match is found, or to start the search over, select the **Reset** button to clear all the values entered in the Find Member search fields.

4. The search results are returned under the Find Member Results tab, as depicted in [Figure 4-5](#) below. The search may result in a list of multiple members. Using the member's criteria, identify the correct member. The member information that will be displayed is:
 - Name
 - Gender
 - Date of Birth
 - Member ID

Member

Name	Date of Birth	Member ID	Gender
			Female

Eligibility Inquiry

Dates of Service

From: To:

Procedure Codes/Service Codes

Enter a maximum of 10 Procedure Codes or Service Codes separated by a comma or space

Figure 4-5: Member Search Results

5. Go to [Section 5: Submit Eligibility](#) to complete the eligibility verification submission.

4.2 Primary Care Roster or Patient Roster

The **Patient Roster** is created by the Provider and contains a list of the members that are patients of the Provider. The **Primary Care Roster** is an automatic list of the members that have been assigned to Primary Care Providers that are part of the Primary Care Case Management (PCCM) program. Members from the **Primary Care Roster** can be added to the **Patient Roster List**. The user may choose to identify the member by using the **Patient** or **Primary Care Roster**:

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1. Once the user has logged in as a Trading Partner, click on either the **Primary Care Roster** or **Patient Roster** link under the Form Entry heading.
2. The roster screen will display, as shown in [Figure 4-6](#) or [Figure 4-7](#) below, depending on which roster is chosen.
3. Select the **Billing Provider** from the drop-down menu, if applicable. If there is only one Pay-To provider, this field will be grayed out.
4. If using the Primary Care Roster, select the PCP from the drop-down menu.
5. Select the member from the roster list by clicking the radio button.
6. Select the **first letter** of the member's last name from the alphabetical list. If a letter is grayed out, there are no members assigned to the PCP that have a last name which starts with that letter. If using the Patient Roster and the member does not appear, the user will need to add the member to the Provider's Patient Roster before a submission can be completed. For instructions on adding new members, see the [MHP Patient Roster User Guide](#).

NOTE: The user **will not** be able to add members to their **Primary Care Roster**. The **Primary Care Roster** members are assigned by Member Services.

7. Once the correct member is shown, select the radio button next to the member in the roster list.
8. Click the **Verify Eligibility** button to begin the member eligibility verification process.

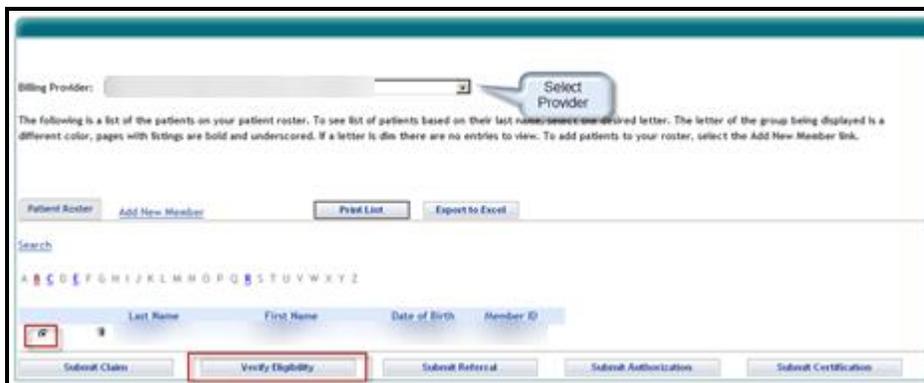


Figure 4-6: Patient Roster

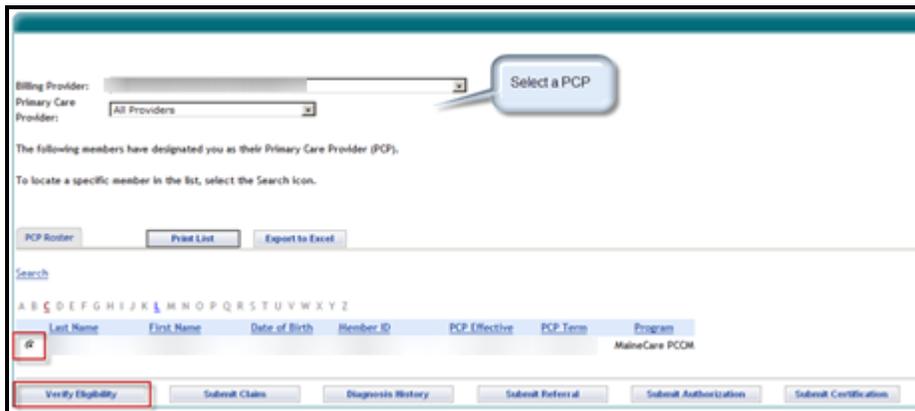


Figure 4-7: Primary Care Roster

9. Go to [Section 5: Submit Eligibility](#) to complete the eligibility verification submission.

5. Submit Eligibility

After locating the correct member for the eligibility verification and clicking Verify Eligibility, the user will be brought to the Verify Eligibility screen, as shown in [Figure 5-1](#) below. To submit the eligibility request, follow these steps:

The screenshot shows the 'Eligibility Inquiry' screen. At the top, it says 'You Are Here: Eligibility Verification'. Below that is a disclaimer: 'Eligibility Inquiry verifies whether a member was eligible for services on the "Dates of Service" submitted. This information does not guarantee payment for the services rendered. If there are any circumstances under which a specified procedure code might be a covered service for the member's plan, (i.e. including emergency, specific place of service requirement, specific provider type requirement, etc.), the procedure code will be listed as covered. However, if not all of the conditions are met at the time of service, the claim may deny. You must reference the appropriate MaineCare policy section to confirm the service will be covered for the specific services rendered.' Below the disclaimer is a link to 'MIHMS Health PAS Online Portal'. There are two callout boxes: 'Additional Eligibility Information' and 'Important Disclaimer Language'. The member information section shows: Member Name, Date of Birth, Member ID, and Gender (Female). Below that is the 'Eligibility Inquiry' section. It has a 'Dates of Service' section with 'From' and 'To' date pickers, both containing '4/18/2014'. Below that is the 'Procedure Codes/Service Codes' section with a text input field containing 'D1120, D1206, D1211, D1351, D1110'. At the bottom right are 'Submit', 'Reset', and 'New Verification' buttons. At the bottom center is a 'Print Receipt' button.

Figure 5-1: Eligibility Inquiry

1. Enter the **Dates of Service (From and To)** associated with the eligibility verification request. These are required fields which must be completed to execute the request.
 - The online portal will default to the current date.
 - The user will receive an error message if the search dates entered are unavailable for search, in which case, new dates may be entered and the search resubmitted.
 - The date can reflect the current date or a past date (up to two years); it cannot be a future date as eligibility cannot be verified in advance.
 - To use the calendar tool, click the calendar icons and select the date from the calendar that displays.
 - To type in the date, click on the **Dates of Service** fields and enter the date in the MM/DD/CCYY format. For example, February 14th, 2008 would be entered as "02/14/2008".

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2. Enter Procedure Code(s). Select the radio button next to the **Procedure Code**. If the procedure code option is selected, it is possible to enter up to ten **Procedure Codes**, separating the codes by a comma or a space. This is an optional search function.
3. Click the **Submit** button to submit the eligibility verification request. Click the **Reset** button to reset all the values. Click **New Verification** to start a new verification.
4. After clicking Submit, multiple tabs will populate below the Eligibility Inquiry tab, as shown in [Figure 5-2](#) below.
 - Enrollments
 - Other Insurance
 - Cost of Care (when applicable)
 - PCP Assignment
 - Lock-In
 - Limitations (when procedure codes are used for the eligibility inquiry)

Eligibility Inquiry

Dates of Service

From *: 4/16/2014 To *: 4/16/2014

Procedure Codes/Service Codes

Enter a maximum of 10 Procedure Codes or Service Codes separated by a comma or space

Enrollments

Plan	Coverage Status	Coverage Level	Plan Type	Effective Date	Termination Date
MaineCare	Active	Secondary	MEDICAL		
Coverage Code Description: Adult and Children Services	Active				

Other Insurance

Enrollment ID	Plan	Plan Type	Policy Type	Policy Number	Group Number	Status	Carrier Name	Coverage Status	Effective Date	Termination Date
	MEDICARE PLAN A	HospitalOnly				Primary	MEDICARE	Active		
	MEDICARE PLAN B	ProfOnly				Secondary	MEDICARE	Active		
	MEDICARE PLAN D	PHARMACY				Secondary	MEDCO HEALTH	Active		

PCP Assignment

No PCP information found for the member.

Lock-in

No Lock-In information found for the member.

Limitations

Used and available units below are as of 4/16/2014

Procedure Code	Description	Benefit	PA Req	Used	Available	Type
d1110	Dental prophylaxis adult	SERVICE COVERED, NO LIMIT INFORMATION FOUND	Y			
D1110	Dental prophylaxis adult	Dental Services - Adult Prophylaxis W/O PA	N	0.00	1.00	Visits
D1110	Dental prophylaxis adult	Dental Services - Adult Prophylaxis W/O PA FQHC/RHC	N	0.00	1.00	Visits
D1110	Dental prophylaxis adult	Dental Services - Adult Prophylaxis W/O PA Hosp	N	0.00	1.00	Visits

Please note, used units information only refers to visit limits set by Policy as opposed to units available under Prior Authorizations (PA). PA information can be viewed at the Prior Authorization Status Screen. Claims for services that are limited by Policy might be submitted by another provider prior to your claim. This can result in your claim being denied if all units have been used on the prior claim.

Figure 5-2: Eligibility Verification Tabs

NOTE: Some of the fields have been pre-populated with the member and provider information based on the member selected and the provider entering the eligibility, respectively. Additional information on covered services can be found in the [MaineCare Benefits Manual](#).

5. After clicking **Submit**, the **Print Receipt** button will activate. Selecting the **Print Receipt** button opens a new window that displays a printable page with the Tracking Number, Date of Inquiry, Dates of Service, Procedure Code, and ID. All the eligibility results will be shown.
 - This page may be printed by selecting the **Print** button at the bottom of the screen, as shown in [Figure 5-3](#) below.
 - Select Close Window to navigate back to the **Eligibility Verification** page.

No Lock-In information found for the member.

Limitations

Procedure Code	Description	Benefit	PA Req	Used	Available Type
d1110	Dental prophylaxis adult	SERVICE COVERED, NO LIMIT INFORMATION FOUND	Y		
D1110	Dental prophylaxis adult	Dental Services - Adult Prophylaxis W/O PA	N	0.00	1.00 Visits
D1110	Dental prophylaxis adult	Dental Services - Adult Prophylaxis W/O PA FQHC/RHC	N	0.00	1.00 Visits
D1110	Dental prophylaxis adult	Dental Services - Adult Prophylaxis W/O PA Hosp	N	0.00	1.00 Visits

Please note, used units information only refers to visit limits set by Policy as opposed to units available under Prior Authorizations (PA). PA information can be viewed at the Prior Authorization Status Screen. Claims for services that are limited by Policy might be submitted by another provider prior to your claim. This can result in your claim being denied if all units have been used on the prior claim.

Figure 5-3: Print Screen

5.1 Enrollments Tab

The Enrollment tab will display the following member information:

- Plan
- Coverage Status
- Coverage Level
- Plan Type
- Effective Date
- Termination Date

5.1.1 Partial Eligibility

If the coverage status is listed as **partial** instead of **active**, this indicates that the member was not covered for the date span of the request. If the member has partial coverage, the effective date and termination date for the plans are listed, as shown in [Figure 5-4](#) below.

Plan	Coverage Status	Coverage Level	Plan Type	Effective Date	Termination Date
MaineCare Coverage Code Description: Adult and Children Services Coverage Code Description: Section 67 - Nursing Facility Coverage Code Description: Section 97 - PNAI (Appendix C)	Partial	Secondary	MEDICAL		
MaineCare Coverage Code Description: Adult and Children Services Coverage Code Description: Section 67 - Nursing Facility Coverage Code Description: Section 97 - PNAI (Appendix C)	Partial	Secondary	MEDICAL		
Buy In Coverage Code Description: QMB	Partial	Secondary	MEDICAL		

Figure 5-4: Partial Eligibility

5.2 Other Insurance

The Other Insurance tab will display the following member information, if applicable, as shown in [Figure 5-2](#) above.

- Enrollment ID
- Plan
- Plan Type
- Policy Type
- Policy Number
- Group Number
- Status
- Carrier Name
- Coverage Status
- Effective Date
- Termination Date

5.3 PCP Assignment

The PCP Assignment tab will display the following member information, if applicable:

- Effective Date
- Termination Date
- PCP Name
- PCP Address
- PCP Office Number
- PCP Office Hours
- Provider ID
- Coverage Provider
- Coverage Status

5.4 Lock-in

The Lock-in tab is not currently being used.

5.5 Limitations

When a procedure code has been entered, the **Limitations** tab will display the following information, as shown in [Figure 5-5](#) below.

- ‘As of’ Date
- Procedure Code
- Description
- Benefit
- PA Required
- Used
- Available
- Type

Procedure Code	Description	Benefit	PA Req	Used	Available	Type
d1120	Dental prophylaxis child	SERVICE COVERED, NO LIMIT INFORMATION FOUND	Y			
D1120	Dental prophylaxis child	Dental Services - Child Prophy W/O PA FQHC/RHC	N	0.00	1.00	Visits
D1120	Dental prophylaxis child	Dental Services - Child Prophy W/O PA	N	0.00	1.00	Visits
D1120	Dental prophylaxis child	Dental Services - Child Prophy W/O PA Hosp	N	0.00	1.00	Visits
d1206	Application of fluoride varnish	SERVICE COVERED, NO LIMIT INFORMATION FOUND	Y			
D1206	Application of fluoride varnish	Dental Services - Child Floride D1206 W/O PA FQHC/RHC	N	0.00	2.00	Visits
D1206	Application of fluoride varnish	Dental Services - Child Floride D1206 W/O PA	N	0.00	2.00	Visits
D1206	Application of fluoride varnish	Dental Services - Child Floride D1206 W/O PA Hosp	N	0.00	2.00	Visits
d1211	UNID	PROCEDURE OR SERVICE CODE NOT FOUND	N			
d1351	per tooth	SERVICE COVERED, NO LIMIT INFORMATION FOUND	N			

Note: Used units information only refers to visit limits set by Policy as opposed to units available under Prior Authorizations (PA). PA information can be viewed at the Prior Authorization Status Screen. Claims for services that are limited by Policy might be submitted by another provider prior to your claim. This can result in your claim being denied if all units have been used on the prior claim.

Figure 5-5: Limitations Tab

The search returns all situations in which the procedure code is potentially covered. In situations when policy-set limits have been met, additional units are sometimes available with prior authorization (as indicated for procedure code D1120 in [Figure 5-5](#) above).

For example, in [Figure 5-5](#) above, the information for D1120 may be read as follows:

1. For dental services with PA (indicated by a “Y” in the **PA Req** column):
 - D1120 service is covered- no limit information found for service that requires a PA. This scenario identifies those situations where the limit of 1 service per rolling 6 months has been met.
2. For dental services without PA, the units displayed represent the units allowed by policy:
 - D1120 dental service– Child Prophy W/O PA FQHC/RHC allows one unit per rolling six months if delivered in a Federally Qualified Health Center or a Rural Health Center.
 - D1120 dental service– Child Prophy W/O PA allows one unit per rolling six months if delivered in routine dental settings.
 - D1120 dental service– Child Prophy W/O PA hosp allows one unit per rolling six months if delivered in a hospital setting (as specifically defined by policy).

For more information on covered benefits, consult the [MaineCare Benefits Manual](#) at the link provided:

IMPORTANT NOTE: Members with Qualified Medicare Beneficiaries (QMB) Program eligibility participate in the Medicare Buy-In Plan where MaineCare and Medicare participate in cost sharing. Procedure codes will show up as covered, yet this coverage is only for MaineCare’s cost sharing portion. This does not apply to members with QMB Plus who are covered by full MaineCare.