nphies

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SITE ELIGIBILITY

Version 1.1

nphies

Table of Contents

Version Control:

Version	Change	Section
1.1	- Added error codes (1680,1681,1682) - Added BRVR section - Newly Added Rules	- Error codes - BRVR - Newly Added Rules

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 recived an eligibility request, then they will include siteEligiblity 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	1680	Provider outside member Network	Facility is outside the member covered policy network.
5	1681	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.
6	1682	Patient coverage is suspended	Insurance coverage can be suspended for any reason (regulation, financial, legal, etc.)

- 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	CoverageEligibiltyResponse.extension.siteEligibility	CoverageEligibiltyResponse.extension.siteEligibility SHALL be provided when CoverageEligibiltyResponse.outcome="complete"	The siteEligibility is required when outcome is "complete"
BV-00535	BV	Business and Validation Rule	CoverageEligibiltyResponse.extension.siteEligibility	The CoverageEligibiltyResponse.extension.siteEligibility value SHALL not be "eligible" if for every array entry of CoverageEligibiltyResponse.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 CoverageEligibiltyResponse.extension.siteEligibility	The CoverageEligibiltyResponse.extension.siteEligibility value SHALL not be "eligible" if no insurance element is provided or for every array entry of CoverageEligibiltyResponse.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 CoverageEligibiltyResponse.extension.siteEligibility	The CoverageEligibiltyResponse.extension.siteEligibility value SHALL be "eligible" if at least in one array entry of CoverageEligibiltyResponse.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 CoverageEligibiltyResponse.extension.siteEligibility	The CoverageEligibiltyResponse.insurance.extension.siteEligibility SHALL not be "eligible" if the related	The insurance siteEligibility field cannot have a value "eligible" if related insurance is not in force

				CoverageEligibilityResponse.insurance.inforce value is "false"	

- 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 eligiblity response if the patient was not eligible.
- The **CoverageEligibiltyResponse.extension.siteEligibility** value SHALL not be "**eligible**" if for every array entry of **CoverageEligibiltyResponse.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.