

SAGE MEDI-CAL ELIGIBILITY VERIFICATION: 270/271 REAL-TIME REQUEST

For Provider Connect Users



Substance Use Disorder Information System

Version 1.0



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Overview of Financial Eligibility in Provider Connect

Financial Eligibility is the term used to identify if a patient is either eligible for or already actively enrolled for Drug Medi-Cal or other financial benefits within the SAPC network. This information is recorded in Provider Connect using the Financial Eligibility Form, specifically under the guarantor details. The Financial Eligibility Form provides SAPC and providers with essential information needed for reimbursement.

There are four guarantor options in Sage available to providers:

1. Drug Medi-Cal
2. LA County Non-DMC
3. Self-Pay
4. Applying for Medi-Cal

Each of these guarantors has SAPC eligibility considerations and documentation requirements within the system. This is described in the Provider Manual and has been covered in various provider meetings and Sage meetings, all of which are available on the SAPC website. Provider staff should review these documents to ensure proper completion and to reduce billing errors.

What is the Real-Time 270 Eligibility Request?

The Real-Time 270 Eligibility Request Form is the process in which Sage can request Medi-Cal Eligibility directly from the California Department of Health Care Services (DHCS) in real-time. Providers can receive an immediate response via a 271 file to determine current or previous eligibility status, whether active or inactive status.

What is the Difference Between 270 and 271 Files?

The **270 file** is the name of the actual request sent from Sage to DHCS. Where the 271 file is the response file sent from DHCS to Sage.

The **271 Response data** is automatically posted to the Financial Eligibility Form in Sage with up-to-date Medi-Cal eligibility information directly from DHCS.

All the information in the 270 file is automatically populated from the Sage in the background when sending the file. This includes all the required provider information and subscriber information.

Provider information, including Medi-Cal provider number and/or NPI number is taken from the information gathered during implementation and entered in Sage. Any changes to this information need to be communicated immediately to SAPC so that the system reflects the correct information in processing this and other requests.

The subscriber information required for transmission of the 270 Request is gathered from the Financial Eligibility Form completed for each patient by the provider upon admission. Any errors on this form will either result in an error or no eligibility status on the 271 Response file.

It is essential that the information entered on the Financial Eligibility Form is accurate. If the Financial Eligibility Form has not been fully submitted, has an error that prevented it from being submitted or is not completed at all, the 270 Request will not run correctly and will display an error message.

Please ensure the following Financial Eligibility information is accurate (same as any legal documentation and information that Medi-Cal has on file) and complete before submitting:

1. DMC Guarantor saved and submitted
2. Name
3. Date of Birth
4. Address
5. Social Security Number
6. Subscriber Policy Number
7. Subscriber Client Index Number

When Would Providers Utilize the 270 Request?

The 270 Request can only be sent after a patient has been entered/admitted into Sage with a completed Financial Eligibility Form. Providers can use this process to verify initial eligibility, however a provider admission must be entered. Providers cannot use this form without an active episode and completed Financial Eligibility Form. Providers can continue to use their preferred method of verifying initial eligibility if they choose not to enter the provider admission before verifying eligibility.

The other primary use of this form is to verify ongoing eligibility each month per state and county regulations. The process is the exact same for ongoing eligibility as is for initial. There are multiple methods to verify initial or continuing eligibility, including:

1. Logging into the Medi-Cal Providers website (<https://www.medi-cal.ca.gov/Eligibility/Login.asp>)

2. Contact the toll-free DPSS customer service line (866-613-3777)
3. Contact Medi-Cal Directly (800-541-5555)
4. If your agency has obtained a Point of Service (POS) device, this may be used to verify initial or continuing eligibility

Typically, the above methods are used to verify current eligibility to meet the monthly verification requirement. However, the 270/271 process makes it easier for providers to both verify eligibility within the Sage system and update the Financial Eligibility Form automatically.

Each provider agency has its own schedule for verifying eligibility and should continue to follow those guidelines set by your agency. Those with the appropriate roles and permissions to run this process can verify eligibility at any time during the month.

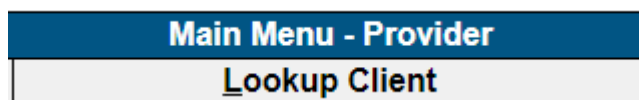
Lastly, this process is only for Medi-Cal eligibility verification. It cannot be used to verify any other benefit type, such as MHLA, AB-109, CalWORKS, General Release (GR), etc. Providers must follow up with the procedures outlined by those other programs the patient may be enrolled in order to verify eligibility for those programs.

How to Run the Real-Time 270 Eligibility Request

Please note: Before running the 270 Eligibility request, the Financial Eligibility Form must be accurately completed with a ***Drug Medi-Cal Guarantor and Subscriber Client Index Number***. The request cannot process without this information.

To run the Real-time 270 Eligibility Request process, providers should follow the instructions below:

1. From the Main Menu or top right corner navigation link, click on “Lookup Client” to search for the patient you are trying to verify.



2. Click on the blue hyperlink for the correct patient enrolled at your agency.
 - a. Note: The patient must be currently admitted to your program. You must NOT use the “Add New Client/Client Search” option to find the patient as you must ensure the patient is already enrolled at your program, has a completed Financial Eligibility Form and to avoid accidentally creating a duplicate record.
3. From the patient’s chart, click on “Real-time 270 Eligibility Request”

Demographic
Cal-OMS Admission
Cal-OMS Annual Update
Cal-OMS Discharge
Financial Eligibility
Real-time 270 Eligibility Request

4. In “Episode Number,” select the Episode Number associated with your agency
5. In “Guarantor,” select “**California Department of Alcohol and Drugs**”
6. In “From Date,” the admission date for this episode is automatically populated
7. In “Through Date,” today’s date – the date you are submitting the file – is automatically populated.
 - a. Note: If you need a different date range, you can manually enter that information. For instance, if you need to verify eligibility for a particular month during the treatment period.

Submit Real-Time Request

8. Verify the information is correct, then click on the “Submit Realtime 270 Request” button to send the request to DHCS.

Real Time Inquiry (270) Request	
Episode Number	<input type="text"/> *
Guarantor	<input type="text"/> *
From Date	<input type="text"/>
Through Date	<input type="text"/>

Submit Realtime 270 Request

Post Inquiry

View Report

9. Once submitted, the system will display a message providing further instructions, as outlined below.

**The Eligibility Request has been submitted.
Please click the Post Inquiry button to post the eligibility response data to the system**

Real Time Inquiry (270) Request

Post Inquiry

10. Click the “Post Inquiry” button on the bottom of the form to post the information from the 271 Response onto the Financial Eligibility Form, under the Drug Medi-Cal Guarantor section.

- a. This information is posted to the subscriber information section in the guarantor details.
- b. Note: Providers must click “Post Inquiry” before viewing the report. You cannot view the report without posting.

11. After clicking “Post Inquiry,” a new message will display with further instructions to view the report.

**Your inquiry has been posted.
Please click the View Report button to see detailed Eligibility Response (271) information.**

View 271 Response Report

12. Next, click the “View Report” button to view the 271 Response with the eligibility information for the date range selected.

- a. This will open a new window. Popups for this site must be allowed to enable window to open. Please check the popup blocker settings on your browser if the window does not automatically open.

11/29/2018

View Eligibility Response (271).t

Eligibility Response (271) Response Data

File Name: Real-Time 270/271 Processing	File Status: Posted	File Version: 271v5010
Data Entry By: ProviderConnect WebSvcs (do not edit)	Data Entry Date: 11/29/2018	Data Entry Time: 09:09 AM

Verifying Eligibility from 271 Response Report

The 271 Response is the form from the State that shows eligibility information. Once the report is viewable (after clicking “View Report”), you will see up to five inquiry response lines depending on the patient’s eligibility status for particular domains within the Medical system of care.

The information presented on the report is a simplified version of other types of eligibility verification system (POS, DHCS login, telephone). The aide codes, county codes and specific subscriber policy or CIN numbers will not be transmitted on this report. It will only display basic eligibility and coverage information.

Additionally, the report will not provide specific details regarding service delivery (e.g., eligibility specifically for substance use services within LA County). Since DMC is an entitlement within the broader Medi-Cal system, if a patient has active Medi-Cal coverage, DMC is included in that coverage.

Although a date range can be selected in the 270 request, eligibility information will only be retrieved for the month entered in the “through date” field of the date range.

Interpreting the 271 Response Data Report

Guarantor: CALIFORNIA DEPARTMENT OF ALCOHOL AND DRUGS

1.

Inquiry Type	Generic: Financial Eligibility
Eligibility Or Benefit Information	(W) Other Source of Data

2.

Inquiry Type	Generic: Financial Eligibility
Eligibility Or Benefit Information	(1) Active Coverage
Service Type Code	(30) Health Benefit Plan Coverage
Insurance Type Code	(MC) Medicaid

Inquiry Type: Reports the type of request sent either for a specific service or HCPC code or for general coverage eligibility.

“Generic: Financial Eligibility” – This will always be the inquiry type displayed when running the eligibility. This indicates the inquiry type was a general coverage across the general Medi-Cal benefits and not specific to a HCPC code or service.

Eligibility Or Benefit Information: Code that identifies the current eligibility or benefit status.

“(1) Active Coverage” means for there is current and active eligibility for the date range chosen and for the specific Service Type Code and Insurance Type Code listed directly beneath the Eligibility Information.

“(6) Inactive Coverage” displays when the patient does not have eligibility established for that date, Service Type Code and Insurance Type Code.

Important Note: If the response displays “(6) Inactive Coverage, providers should NOT immediately discharge the patient. Providers need to investigate the reason for inactive coverage and assist the patient reactivate

or enroll in Medi-Cal using Case Management benefits. Providers should contact their CPA for additional information on treating patients who have lost Medi-cal during treatment.

Additional Note: There are a number of other information codes and modifiers that can be displayed here, including Share of Cost, Deductible, Spend Down, Stop Loss, etc. If a patient’s eligibility shows anything other than “(1) Active Coverage,” it is very important for the provider to follow up with DPSS or Medi-Cal directly to determine what coverage or limitations exist with that patient’s eligibility.

Service Type Code: Reports on the classification of services the patient is eligible for.

“(30) Health Benefit Plan Coverage” indicates general healthcare benefits for the patient’s policy or contract. This is the code used to describe the patient’s general eligibility for a full scope of services under the insurance type. Additional limitations may be displayed in subsequent Inquiry Types listed on the 271 Response.

Insurance Type Code: Code identifying the insurance policy with specific insurance program.

(MC) Medicaid indicates the patient is eligible for the local Medi-Cal program.

The above display is an example of an active coverage response that will meet criteria for eligibility within the SAPC system of care for Drug Medi-Cal. There may be other variations that also meet criteria for eligibility, however those require further investigation by the provider to ensure active DMC coverage.

Additionally, when there are multiple Inquiry Types on the same 271 Response, providers should look for the type that corresponds with Insurance Type Code: (MC) Medicaid. This will be the Inquiry section for SAPC-related services. Where the other Inquiry sections may also be important for other types of care within the Medi-Cal system, they are not specifically relevant for the purpose of meeting the monthly eligibility verification requirement for SAPC.

Troubleshooting Errors

The primary error that providers may encounter is likely related to submitting a Real-Time

request prior to the Financial Eligibility being fully completed. If the file is transmitted to DHCS without all required information, providers will still receive a 271 response. However, the response will look as follows:

Guarantor: CALIFORNIA DEPARTMENT OF ALCOHOL AND DRUGS

1.

Inquiry Type	Generic: Financial Eligibility
Valid Request Indicator	(N) No
Follow-up Action Code	(C) Please Correct and Resubmit

A report that displays a Follow-up Action Code of “(C) Please Correct and Resubmit”, indicates some required piece of information was not completed. Providers should ensure the Financial Eligibility Form is fully completed with all the correct information per the instructions on page 4 of this user guide.

Documenting Results and Updating Guarantor Information

SAPC requires providers to verify continued eligibility on a monthly basis. The 271 Response Report will satisfy this requirement. Your agency should continue to document meeting this requirement in the same manner it is currently using. The 271 response report makes it easier to verify the information, but does not substitute for proper verification documentation.

Additionally, once the provider clicks the “Post Inquiry” button, the information will automatically populate into the corresponding fields on the DMC guarantor within the Financial Eligibility Form. Providers cannot view the report without clicking “Post Inquiry.” The system will record the date and time the guarantor information is updated, which will be visible on the main Financial Eligibility screen under “Episode-Based Eligibility Information.”

Episode-Based Financial Eligibility		
Record Date	Admission Date	Episode Number
12/18/2018 12:54:26 PM	5/22/2018	3

This date changes each time the form is updated. This process will not create a historical record for each time the 270 inquiry was requested. Should a provider require the monthly record of eligibility verification, it is recommended to print this report and upload to Sage or keep in a separate and secured location for auditing purposes.