Administrative Simplification

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Best Practice Recommendation for

Requesting and Receiving Coverage Information for Eligibility and Benefits (270-271 5010 Transaction & Web Access)

For use with ANSI ASC X12N 270/271 (005010X279E1)
Health Care Eligibility Benefits
Inquiry and Response Implementation Guide

Version 3.34

Version	
Issue Date	**Explanation**
02-14-2011	Initial release
03-15-2011	Clarified the benefit information that will be provided for Mental Health (pg.7)
08-16-2011	Amended: Change Service Delivery Limits to Visit Limits
12-14-2011	Aligned Web-based Information to be consistent with transaction (pg. 9-10). Added Service Types (pg. 44)
02-01-2012	Change "Lifetime Payment Maximum" to 'Yearly or Lifetime Payment Maximum" (pg. 6)
09-24-12	Clarify that Real-time Exchange is one service type code inquiry (pg. 11)
07-02-14	Minor corrections
03-10-15	Added Coverage 'Date Range' for Eligibility Request, And Valid Plan Dates
04-11-15	Messages must be understandable (pg. 36)
06-05-17	Clarification about alignment between transaction and website
09-11-17	Integrated EB Guidelines into document
10-15-17	Reorganization of document
01-04-18	Editing of document
06-18-18	Clearly differentiating EB loops where co-pay amount is the only difference
01-13-19 & 03-26-19	Dual Coverage
01-08-20	Placement of Washington State Balance Billing Message
08-21-20	TeleHealth Service Type added to Appendix of Service Types
04-08-24	Designating found but inactive coverage.

Table of Contents

Best Practice Recommendation
Requesting and Receiving Coverage Information for Eligibility and Benefits

Topic: Minimum standard set of eligibility and benefit coverage information

Goals:
1) Define an acceptable set of coverage information that will allow a provider to obtain a general idea about a patient's cost share for a service or treatment (e.g. they will know there is a 20% coinsurance but not $43.29 in patient liability)

2) Reduce the need for telephone calls to obtain eligibility and benefit related information about a patient

Summary: This document outlines the minimum standard set of eligibility and benefit information that should be available to providers whether they access the health plan website directly or use the 5010v of the HIPAA 270-271 transaction set.

Applicability: All providers and health plans are encouraged to follow these recommended Best Practices. However, providers should be aware that information received from the following organizations may not be consistent with this best practice:

- Medicare
- Self-funded plans
- FEP
- Blue Card
- NASCO
- And there may be others

Overview

This Best Practice Recommendation BPR outlines a set of information that should be communicated by the health plans to provider organizations about a patient's eligibility and benefit coverage. This information will be communicated via two different methods:

a) The health plan's website

b) Electronically using the HIPAA 271 transaction

The information may also be available from a Customer Service type department. The information returned must be consistent across all available sources.

For all fields specified in the transaction TR3, the content of the transaction and of the website must match. A health plan's website and their transaction must convey, at minimum, the set of information outlined in this BPR. For each and every data field specified in the TR3, the website cannot report less or contrary information than is reported in the transaction. However, the website content is not limited to the information that can be contained in the transaction TR3. A

health plan's website may expand beyond the set of information that can be formatted in the transaction TR3. The entire patient's eligibility and coverage information that is displayed on a health plan's website should be clearly conveyed and easily accessible to a provider.

The formatting/presentation of the information may vary depending upon the method. For a specific patient at a given point in time the information presented in the transaction and on the website must match, although there doesn't need to be a specific field on the website that corresponds exactly to every field in the transaction. As an example, the BPR calls for the health plan to communicate whether or not a patient has eligibility. In the transaction, that information will be communicated by placing a value in a particular field. On the website, that same information may be communicated simply by presenting eligibility and benefit information, i.e. the website need not have a single, specific, display field that explicitly states that coverage is in place; conveyance of eligibility and benefits would satisfy as communicating this fact.

Reminder: This BPR only discusses a subset of the information to be exchanged in the transaction and on the website.

Transaction Compliance with the HIPAA Mandated TR3

This BPR Document is intended to accompany the Technical Report Type 3 (TR3), previously referred to as the Implementation Guide, for the ASC X12N Health Care Eligibility Benefit Inquiry Response 270-271 Transactions. A complete version of this and all other TR3s can be purchased at http://www.wpc-edi.com.

Health plans must be able to receive a compliant 270 transaction as well as produce and send a compliant 271 transaction to the provider or a clearinghouse. The HIPAA mandated 270-271 TR3 specifies the complete set of requirements that must be met in order to be compliant. One of the objectives of this BPR document is to recommend best practices for how the 270-271 transaction should be used to accomplish specific business objectives related to the exchanging of eligibility and benefit information.

The intent of this BPR document is to expand upon and NOT to repeat the requirements contained in the TR3. However, requirements from the TR3 will be included in this document when the requirement was in a prior version but was typically not followed OR is included in a new version and, as such, may be overlooked in the implementation process, AND would significantly enhance administrative simplicity if it was followed. In these cases, the appropriate section of the TR3 will be referenced, but the details of the requirement will not be repeated

Minimum Standard Set of Eligibility and Benefit Information to be Reported

A patient's eligibility coverage and benefit information varies depending upon the specific plan in which they are enrolled. The capabilities and information listed in each of the following sections represent the ***minimum*** set of information to be provided by a health plan, ***to the extent***

that it is appropriate for the specific patient's plan and provided the information is available to the health plan. If a listed information element, e.g. deductible, PCP, etc., is not appropriate for the patient's plan or is not electronically available to the health plan, the element may not be presented for that patient. Health plans may always provide more capabilities and information depending upon their policies and level of system sophistication.

The Best Practice Recommendation calls for health plans to make benefit information available by service type. Note: benefit information by diagnosis and/or procedure is not included as a best practice recommendation because the demand for and usefulness of doing so has not been established.

WHAT INFORMATION WILL BE REPORTED: The below four sections of this document identify the minimum set of eligibility and benefit information to be reported on a health plan's website or via a 270-271 transaction set exchange.

I. General Eligibility Coverage Information
II. Contract Level Benefit Information
III. Standard Set of Services - Benefit Information
IV. Explicitly Requested Services - Benefit Information

HOW THAT INFORMATION WILL BE REPORTED: The remaining sections of this document will describe how that information should be reported:

Web-based Access

270-271 Transaction Exchange of the Information

271 Response Transaction

Guidelines for Using the EB Segments

I. General Eligibility Coverage Information
II. Contract Level Benefit Information
III. Standard Set of Services - Benefit Information
IV. Explicitly Requested Services - Benefit Information

WHAT INFORMATION WILL BE REPORTED (minimum set)

I. General Eligibility Coverage Information

A. Date Range: From the previous 12 months until the end of the current month

Per Phase I CORE 154: Eligibility and Benefit 270/271 Data Content Rule

When using the v5010 of the 270 transaction you may request a benefit coverage date 12 months in the past or up to the end of the current month. If the inquiry is outside of this date range and the health plan (or information source) does not support eligibility inquiries outside of this date range, the v5010 271 must include the AAA segment with code "62" Date of Service Not Within
Allowable Inquiry Period in the AAA03-901 Reject Reason Code data element

B. Eligibility Coverage Information

The following information will be provided for every patient, given the availability caveat highlighted above. The information highlighted in **bold** should always be available.

Information Elements
Subscriber Name
Patient Name
Patient's Relationship to Subscriber
Patient Date of Birth
Patient Gender
Patient Member Number
Group Name
Group Number
Plan Type
Coverage Date (aka Policy Effective Date)
Other Coverage [*1]
Primary Care Physician (PCP) [*1]
Eligibility Status

[*1] - This information should be sent if it is in the health plan's records and appropriate to the coverage. The health plans will send the information that they have. The accuracy of the information cannot be assured.

Note: As more fully described in the Overview section above, *the entirety of information outlined in the TR3 must be communicated via a health plan's transaction and website, though the formatting/presentation of the information may vary depending upon the method*.

II. Contract Level Benefit Information

The following table lists the Contract Level Limitations for which information will be available, given the availability caveat highlighted above.

	In-Network Provider				Out of Network Provider			
	Individual Coverage		Family Coverage		Individual Coverage		Family Coverage	
Contract Level Limits	**Benefit Limit Amount**	**Benefit Amount Remain**	**Benefit Limit Amount**	**Benefit Amount Remain**	**Benefit Limit Amount**	**Benefit Amount Remain**	**Benefit Limit Amount**	**Benefit Amount Remain**
Deductibles								
Out of Pocket (Stop Loss) Maximums								
Yearly or Lifetime Payment Maximum			***N.A.***	***N.A.***			***N.A.***	***N.A.***
Spend Down[*1]			***N.A.***	***N.A.***			***N.A.***	***N.A.***

N.A. - Not Applicable

[*1] *Spend Down:* The responsibility amount due from the patient before the health plan (typically Medicaid) begins to have any financial responsibility for their medical benefits and thus before any claims will be paid. (More detail can be found in section 1.4.9 of the TR3.)

For each of the Contract Level Limitations (as appropriate for the health plan), the Benefit Limit Amount and the Benefit Amount Remaining will be provided for Individual, In-Network coverage. These amounts may be also available for the Family, In-Network coverage, depending upon the specific patient's plan. If it is appropriate to the patient's plan, these amounts may also be separately described for Out of Network coverage.

III. Standard Set of Services - Benefit Information

The following is the baseline set of services for which benefit coverage information should generally be available from health plans as part of a standard request for benefits. For benefits related to other service types, individual requests for those service types should be made.

If the service level benefit is provided by the health plan as part of the member's coverage, the following benefit information will be made available.

	In-Network Provider					
Service Type	**Co-Pay**	**Co-Ins**	**Service Specific Deductible**	**Benefit Limit**	**Visit Limits**	**Benefit Remain**
Medical Care						
Professional (Physician) Visit Office[*1]						

Service Type	In-Network Provider					
	Co-Pay	Co-Ins	Service Specific Deductible	Benefit Limit	Visit Limits	Benefit Remain
Hospital*2						
Emergency Services						
Urgent Care						
Mental Health *3						
Vision (Optometry) *4						
Pharmacy - Prescription*4						
Chiropractic						
Dental Care *4						

Service Type	Out of Network Provider					
	Co-Pay	Co-Ins	Service Specific Deductible	Benefit Limit	Visit Limits	Benefit Remain
Medical Care						
Professional (Physician) Visit Office*1						
Hospital*2						
Emergency Services						
Urgent Care						
Mental Health *3						
Vision (Optometry) *4						
Pharmacy - Prescription*4						
Chiropractic						
Dental Care *4						

*1 - Benefit information will be provided for the following - Physician Visit-Office: Sick and Physician Visit-Office: Well

*2 - Benefit information will be provided for the following - Hospital - Inpatient and Hospital - Outpatient

*3 - Benefit information will be provided for the following - Psychiatric - Inpatient, Psychiatric - Outpatient and Substance Abuse

*4 - In these and other circumstances, the full range of benefit information may not be provided. These circumstances occur when:

- Benefit tiers are too complex to exchange electronically. In this situation, applicability of the benefit and the dates of coverage must be provided.
- An organization other than the health plan administers the service, i.e. 'carve out'. In this situation, applicability of the benefit, the responsible organization name and dates of coverage must be provided.

The following describes the information that will be available for In-Network coverage, as appropriate, for each of the Service Types listed above. If and as appropriate to the patient's coverage, this information may also be separately described for Out of Network coverage.

- *Copay*: The amount to be paid to the provider by the patient at the time of the visit.

- *Coinsurance*: The percentage of the allowed amount to be paid to the provider by the patient after the health plan has paid their portion.
- *Deductible*: This is the amount the patient pays before their benefit begins. If there is no benefit than a zero is required. (If the deductible is not zero, a copay and/or coinsurance may be required).

  For some services, a specific deductible amount is reported ONLY if that deductible amount is NOT included as part of the Contract Level Medical Deductible Amount. In this document, that situation will be called 'Service Specific Deductible. *Benefit Limit*: Information about any limits that apply to this Service Level Benefit for a patient, e.g. number of visit, number of days, etc.

- *Benefit Remaining*: If there is a benefit limit, this is information about how much of that limit remains. For the Psychiatric and Substance Abuse benefits, health plans may indicate that the provider should call customer service for this information.

- *Visit Limitations*: For some benefit plans, there may be limitations pertaining to the dollar amount for each visit and/or the frequency and time frame in which the services must be delivered, i.e. Benefit Limit is 12 visits, Visit Limits is no more than 2 visits per month

Note: *Pre-Authorization Requirement*:

This document acknowledges that informing providers about the need for a pre-authorization will help them to expedite their workflow. It also recognizes that a) the requisite clinical information that is necessary for the health plan to make that determination is not always available to health plans at the time that a provider requests eligibility/benefit information, and b) in those cases where a determination could be made, significant programming work is required of health plans and provider organizations -- to extract this information from the health plan system, exchange it in a 270-271 transaction set and incorporate it into the provider's production system. As such, there will not be a best practice recommended at this time. However, a future best practice recommendation is envisioned and is likely to take shape as outlined below.

For a service type (not a procedure), information should be provided to indicate which or the following situations apply.

- A certification or pre-authorization is ***always required*** for all diagnoses and procedures related to that service type, OR
- A certification or pre-authorization is ***never required*** for any diagnoses or procedures related to that service type, OR
- The certification or pre-authorization requirements are ***not accessible or the rules are more complex*** than can be returned in the transaction

Health plans and provider organizations are encouraged to begin programming efforts in this direction.

IV. Explicitly Requested Services - Benefit Information

In addition to the baseline set of services listed in section III above, benefit information may be explicitly requested for specific services. Over time, health plans will increase the number of services for which they provide benefit information on their website and in the transaction. When a health plan provides a service level benefit as part of the member's coverage, the benefit information described above should be available.

HOW THAT INFORMATION WILL BE REPORTED

Web-based Access to the Information

The Minimum Standard Set of Eligibility and Benefit Information outlined above will be available on each health plan's website. The specific design of how this information is presented on their website is left to each health plan. However, to enhance usability by the provider, a Best Practice Recommended design should consider the following factors:

- *Single sign-on*: The provider should be able to use their OHP credential to access the health plan's site.

- *Number of 'clicks'*: The provider should be able to get to the eligibility & benefit information with as few 'clicks' as possible. Fewer clicks should be required to get to basic eligibility information compared to detailed benefit information.

- *Options for Patient Search*: The website should offer providers multiple ways to "look-up" a patient. Each of the look-up options will be a different combination of data elements from the following list.
    - First Name
    - Last Name
    - Member Date of Birth
    - Subscriber ID (Some health plans may refer to this as Member ID)

  Each option should require the provider to enter only the minimum number of data elements (1-4) that is consistent with the health plan's patient privacy & security requirements per HIPAA regulations.

- *Time Period*: The health plan's system should respond to each query in no longer than 20 seconds from the point that their system receives the query. (A query is initiated when the provider enters "enter", "submit" or other similar command on their Web browser.) Time periods may appear longer to the provider depending upon the type of computer they are using, type of browser, speed of the Internet, etc.

- *Listing of the Standard Set of Services:* For the standard set of services for a selected member for In-Network and Out of Network, clearly identify those services for which benefits apply as well as services for which benefits do not apply. When a benefit

applies, display the benefit information. Examples of how this may be done include, but are not limited to,

- Listing all services in the standard set and displaying either the benefit or "Does Not Apply"
- Displaying services, and related benefit information in two groups – one group for which benefits apply and one group for which benefits do not apply
- Other method that is easily understood by providers.

- *Carved Out Services*: If an organization other than the health plan administers the service, the website must, as a minimum, indicate whether or not the patient is eligible for the benefit and, if so, provide the responsible organization name and dates of coverage. Ideally a contact phone number or link will be reported on the health plan's site that will point the provider to where the patient responsibility information can be found.

- *Service Specific Deductible:* The site will provide one or the other of the following:

  EITHER A.

  1. Provide a tagline that indicates "Unless otherwise indicated for a specific service, any deductible amount for that service is included as part of the Contract Level Medical Deductible Amount", and
  2. For a specific service, indicate any specific deductible amount that is not included as part of the Contract Level Medical Deductible Amount

  OR B.

  For every specific service, indicate whether or not there is any deductible amount that is not included as part of the Contract Level Medical Deductible Amount

- *Deductible and Patient Responsibility:* Indicate whether or not deductibles, both contract level and/or service-specific, apply to the patient's out of pocket responsibility

- *Printer-Friendly Report*. The provider should be able to easily print out a readable, paper version of the information that is on the website.

HOW THAT INFORMATION WILL BE REPORTED

270-271 Transaction Exchange of the Information

The Minimum Standard Set of Eligibility and Benefit Information outlined above will be implemented in Real-time and Batch Exchange of the HIPAA 270-271 Health Care Eligibility Benefits Inquiry and Response transaction. More specific best practice requirements associated with the transaction include:

Transaction Turnaround

The provider organization will send the 270 Inquiry transaction and health plans will reply with the 271 Response transaction.

When receiving a batch transmission of the 270 Inquiry transaction, health plans will respond with a 999 Acknowledgment transaction prior to processing the 271 Response.

Time Period

For Real-time Exchange (i.e. for one service type code inquiry at a time via an electronic connection that stays open until the response is provided):

> Health plans will respond, with a 271 transaction for each valid eligibility request contained in a 270 transaction, as soon as possible and not later than 20 seconds after receiving the 270 transaction. Response errors, either via a 271 AAA segment or via a '999' as appropriate, will be returned in the same time frame.

For Batch Exchange (i.e. for one or more service type code requests and responses that are exchanged in batches. When sending batch transactions, unlike Real-time, the electronic connection does not stay open):

> For each batch of 270 transactions received by 9 PM on a business day, health plans will respond, with one or more 271 transactions, for every eligibility request contained in the respective 270 transaction, as soon as possible and not later than 7 AM on the next business day. Response errors, either via a 271 AAA segment or via a '999' as appropriate, will be returned within one hour of receiving the batch.

For both types of exchanges, the time period starts when the health plan receives the 270 transaction, either from a clearinghouse or directly from a provider organization and ends when all eligibility requests pertaining to that health plan's members contained in the 270 transaction are answered, i.e. via the sending of one or more related 271 transactions, either to a clearinghouse or directly to a provider organization.

If a health plan partner's with a clearinghouse to process/exchange transactions, the health plan is responsible for their clearinghouse's response and the ability of their clearinghouse to provide a compliant transaction and to be compliant with CORE rules.

Scope of Response

The scope of response, within the time period, includes a reply to every request for information that is contained within the 270 transaction that is not forwarded to another health plan. The scope includes, as appropriate, either a Member Not Found response or a response with eligibility/benefit information. The scope does not include responding to a request for information that is forwarded to another health plan, e.g. Blue Card or FEP.

Returning 270 Information on the 271

Information submitted in the 270 request may or may not be used by the health plans in determining the 271 response. Any information submitted on the 270 that is used by the health plan in determining the response, must be returned in the 271.

Providers may include the Patient Account Number as their internal tracking number in the 270 request. If the Patient Account Number is contained in the 270 request (Loop 2100C/D, REF01= 'EJ', REF02 = patient account number), it must be returned in the 271 response.

Patient Identification & Search

Providers should include the following patient identifying information on all 270 Request transactions

- Patient First Name
- Patient Last Name
- Patient Date of Birth
- Patient Member ID

The health plan will check for that patient as both a subscriber and a dependent, regardless of whether the patient was identified as a subscriber or dependent in the inquiry. More specifically, if a match on patient exists, the response will contain eligibility and benefit information for that patient even if the inquiry specifies the patient as a dependent and the health plan system has the patient as the subscriber, or vice versa.

Overview - Service Type Request (270) & Response (271)

The Best Practice Recommendation will call for health plans to make benefit information available by service type. As the demand for and usefulness of providing benefit information at the diagnosis and/or procedures level has not been established, it will not be included as a Best Practice Recommendation. If a provider does send a request with EQ02 = valid composite medical procedure Id and the health plan does not provide eligibility/benefit information by diagnosis/procedure, the response returned by the health plan will be the same as if the provider sent a request with EQ01 = 30.

Using the 270 transaction, providers can request benefit information for the standard set of services (EQ01=30) and/or they can request information for one or more specific service (e.g. EQ01=64 for Acupuncture). Requests for benefit information are made by repeating the EQ01 data element for each desired service type (up to 99 times) as long as all of the information in the 2110C/D loop is the same for all of the requested services. If the information is different for each requested service type, separate EQ segments must be used.

Usage Notes:

1. 270 Data Elements typically ignored

   The following fields do not need to be populated in the transaction. In many cases, the health plans will not even look at the field. In all cases, the health plan will send the exact same response regardless of the values that are in the fields.

Data Element
Provider Information (PRV01-PRV06) *1
Date-Time Information (DTP01-DTP03)
Composite Medical Procedure Identifier (EQ02)
Coverage Level Code (EQ03)
AMT01-02, III01-02, REF01-02

   *1 – If the health plan needs this field to process the 270, they will notify the provider

2. Information Reporting conventions for 271 Response to EQ01 codes

   a. If one of the EQ01 codes = '30' OR IF one of the EQ01 codes is not supported by the health plan,

      Participating health plans have agreed to respond with General Eligibility Coverage and Standard Service Benefit information for the member's policy. See the sections I, II and III below**.**

   b. If one of the EQ01 codes contains something other than '30' . . .

      If the member's policy does have a covered benefit for the service type(s) that is specified in EQ01, then the health plan will respond with detailed benefit coverage data for that service type. See the section IV below**.**

      If the member's policy does not have a covered benefit for the service type that is specified in EQ01, then the health plan will not respond with detailed benefit coverage information but will include the following EB segment in Loop 2110C/D

	Non-Covered Benefit Values
EB01	**'I'**
EB02	Omit

	Non-Covered Benefit Values
EB03	HIPAA code that was in EQ01
EB04	Omit
EB05	Omit
EB06	Omit
EB07	Omit
EB08	Omit
EB09	Omit
EB10	Omit
EB11	Omit
EB12	Omit

Omit – No value is put between the field delimiters

HOW THAT INFORMATION WILL BE REPORTED

271 Response Transaction

Guidelines for Using the EB Segments to convey the minimum set of Information

1. *The 271 should respond to each unique service type contained in the 270 EQ01, even if multiple types are contained in the 270 EQ01. Unique service types = Non-repeating service type and no services types that are included within a '30'.*

2. *A 271 EB*1 segment is required.*

   For coverage that is found and active:

   Each and every service type that is specified in a 270 EQ01 for which the member has active coverage and which is supported by the health plan, will be represented in an EB segment with EB01=1. If 270 EQ01 contains a 30, this includes all service types that comprise a 30 if they are supported by the member's contract.

   - EB02 = IND, FAM or blank (blank assumes individual)
   - EB05 = Plan Name (required by CORE if one exists)

   Example:

   EB*1**30**Gold Plan~

   OR

   EB*1**30^33^35^47^48^50^62^ 86^88^98^AL^MH^UC **Gold Plan~

   OR

   EB*1**30**Gold Plan~
   EB*1**33^35^47^48^50^62^ 86^88^98^AL^MH^UC~

   OR

   EB*1*IND*30**Gold Plan~
   EB*1*IND*33^35^47^48^50^62^ 86^88^98^AL^MH^UC~

   For coverage that is found but is inactive:

   Each and every service type that is specified in a 270 EQ01 for which the member has inactive coverage, will be represented

   - With an EB segment with EB01=6 , and
   - With a DTP segment for the start date of coverage and a DTP segment for the end date of coverage

   EB*6**30*PR*PREFERRED PROVIDER PLUS~
   DTP*356*D8*20170101~
   DTP*357*D8*20230930~

3) *Health plans may return more than the service code(s) requested in 270 EQ01 when the codes are related.*

For example, if EQ01=73 (diagnostic medical) then information about service code 73 as well as service codes 4 (diagnostic x-ray) and 5 (diagnostic lab) may be returned.

Example:

EB*1**73^4^5

4) *A member's **deductible and out-of-pocket-max** will always be reported at the '30' level (Plan level) and only be reported at the service type level if different.*

Regardless of the value of 270 EQ01, a member's deductible and out-of-pocket-max will be represented with a suite of appropriate EB segments where EB03=30. (Note: EB03=30 segments contain deductible and out-of-pocket-max as defined within that health plan's policy). As appropriate to the health plan and coverage, possible EB segments are:

- EB01= C for deductible, EB01=G for out of pocket maximums, EB01=Y for Spend down (Medicaid)
- EB02 = IND and FAM, as appropriate
- EB12 = appropriate designation(s) for in-network and out of network
- EB06 and EB07 contain the appropriate value – e.g. contract and remaining as appropriate

Example

- EB*C*IND*30****500

For all service types that comprise a 30 (e.g. 1, 33, 35, 47, 48, 50, 86, 88, 98, AL, MH, and UC) OR service types that are specifically requested in the EQ01 for which the member has active coverage and the health plan can support OR additional service types returned by the health plan:

a) Service types that have the same deductible and out-of-pocket-max as the "30" (plan level) will NOT be reported again at the service type level. Service types that have a different deductible and out-of-pocket-max than the "30" (plan level) will be reported at the service type level.

Example

- EB*C*IND*30****500
- EB*C*IND*35****100

b) Service types with the same member responsibility information should appear on the same line using the repeating function in EB03.

c) If an explicit service type is requested along with a generic '30' and they have the same deductible and out-of-pocket-max as the '30' it will NOT be separately represented in an EB segment but will be identified alongside the '30'

Example

- EB*C*IND*30^83****500

5) *A member's **copay and coinsurance** may be reported in the 271 in one of the following two ways*:

A health plan may EITHER:

Report copay and coinsurance at the '30' (plan level) and only with the service type if different than what is reported at the '30'.

Regardless of the value of 270 EQ01, copay and coinsurance information will be represented with a suite of appropriate EB segments where EB03=30. (Note: EB03=30 segments contain the copay and coinsurance as defined within that health plan's policy). As appropriate to the health plan and coverage, possible EB segments are:

- EB01= A for coinsurance, EB01=B for copay
- EB02 = IND and FAM, as appropriate
- EB12 = appropriate designation(s) for in-network and out of network

Example
- EB*B*IND*30****50

For all service types that comprise a 30 (e.g. 1, 33, 35, 47, 48, 50, 86, 88, 98, AL, MH, and UC) OR service types that are specifically requested in the EQ01 for which the member has active coverage and the health plan can support OR additional service types returned by the health plan:

a. Service types that have the same copay and coinsurance as the "30" (plan level) will NOT be reported again at the service type level. Service types that have a different copay and/or coinsurance from that of the (plan level) will be reported at the service type level.

   Example
   - EB*B*IND*30****50
   - EB*B*IND*35****10

b. Service types with the same member responsibility information should appear on the same line using the repeating function in EB03.

c. If an explicit service type is requested along with a generic '30' and they have the same deductible and out-of-pocket-max as the '30' it will NOT be separately represented in an EB segment but will be identified alongside the '30'

   Example

   - EB*B*IND*30^78****500

OR

Only report copay and coinsurance with the service type and NOT with the "30" (plan level).

For all service types that comprise a "30" (e.g. 1, 33, 35, 47, 48, 50, 86, 88, 98, AL, MH, and UC) OR service types that are specifically requested in the EQ01 for which the member has active coverage and the health plan can support OR additional service types returned by the health plan, the copay and coinsurance for those service types will be represented in EB segment(s) with EB03 = that service type.

6) *Different **co-pay amounts** for the same STC (Service Type Code) will be explained.*

If multiple EB loops are used to report co-pays (EB01=B) for the same STC and all values are the same except for the $amount, e.g.

EB*B*IND*98***27*40****U*Y

EB*B*IND*98***27*30****U*Y

then an associated MSG segment will be used to uniquely account for and explain the different dollar amount in EB07

*7) Any **benefit limits** will be reported for each service type or procedure code*

In addition, each and every service type that is specified in a 270 EQ01 for which the member has active coverage and that is supported by the health plan and has a benefit limit will be represented in EB segment with EB01=F and EB03 = that service type along with the other appropriate values for the benefit maximum and the benefit remaining. If 270 EQ01 contains a 30, this includes all service types that comprise a 30 that are supported by the member's contract and have benefit limits. This also includes service types added by the health plan (e.g. #3 above) that have benefit limits.

Benefit information may be reported at the procedure code level (EB13) rather than at the service type level.

I. General Eligibility Coverage Information

	Location in 271 Transaction	
Data Element	**For patient as subscriber**	**For patient as dependent**
Transaction Reference Number	TRN02 (that matches to the respective 270 transaction)	
Subscriber Name	Loop 2100C, NM1 Segment	
Patient Name	Same as Subscriber Name above	Loop 2100D, NM1 Segment, NM101-NM105
Patient's Relationship to Subscriber	Loop 2100C, INS Segment, INS01-INS02, INS01='Y', INS02: See TR3 for full list of values	Loop 2100D INS Segment, INS01= N, INS02: See TR3 for full list of values
Patient Date of Birth	Loop 2100C, DMG Segment, DMG02	Loop 2100D, DMG Segment, DMG02
Patient Gender	Loop 2100C, DMG Segment, DMG03="F" – Female, "M" – Male, "U" - Unknown	Loop 2100D, DMG Segment, DMG03="F" – Female, "M" – Male, "U" - Unknown
Patient Member Number	Loop 2100C, NM1 Segment, NM109	Loop 2100D, NM1 Segment, NM109
Group Number	Loop 2100C, REF Segment, REF01-02, REF01 = '6P' - Group Number	Loop 2100D, REF Segment, REF01-02, REF01 = '6P' -Group Number
Coverage Date (aka Policy Effective Date) *2	Loop 2100C, DTP Segment, DTP01-DTP03	Loop 2100D, DTP Segment, DTP01-DTP03
Eligibility Status	EB Segment = EB*1**30*	
Group Name	Loop 2100C, REF Segment, REF03	Loop 2100D, REF Segment, REF03
Plan Type	Loop 2110C, EB Segment, EB04-EB05	Loop 2110D, EB Segment, EB04-EB05
Other Coverage*1	Loop 2120C, Segments, NM101 = 'PRP' - Primary, 'SEP – Secondary Payer' or 'TTP – Tertiary Payer'. Other fields as appropriate to the payer. (See TR3 for full list of values)	Loop 2120D, Segments, NM101 = 'PRP' - Primary, 'SEP – Secondary Payer' or 'TTP – Tertiary Payer'. Other fields as appropriate to the payer. (See TR3 for full list of values)
Primary Care Physician (PCP) *1	Loop 2120C, NM101 = 'P3' -Primary Care Provider. (See TR3 for full list of values) PCP Name (NM1) and phone number (PER Segment).	Loop 2120D, NM101 = 'P3' -Primary Care Provider. (See TR3 for full list of values) PCP Name (NM1) and phone number (PER Segment).
Washington State Balance Billing Message *These instructions implement section 7(4) of the Balance Billing Protection Act (Chapter 427, Laws of 2019), to communicate that a patient's health insurance plan is subject to the*	The message to be placed in the 271 transaction is: "Services provided to this patient are subject to the Balance Billing Protection Act. Please see RCW 48.49.020 for details." The placement of the message within the 271 transaction is as follows: a. In an existing: o Loop 2110C - SUBSCRIBER ELIGIBILITY OR BENEFIT INFORMATION, OR o Loop 2110D - DEPENDENT ELIGIBILITY OR BENEFIT INFORMATION b. For the EB segment where EB01=1,2,3,4,5,6,7,8 (active or inactive coverage)	

Data Element	Location in 271 Transaction	
	For patient as subscriber	For patient as dependent
requirements of the Act.	Place the message in the MSG segment Example: EB*1*IND*30*PR*THIS IS THE PLAN NAME~ MSG* Services provided to this patient are subject to the Balance Billing Protection Act. Please see RCW 48.49.020 for details~ Note to providers - there is a limit of 10 messages per each 2110 Loop. If this messages causes the health plan to have more than 10 messages, a separate Loop for the message may be created.	

*1 - This information should be sent if it is in the health plan's records and appropriate to the coverage. The health plans will send the information that they have. The accuracy of the information cannot be assured.

*2 - See section 1.4.7.1 of the TR3 for specific values to be used depending upon coverage conditions.

The following are the minimum standard set of coverage date values to be reported in the 271 transaction:

- If active coverage and single plan or plan period, then Loop 2100C/D DTP01 = 291 – Plan range of date or = 346 – Plan Begin date
- If active coverage and multiple plans or plan periods, then Loop 2110C/D DTP01 = 291 – Plan range of date or = 346 – Plan Begin date for each plan or period
- If active coverage and benefit dates are different from the 2100C/D or 2110 C/D Plan or Plan Begin date, either 348 - Benefit Begin date or 292 - Benefit date must be returned in the 2110C/D loop with the associated EB03 benefit.

Note: Per TR3 guidelines, Plan dates represent coverage dates in the plan or program that is being represented in the response. This date does not have to represent the historical beginning of eligibility for the plan, only the most recent plan date(s). For example, Medicaid may only report plan dates in one month periods of time.

Note: Unfortunately, per HIPAA mandated specifications, valid data values may vary between transactions. Make sure to refer to each specific TR3 for appropriate data values before usage.

II. Contract Level Benefit Information

A. Deductible and Accumulator Information

1. Individual

Deductible	Total Amount	Per Period	Amount Remaining
In-Network	Y	As appropriate	Y
Out of Network	Y	As appropriate	Y

2. Family

Deductible	Total Amount	Per Period	Amount Remaining
In-Network	Y	As appropriate	Y
Out of Network	Y	As appropriate	Y

For each type of deductible, e.g. Individual Medical In-Network, Family Medical Out of Network, etc., there will be 2 related EB segments. One EB segment will contain information about the total amount of the deductible for the specified period – either calendar year (EB06=23) or contract year (EB06=25). The other EB segment will contain information about how much of the deductible is remaining at the time the transaction was generated (EB06=29).

The values listed in EB02 and EB06 are typical for the basic deductible information. There may be slight variations between health plans.

	Standard Deductible & Accumulator Values
EB01	**'C'**
EB02	• '**IND**' – Individual • '**FAM**' – Family
EB03	'**30**' – Medical or Omit
EB04	Omit or a Standard Value
EB05	Plan Name if appropriate. Check with the health plan for values and meanings.
EB06	➢ '**22**' – When EB07 contains the total deductible amount for the service year ➢ '**23**' – When EB07 contains the total deductible amount for the calendar year ➢ '**25**' - When EB07 contains the total deductible amount for the contract period ➢ '**29**' – When EB07 contains the remaining deductible amount for the specified period
EB07	Deductible Amount
EB08	Omit
EB09	Omit
EB10	Omit
EB11	Omit
EB12	• '**Y**' – if only for In-Network

	Standard Deductible & Accumulator Values
	• '**N**' – if only for Out of Network • '**U**' - if requirements not accessible or rule too complex • '**W**' – if for both In-Network and Out of Network

Omit – No value is put between the field delimiters

B. Out of Pocket Maximums and Accumulator Information

1. Individual

Out of Pocket Maximum	Total Amount	Per Period	Amount Remaining
In-Network	Y	As appropriate	Y
Out of Network	Y	As appropriate	Y

2. Family

Out of Pocket Maximum	Total Amount	Per Period	Amount Remaining
In-Network	Y	As appropriate	Y
Out of Network	Y	As appropriate	Y

For each type of out of pocket maximum, e.g. Individual In-Network, Family Out of Network, etc., there will be 2 related EB segments. One EB segment will contain information about the total amount of the out of pocket maximum for the specified period, e.g. calendar year (EB06=23). The other EB segment will contain information about how much of the out of pocket maximum is remaining at the time the transaction was generated, e.g. annual period (EB06=29).

The value listed in EB02 and EB06 are typical for the basic out of pocket maximum information. There may be slight variations between health plans.

	Standard Out of Pocket Max & Accumulator Values
EB01	**'G'**
EB02	• '**IND**' – Individual • '**FAM**' – Family
EB03	'**30**' – Medical or Omit
EB04	Omit or a Standard Value
EB05	Plan Name if appropriate. Check with the health plan for values and meanings.
EB06	➢ '**22**' – When EB07 contains the total out of pocket maximum amount for the service year

	Standard Out of Pocket Max & Accumulator Values
	➢ '**23**' – When EB07 contains the total out of pocket maximum amount for the calendar year ➢ **25**' - When EB07 contains the total out of pocket maximum amount for the contract period ➢ '**29**' – When EB07 contains the remaining out of pocket maximum amount for the specified period
EB07	Out of Pocket Maximum Amount
EB08	Omit
EB09	Omit
EB10	Omit
EB11	Omit
EB12	• '**Y**' – if only for In-Network • '**N**' – if only for Out of Network • '**U**' - if requirements not accessible or rule too complex • '**W**' – if for both In-Network and Out of Network

Omit – No value is put between the field delimiters

C. Spend Down (Medicaid)

Individual

Spend Down

Total Amount	Per Period	Amount Remaining
Y	Contract	Y

For Spend Down, there will be 2 related EB segments. One EB segment will contain information about the total amount of the patient's responsibility before their benefits begin. The other EB segment will contain information about how much of the patient's responsibility has yet to be met at the time the transaction was generated.

The value listed in EB02 and EB06 are typical for cost containment information.

	Spend Down Values
EB01	**'Y'**
EB02	**IND**' – Individual
EB03	'**30**' – Medical or Omit
EB04	Omit or a Standard Value
EB05	Plan Name if appropriate. Check with the health plan for values and meanings.
EB06	**25**' - When EB07 contains the total spend down amount for the contract period **29**' – The remaining patient responsibility to be met

	Spend Down Values
EB07	Spend Down Amount
EB08	Omit
EB09	Omit
EB10	Omit
EB11	Omit
EB12	• '**Y**' – if only for In-Network • '**N**' – if only for Out of Network • '**U**' - if requirements not accessible or rule too complex • '**W**' – if for both In-Network and Out of Network

Omit – No value is put between the field delimiters

III. Standard Set of Services - Benefit Information: Copay, Coinsurance, Deductible & Limitations

This section talks about obtaining information about the Standard Set of Services. The Standard Set of Services information will be provided in the 271 response when, in the 270 request, EITHER EQ01='30' OR the service type contained in EQ01 is not a separately coded, covered benefit for the member.

If a member does not have coverage for one of the standard service type(s) in the set, the health plan will not include any information about that service in the 271 response.

For each of the service types listed below, health plans will provide benefit information as long as the member has coverage for that service type. (Each service may have multiple EB segments to describe the related benefits.) Depending upon their policies and capabilities, health plans may supply more information about the services listed below, or about other services. (See table in Appendix.)

Benefit information for each service within the set currently includes:

A. Copay, Coinsurance and Overriding Deductible Information
B. Maximum Benefit Limit and Accumulator Information
   - Dollar Amount
   - Number of Days
   - Number of Visits
   - Limitation about the benefit period
C. Service Delivery Limitations

Note: The EB03 column of each table indicates how each specified type of service will be coded in the transaction.

Information about the following Standard Set of Services must be provided in the 271 when EQ01=30 in the 270 transaction. ('*' indicates service types that comprise a Health Benefit Plan Coverage - service type code '30, e.g. 1, 33, 35, 47, 48, 50, 86, 88, 98, AL, MH, and UC.) Information about the other listed service, e.g. BY, BZ, A7, A8, AI will be provided as part of a '30', when those benefits exist.

1.

Medical Care	EB03 =
Medical Care *	'1'

2.

Physician Office Visit	In-Network	Out of Network	EB03 =
Professional (Physician) Visit Office *	Y	Y	'98'
As well as:			
Professional (Physician) Visit Office - *Sick*	Y	Y	'BY'

Physician Office Visit	In-Network	Out of Network	EB03 =
Professional (Physician) Visit Office - *Well*	Y	Y	'BZ'

3.

Hospital	In-Network	Out of Network	EB03 =
Hospital *	Y	Y	'47'
As well as:			
Hospital –Inpatient *	Y	Y	'48'
Hospital – Outpatient *	Y	Y	'50'

4.

Emergency Service	In-Network	Out of Network	EB03 =
Emergency Services *	Y	Y	'86'

5.

Urgent Care	In-Network	Out of Network	EB03 =
Urgent Care *	Y	Y	'UC'

6.

Mental Health	In-Network	Out of Network	EB03 =
Mental Health *	Y	Y	'MH'
As well as the below if consistent with health plan privacy policy			
Psychiatric - Inpatient	Y	Y	'A7'
Psychiatric - Outpatient	Y	Y	'A8'
Substance Abuse*[1]	Y	Y	'AI'

[1]- There is typically no difference in copay amounts for the different type of chemical dependency, eg. alcohol, drugs, etc.

7.

Vision	In-Network	Out of Network	EB03 =
Vision (Optometry) *	Y	Y	'AL'

8.

Chiropractic	In-Network	Out of Network	EB03 =
Chiropractic *	Y	Y	'33'

9.

Dental	In-Network	Out of Network	EB03 =
Dental *	Y	Y	'35'

10.

Pharmacy	EB03=
Pharmacy – *Prescription* *	'88'

A. Copay, Coinsurance and Overriding Deductible Information

The following table identifies how the EB segment of Loop 2110C (for Subscriber) and 2110D (for Dependent) will be coded.

The copay, coinsurance & deductible information contained in the respective EB03=30 segment (EB01=B,A,C) will apply to all service types that comprise a Health Benefit Plan Coverage - service type code '30', unless otherwise indicated. In other words, for the specific service types that comprise a Health Benefit Plan Coverage - service type code '30', the copay, coinsurance & deductible information for that specific type will only be reported in its own EB segment when that information is different than the information associated with the respective EB03=30 segment.

Illustration:

Assuming that

- the coverage dates for the service types are the same as the coverage date for the overall plan.
- the deductible for the plan is $500 AND all service types in a '30' apply to that deductible, except for 'AL'
- service type 'AL' has its own deductible requirement of $100 . . .

Loop 2100C DTP*307*RD8*201501-20151231	Plan date (307) the same for the contract and all service types
Loop 2110C • EB*1*IND*1*30***Gold Plan • EB*C*IND*30****500 • EB*C*IND*AL****100	• All active service types are listed in EB*1. • The deductible for all active service types that are part of the '30' fall into the $500 deductible level, unless otherwise listed

Copay information will not be available in the 271 for the following situations:

- The complexity of benefits is not supported within the structure of the 271
- The health plan would like the provider to call customer service for benefit specific information. This is designated when EB01 = 'U' for the service type specified in EB03.
- The service type code is too general for an EB='B' segment to apply, e.g. for a '30' - Medical Service, there will be no EB='B' segment.

  In most cases, there will be at least one EB='B' segment for copay. If there is no copay for that service, or if the copay is waived, the copay value will be '0'. Other EB segments will be included as appropriate to the benefit.

	Standard Copay Values	**Standard Co-Insurance Values**	**Standard Deductible Values**
EB01	**'B'**	**'A'** *3	**'C'**
EB02	V*3	V*3	V*3
EB03	See each service above	See each service above	See each service above
EB04	V*1a	V*1a	V*1a
EB05	V*1b	V*1b	V*1b
EB06	V*2	V*2	V*2
EB07	Copay Amount due from the patient or '0' if no copay or copay waived.	Omit	V*4
EB08	Omit	Coinsurance Percent -due from the patient – from .0-1	Omit
EB09	Omit	Omit	Omit
EB10	Omit	Omit	Omit
EB11	V*5	V*5	V*5
EB12	• '**Y**' – if only for In-Network • '**N**' – if only for Out of Network • '**U**' - if requirements not accessible or rule too complex • '**W**' – if for both	• '**Y**' – if only for In-Network • '**N**' – if only for Out of Network • '**U**' - if requirements not accessible or rule too complex	• '**Y**' – if only for In-Network • '**N**' – if only for Out of Network • '**U**' - if requirements not accessible or rule too complex

	Standard Copay Values		Standard Co-Insurance Values		Standard Deductible Values
	In-Network and Out of Network		• '**W**' – if for both In-Network and Out of Network		• '**W**' – if for both In-Network and Out of Network

Omit – No value is put between the field delimiters

*3 – WDS will use 'D' rather than 'A'

V*1a - Will contain Omit or a standard value

V*1b - Plan Name if appropriate. Check with the health plan for values and meanings

V*2 - Will contain Omit or the time period appropriate to the benefit

V*3 - Will contain Omit or appropriate value from the TR3

V*4 - Only put a deductible amount if it is different than the amount specified in the contract level deductible information. In other words,

- If a deductible amount does not need to be met for the specific benefit to apply, the deductible amount, EB07, will be '0'.
- If a deductible amount does need to be met and the deductible amount is different than the general information, then EB07 will contain a value greater than '0'.

V*5 - This document acknowledges that informing providers about the need for a pre-authorization will help them to expedite their workflow. It also recognizes that a) the requisite clinical information that is necessary for the health plan to make that determination is not always available to health plans at the time that a provider requests eligibility/benefit information, and b) in those cases where a determination could be made, significant new programming work is required of health plans and provider organizations to extract this information from the health plan system, exchange it in a 270-271 transaction set and incorporate it into the provider's production system. As such, the best practice recommendation for exchanging pre-authorization related information is as follows:

For exchanging the pre-authorization requirement for a requested procedure (EQ02 = valid composite medical procedure Id)

At the time of an eligibility/benefits request, the health plan is unlikely to have sufficient information to determine the need for a pre-authorization for a specific procedure (i.e. medical notes will not have been provided.) As such, if the health plan cannot respond to an EQ02 = valid composite medical procedure Id, the response returned by the health plan will be the same as if the provider sent a request with EQ01 = 30.

For exchanging the pre-authorization requirement for a requested service type (EQ01 = valid service type code)

At this time, no best practice will be recommended for the content of EB11.

However, a future best practice recommendation is envisioned and is likely to take shape as outlined below. Health plans and provider organizations are encouraged to begin programming efforts in this direction.

Likely future best practice recommendation for the content of EB11:

- 'Y' if a certification or pre-authorization is **always required** for all diagnoses and procedures related to that service type
- 'N' or Omit if a certification or pre-authorization is **never required** for any diagnoses or procedures related to that service type
- 'U' if the certification or pre-authorization requirements **are not accessible or the rules are more complex** than can be returned in the transaction

B. Maximum Benefit Limit and Accumulator Information

For each service type,

If the service type has maximum benefit limitations

NOTE: When a provider creates a 270 Request transaction with EQ01 = 30, some health plans interpret HIPAA Privacy regulations as preventing them from sending the level of benefit information described below for service types:

- MH - Mental Health
- A7 – Psychiatric-Inpatient
- A8 – Psychiatric-Outpatient
- AI – Substance Abuse

In these cases, the health plan will include an EB record with EB01 = 'U' in the transaction to indicate that customer service should be contacted for this information.

To get this level of benefit information, the provider can either contact customer service for the information or can send a 270 transaction with EQ01 = MH, A7, A8 and/or AI. The above service types can be sent by themselves, along with service type '30', or along with other service types.

In the 271, an EB segment pair will identify the benefit maximum limitations (benefit $amount, # of visits, # of days) and the remaining benefit for each of those limitations. There will be at least two EB segments, with EB01 = 'F' (Limitation).

- *One of the two paired EB segments* will identify the benefit maximum limitation for the service type. EB06 will indicate the benefit period -- a calendar year (EB06='23') or a contract year (EB06='25') or an episode of care (EB06 = '26'). The following fields will be used depending upon the type of benefit limitation for that period:
  - EB07 will contain any maximum benefit dollar amount. By convention this field will only be used for the benefit dollar amount, if one exists. It will not

be used for any other limitation as EB06 doesn't qualify for that limitation. (EB06 defines the benefit period.)
- EB09 will identify whether there is a benefit maximum limitation related to number of days or number of visits.
- EB10 will contain the benefit maximum limitation related to EB09

For example, if the benefit maximum limitations for a contract year are $5000 and 12 visits then EB06 = 25, EB07 = 5000, EB09 = VS, EB10 = 12

- *The other EB segment of the pair* will identify the benefit remaining for the service type (EB06 will = '29'). The following fields will be used depending upon the type of benefit limit
  - EB07 will contain any remaining benefit dollar amount. By convention this field will only be used for the benefit dollar amount, if one exists. It will not be used for any other limitation as EB06 doesn't qualify for that limitation. (EB06 defines the benefit period.)
  - EB09 will identify whether there is a benefit remaining related to number of days or number of visits.
  - EB10 will contain the benefit remaining related to EB09

  For example, if the benefit maximum remaining for the contract year are $2000 and 4 visits then EB06 = 29, EB07 = 2000, EB09 = VS, EB10 = 4

If a service type has more than two benefit limitations, e.g. benefit dollar amount and number of visits and number of days, then an additional pair(s) of EB segments will be required. The first EB segment of the second pair will specify the benefit maximum limitation(s) that can't fit in the first pair. The second EB segment of the second pair will specify benefit remaining that can't fit in the first pair.

	Benefit Description Values
EB01	**'F'**
EB02	Omit
EB03	See each service above
EB04	Omit
EB05	Omit
EB06	➢ '**23**' – For benefit limitations for the calendar year ➢ '**25**' - For benefit limitations for the contract year ➢ **'26'** – For benefit limitations for an episode of care ➢ '**29**' – For a benefit remaining
EB07	Omit or Benefit Dollar Amount
EB08	Omit
EB09	Omit or • **'DY'** – Days

	Benefit Description Values
	• **'VS'** – Visits
EB10	Omit or EB09-related quantity for benefit limitation or benefit remaining
EB11	See V[5] note above re pre-authorization
EB12	• '**Y**' – if only for In-Network • '**N**' – if only for Out of Network • '**U**' - if requirements not accessible or rule too complex • '**W**' – if for both In-Network and Out of Network

Omit – No value is put between the field delimiters

C. Service Delivery Limitations

If the service type has service delivery limitations

For some benefit plans, there may be limitations pertaining to the frequency and time frame in which the services must be delivered, e.g. 12 visits, 3 visits per week for 1 month. In these cases, the HSD segment will be used to specify those limitations.

	Service Delivery Values
HSD01	• **'DY'** – Days • **'VS'** – Visits
HSD02	Quantity of HSD01 (same as EB09)
HSD03	• **'DA'** – Days • **'MO'** – Months • **'VS'** – Visits • **'WK'** – Week • **'YR'** – Years
HSD04	Quantity of HSD01 within the time period of HSD03
HSD05	• **'21'** – Years • **'26'** – Episode • **'27'** – Visit • **'32'** – Lifetime • **'34'** – Month • **'35'** – Week
HSD06	HSD05 Duration in which benefits need to be delivered
HSD07	Omit
HSD08	Omit

Omit – No value is put between the field delimiters

For the example of 12 visits, 3 visits per week for 1 month

	Service Delivery Values
HSD01	**'VS'** - Visits
HSD02	12
HSD03	**'WK'** – Week
HSD04	3
HSD05	**'34'** – Month
HSD06	1
HSD07	Omit
HSD08	Omit

Omit – No value is put between the field delimiter

IV. Explicitly Requested Services - Benefit Information

This section talks about obtaining information about explicitly requested service types specified in EQ01 in the 270 request.

Note: If the member's policy ***does not have*** a covered benefit for the service type that is specified in EQ01, then the health plan will respond with an EB01='1' (non-covered) response.

When the member's policy ***does*** provide coverage for the specified service, health plans will respond in the following ways, depending upon the service type that is explicitly requested:

1. *Request for a service type that is supported by the plan, and benefit detail is not too complex*. If a member has coverage for the requested service type, the health plan will provide benefit information as described below. (Each service may have multiple EB segments to describe the related benefits.) Depending upon their policies and capabilities, health plans may supply additional information. (See table in Appendix).

2. *Request for a service type that is not separately coded by the plan*. If the requested service is not separately coded by the plan, the response returned by health plan will be the same as if the provider sent a request with EQ01 = 30.

3. *Request for a service type that is supported by the plan, but benefit detail is too complex*. If a member has coverage for the requested service type and the health plan's system is not able to provide detail benefit information within the 271 transaction, they will respond with an EB segment with EB01 = 'U' for the service type specified in EB03

Benefit information for each supported service type currently includes:

A. Copay, Coinsurance and Overriding Deductible Information

B. Maximum Benefit Limit and Accumulator Information
   - Dollar Amount
   - Number of Days
   - Number of Visits
   - Limitation about the benefit period

C. Service Delivery Limitations

A. Copay, Coinsurance and Overriding Deductible Information

The following table identifies how the EB segment of Loop 2110C (for Subscriber) and 2110D (for Dependent) will be coded.

Copay information will not be available in the 271 for the following situations:

- The complexity of benefits is not supported within the structure of the 271
- The health plan would like the provider to call customer service for benefit specific information. This is designated when EB01 = ' 'U' for the service type specified in EB03.
- The service type code is too general for an EB='B' segment to apply, e.g. for a '30' - Medical Service, there will be no EB='B' segment.

  In most cases, there will be at least one EB='B' segment for copay. If there is no copay for that service, or if the copay is waived, the copay value will be '0'. Other EB segments will be included as appropriate to the benefit.

	Standard Co-Pay Values	**Standard Co-Insurance Values**	**Standard Deductible Values**
EB01	**'B'**	**'A'**[*3]	**'C'**
EB02	V[*3]	V[*3]	V[*3]
EB03	V[*6]	V[*6]	V[*6]
EB04	V[*1a]	V[*1a]	V[*1a]
EB05	V[*1b]	V[*1b]	V[*1b]
EB06	V[*2]	V[*2]	V[*2]
EB07	Copay Amount due from the patient or '0' if no copay or copay waived.	Omit	V[*4]
EB08	Omit	Coinsurance Percent -due from the patient – from .0-1	Omit
EB09	Omit	Omit	Omit
EB10	Omit	Omit	Omit
EB11	V[*5]	V[*5]	V[*5]
EB12	• '**Y**' – if only for In-Network • '**N**' – if only for Out of Network • '**U**' - if requirements not accessible or rule too complex • '**W**' – if for both In-Network and Out of Network	• '**Y**' – if only for In-Network • '**N**' – if only for Out of Network • '**U**' - if requirements not accessible or rule too complex • '**W**' – if for both In-Network and Out of Network	• '**Y**' – if only for In-Network • '**N**' – if only for Out of Network • '**U**' - if requirements not accessible or rule too complex • '**W**' – if for both In-Network and Out of Network

Omit – No value is put between the field delimiters
*3 – WDS will use 'D' rather than 'A'
V*1a - Will contain Omit or a standard value
V*1b - Plan Name if appropriate. Check with the health plan for values and meanings
V*2 - Will contain Omit or the time period appropriate to the benefit
V*3 - Will contain Omit or appropriate value from the TR3
V*4 - Only put a deductible amount if it is different than the amount specified in the contract level deductible information. In other words,

- If a deductible amount does not need to be met for the specific benefit to apply, the deductible amount, EB07, will be '0'.
- If a deductible amount does need to be met and the deductible amount is different than the general information, then EB07 will contain a value greater than '0'.

V*5 - This document acknowledges that informing providers about the need for a pre-authorization will help them to expedite their workflow. It also recognizes that a) the requisite clinical information that is necessary for the health plan to make that determination is not always available to health plans at the time that a provider requests eligibility/benefit information, and b) in those cases where a determination could be made, significant new programming work is required of health plans and provider organizations to extract this information from the health plan system, exchange it in a 270-271 transaction set and incorporate it into the provider's production system. As such, the best practice recommendation for exchanging pre-authorization related information is as follows:

For exchanging the pre-authorization requirement for a requested procedure (EQ02 = valid composite medical procedure Id)

At the time of an eligibility/benefit request, the health plan is unlikely to have sufficient information to determine the need for a pre-authorization for a specific procedure (i.e. medical notes will not have been provided.) As such, if the health plan cannot respond to an EQ02 = valid composite medical procedure Id, the response returned by health plan will be the same as if the provider sent a request with EQ01 = 30.

For exchanging the pre-authorization requirement for a requested service type (EQ01 = valid service type code)

At this time, no best practice will be recommended for the content of EB11.

However, a future best practice recommendation is envisioned and is likely to take shape as outlined below. Health plans and provider organizations are encouraged to begin programming efforts in this direction.

Likely future best practice recommendation for the content of EB11:

- 'Y' if a certification or pre-authorization is **always required** for all diagnoses and procedures related to that service type

- 'N' or Omit if a certification or pre-authorization is **never required** for any diagnoses or procedures related to that service type
- 'U' if the certification or pre-authorization requirements **are not accessible or the rules are more complex** than can be returned in the transaction

V*6 - EB03 will contain the service type code supplied in EQ01 or may contain a service type that is related to but different than what was supplied in EQ01. For example – EQ01 in the 270 may contain a 33 (chiropractic). The health plan may respond in the 271 with an EB03=33 (chiropractic) and an EB03 = 4 (diagnostic x-ray)

B. Maximum Benefit Limit and Accumulator Information

For each service type specified in EQ01 in the 270 request,

If the service type has maximum benefit limitations

In the 271, an EB segment pair will identify the benefit maximum limitations (benefit $ amount, # of visits, # of days) and the remaining benefit for each of those limitations. There will be at least two EB segments, with EB01 = 'F' (Limitation).

- *One of the two paired EB segments* will identify the benefit maximum limitation for the service type. EB06 will indicate the benefit period -- a calendar year (EB06='23') or a contract year (EB06='25') or an episode of care (EB06 = '26'). The following fields will be used depending upon the type of benefit limitation for that period:
  - EB07 will contain any maximum benefit dollar amount. By convention this field will only be used for the benefit dollar amount, if one exists. It will not be used for any other limitation as EB06 doesn't qualify for that limitation. (EB06 defines the benefit period.)
  - EB09 will identify whether there is a benefit maximum limitation related to number of days or number of visits.
  - EB10 will contain the benefit maximum limitation related to EB09

  For example, if the benefit maximum limitations for a contract year are $5000 and 12 visits then EB06 = 25, EB07 = 5000, EB09 = VS, EB10 = 12

- *The other EB segment of the pair* will identify the benefit remaining for the service type (EB06 will = '29'). The following fields will be used depending upon the type of benefit limit
  - EB07 will contain any remaining benefit dollar amount. By convention this field will only be used for the benefit dollar amount, if one exists. It will not be used for any other limitation as EB06 doesn't qualify for that limitation. (EB06 defines the benefit period.)
  - EB09 will identify whether there is a benefit remaining related to number of days or number of visits.
  - EB10 will contain the benefit remaining related to EB09

For example, if the benefit maximum remaining for the contract year is $2000 and 4 visits then EB06 = 29, EB07 = 2000, EB09 = VS, EB10 = 4

If a service type has more than two benefit limitations, e.g. benefit dollar amount and number of visits and number of days, then an additional pair(s) of EB segments will be required. The first EB segment of the second pair will specify the benefit maximum limitation(s) that can't fit in the first pair. The second EB segment of the second pair will specify benefit remaining that can't fit in the first pair.

	Benefit Description Values
EB01	**'F'**
EB02	Omit
EB03	See Note 1 above
EB04	Omit
EB05	Omit
EB06	➢ '**23**' – For benefit limitations for the calendar year ➢ '**25**' - For benefit limitations for the contract year ➢ **'26'** – For benefit limitations for an episode of care ➢ '**29**' – For a benefit remaining
EB07	Omit or Benefit Dollar Amount
EB08	Omit
EB09	Omit or • **'DY'** – Days • **'VS'** – Visits
EB10	Omit or EB09-related quantity for benefit limitation or benefit remaining
EB11	See V[5] note above re pre-authorization
EB12	• '**Y**' – if only for In-Network • '**N**' – if only for Out of Network • '**U**' - if requirements not accessible or rule too complex • '**W**' – if for both In-Network and Out of Network

Omit – No value is put between the field delimiters

C. Service Delivery Limitations

For some benefit plans, there may be limitations pertaining to the frequency and time frame in which the services must be delivered, e.g. 12 visits, 3 visits per week for 1 month. In these cases, the HSD segment will be used to specify those limitations.

	Service Delivery Values
HSD01	• **'DY'** – Days • **'VS'** – Visits
HSD02	Quantity of HSD01 (same as EB09)
HSD03	• **'DA'** – Days • **'MO'** – Months • **'VS'** – Visits • **'WK'** – Week • **'YR'** – Years
HSD04	Quantity of HSD01 within the time period of HSD03
HSD05	• **'21'** – Years • **'26'** – Episode • **'27'** – Visit • **'32'** – Lifetime • **'34'** – Month • **'35'** – Week
HSD06	HSD05 Duration in which benefits need to be delivered
HSD07	Omit
HSD08	Omit

For the example of 12 visits, 3 visits per week for 1 month

	Service Delivery Values
HSD01	**'VS'** – Visits
HSD02	12
HSD03	**'WK'** – Week
HSD04	3
HSD05	**'34'** – Month
HSD06	1
HSD07	Omit
HSD08	Omit

Appendix

1. **Use of EB12 - In-Network' & 'Out of Network'**
2. **Use of Messages**
3. **Dual Coverage**
4. **Use of AAA Segments for invalid patient search info.**
3. **Service Types and associated information about Benefit Limitations**

1. Use of EB12 to indicate In-Network' and 'Out of Network'.

In the 271 transaction, an EB Loop is used to present detail information about benefits. In that loop, EB12 is used to differentiate whether the benefit information relates to an 'In-Network' provider or an 'Out of Network' provider. Whenever the loop is being used to convey deductible information, that loop should be used as follows;

a. ***If the deductible amounts are different***, then they should always be reported separately. For example, if there is a $500 deductible for in-network and a $1000 deductible for - out of network then two different EB loops should be used; one where E07 = $1000 & EB12 = N and a second EB loop where EB07=$500 and EB12 = Y.
b. ***If the deductible amounts are the same but they accumulate separately***, i.e. the patient's payment to one does not affect the other, then they should be reported separately. For example, there is a $500 deductible for in-network and a $500 deductible for - out of network and a $100 payment to an out of network provider does not affect the deductible when an in-network provider is seen (and vice versa), then two different EB loops should be used, one where E07 = $500 & EB12 = N and a second EB loop where EB07=$500 and EB12 = Y.
c. ***If the deductible amounts are the same and they DON'T accumulate separately***, i.e. the patient's payment to one also applies to the other, then they should NOT be reported separately. For example, there is a $500 deductible for in-network and a $500 deductible for - out of network and a $100 deductible payment to one applies equally to the other, then only one EB loop should be used, where E07 = $500 & EB12 = W.

2. Use of Messages

Use of Messages within the transaction should ONLY be used to convey information that is a) critical for the provider to know and b) cannot be conveyed using standard codes in EB01. For example, rather than include a MSG segment tell the provider to call Customer Service, an EB segment can be sent with EB01=U.

Disclaimers are examples of when messages should not be used. Informing a provider when limits are combined is an example of when messages should be used.

The meaning of information contained in the MSG segment should be understandable to the reader. If codes or abbreviations are used which are not industry standard, the meaning/full description of the codes/abbreviations must be available on the health plan's website. The link to that information must be included in the MSG segment.

3. Dual Coverage

Dual Coverage – the situation where a member has more than one benefit packages from the same payer, e.g. a member is the subscriber of one benefit package from the payer and is a dependent on another benefit package from the same payer – husband and wife, OR a member is a dependent on two benefit packages – child of two parents which are subscribers

on a benefit package OR a member is a subscriber who works for two employers both who provider coverage through the same payer.

This definition applies to a 271 when the patient identified in the 270 request has two coverage packages from the same payer who is the Information Source,

The format and data of a dual coverage 271 will be as follows, depending on the member identification number of the subscriber/patient.

a. In the dual coverage case where the member identification number is tied to more than 1 coverage, then the 271 response should contain a unique 2000 loop for each coverage with an associated 2100 C/D loop that reports the benefit detail for that coverage.

b. In the dual coverage case where each coverage has a different member identification number, then the 271 response will not return details of both coverage and benefits. The 2100/2110 C/D loops are used to report the name and benefit detail for the primary coverage and the 2120C/D loop is used to identify the secondary coverage.

Note: Non-Disclosure situations will be considered by the health plan when processing Dual Coverage.

In the situation when the health plan's patient identification number is not included on the provider's 270, ***if*** both of the below conditions apply:

a. Using only the identifying information contained on the 270, the health plan can uniquely identify the patient as a member that has both primary and secondary coverage with that health plan, AND

b. Using the same 270 identifying information on the payor's web portal, the patient is uniquely identified as the same member that was identified on the 271 and that member has both primary and secondary coverage with that health plan

then this situation should be processed as dual coverage (see above).

Otherwise, the situation should be processed as a multiple match (see below).

Per the 5010 TR3, section 1.3.8 - ***Multiple Matches***

In the event that multiple matches are found in the information source's database (this should be due only to utilizing a search option other than the required search option), it is ***recommended*** that the information source should not return all the matches found. In this case, the information source should return a 271 identifying duplicates found in a AAA segment and if possible in another AAA segment, identifying the missing data elements necessary to provide an exact match.

Workgroup Note: The intent of multiple matches is for the situation when ***different*** patients with the same identifying information are found in the health plan's database. When the above a & b conditions apply, it is the ***same*** patient with multiple coverages

that is found in the health plan's database, and the multiple match recommendation (which is not a requirement) does not apply.

4. Using AAA Segments in the 271 Response Transactions when patient search information is invalid

When a 270 Inquiry transaction contains invalid patient search information, AAA segments are used in the 271 Response transaction to inform the sender about what went wrong. To increase the likelihood that these AAA segments will be used in the same way by all health plans, the following business scenarios were created. The scenarios are intended to address the most common situations when an invalid search is likely to occur. Additional scenarios will be developed as required.

The scenarios depict what should happen depending upon which of the following data elements are provided:

- Subscriber ID
- Last Name
- First Name
- Patient Date of Birth (DOB)

Two scenarios are presented below, each with a number of possible options.

- Scenario A discusses the use of AAA segments when the invalid patient search information is contained in the Subscriber Loop 2100C (when the Patient is the Subscriber).
- Scenario B discusses the use of AAA segments when the invalid patient search information is contained in the Dependent Loop 2100C (when the Patient is a Dependent)

Scenario A - Patient is Subscriber, Loop 2100C

Scenario Options are indicated /displayed in order as referenced in 270/271 TR3, References: 5010 TR3 Section 1.4.8. Scenario A-1 is the required primary search options. Scenarios A2-A3 is the required alternate search options. Support for Options A1-A3 is a best practice for all health plans.

Support for Options 4-6 is optional. However, when the option is supported, the best practice is outlined below.

Scenario A Options	Subscriber ID	Last Name	First Name	Patient DOB	TR3 References for Required Search Options for Maximum Data Elements to be used
1	X	X	X	X	Required **Primary** Search Options
2	X	X		X	Required **Alternate** Search Options
3	X	X	X		Required **Alternate** Search Options
4	X		X	X	Support is Optional
5	X			X	Support is Optional
6		X	X	X	Support is Optional

Scenario A - Patient is Subscriber, Loop 2100C

➢ **Required Primary Search Option**:

If the patient is the subscriber, the maximum data elements that can be required by an information source to identify a patient in **Loop 2100C** are:

- Subscriber ID
- Last Name
- First Name
- Patient Date of Birth (DOB)

If all four of these elements are present, the information source must generate a response provided the patient is in their database. All information sources are required to support the above search option.

When the patient is the subscriber, it is recommended that an Information Source use all four of these elements in locating the patient in their database; however Information Receivers should be aware that the Information Source might not have used all four of these elements.

Scenario	Subscriber ID	Last Name	First Name	Patient DOB
A-1	X	X	X	X

271 Response – AAA			
Possible Match Results	**Resulting AAA03 Response**	**Description of AAA03 Response**	**AAA04 Response**
Unique	None	None	None
Multiple	76	Duplicate subscriber/Insured ID Number	C
None-Not Found	75	Subscriber/Insured Not Found	C
No Name	73	Invalid/Missing Subscriber/Insured Name	C
No DOB	71	Patient Birth Date Does Not Match That for the Patient on the Database	C

AAA04 - Description, C =Please Correct and Resubmit

➢ **Required Alternate Search Options:**

All four pieces of information from the Primary Search Option may not be available (such as in an emergency situation) or there are differences between the identifying information for the individual that the provider has and what the information source has (such as misspelled name). To accommodate these types of situations a set of standardized alternate search options have been defined in addition to the Primary Search Option.

If the patient is the subscriber, the maximum data elements that can be required by an information source for a Required Alternate Search Option to identify a patient in loop 2100C are:

- Subscriber ID
- Last Name
- Either First Name or Patient DOB

Scenario	Subscriber ID	Last Name	First Name	Patient DOB

Scenario A - Patient is Subscriber, Loop 2100C

A-2	X	X		X

271 Response - AAA			
Possible Match Results	**Resulting AAA03 Response**	**Description of AAA03 Response**	**AAA04 Response**
Unique	None	None	None
*Multiple	73	Invalid/Missing Subscriber/Insured Name	C
None-Not Found	72	Invalid/Missing Subscriber/Insured ID	C
No Last Name	73	Invalid/Missing Subscriber/Insured Name	C
No DOB	58	Invalid/Missing Date of Birth	C

AAA04 - Description, C =Please Correct and Resubmit
*Use 73 when there are no match errors on ID#, Last Name or Date of Birth
Note: Code 58 may not be returned if the information source has located an individual and the Birth Date does not match; use code 71 instead.

Scenario	Subscriber ID	Last Name	First Name	Patient DOB
A-3	X	X	X	

271 Response – AAA			
Possible Match Results	**Resulting AAA03 Response**	**Description of AAA03 Response**	**AAA04 Response**
Unique	None	None	None
*Multiple	58	Invalid/Missing Date of Birth	C
None-Not Found	72	Invalid/Missing Subscriber/Insured ID	C
No Name	73	Invalid/Missing Subscriber/Insured Name	C

*Use 58 when there are no match errors on ID# or Name

- **Optional Alternate Search Options:**

If the patient is the subscriber, the maximum data elements that can be required by an information source for an Optional Alternate Search Option to identify a patient in loop 2100C are:

- Patient DOB
- Any 2 of 3 of (Subscriber ID, Last Name, First Name)

Scenario	Subscriber ID	Last Name	First Name	Patient DOB
A-4	X		X	X

271 Response – AAA			
Possible Match Results	**Resulting AAA03 Response**	**Description of AAA03 Response**	**AAA04 Response**
Unique	None	None	None
Multiple	73	Invalid/Missing Subscriber/Insured Name	C
None-Not Found	72	Invalid/Missing Subscriber/Insured ID	C
No Name	73	Invalid/Missing Subscriber/Insured Name	C

Scenario A - Patient is Subscriber, Loop 2100C

271 Response – AAA			
No DOB	58	Invalid/Missing Date of Birth	C

*Use 73 when there are no match errors on ID#, First Name or Date of Birth
Note: Code 58 may not be returned if the information source has located an individual and the Birth Date does not match; use code 71 instead.

Scenario	Subscriber ID	Last Name	First Name	Patient DOB
A-5	X			X

271 Response - AAA			
Possible Match Results	**Resulting AAA03 Response**	**Description of AAA03 Response**	**AAA04 Response**
Unique	None	None	None
Multiple	73	Invalid/Missing Subscriber/Insured Name	C
None-Not Found	72	Invalid/Missing Subscriber/Insured ID	C
No DOB	58	Invalid/Missing Date of Birth	C

Note: Code 58 may not be returned if the information source has located an individual and the Birth Date does not match; use code 71 instead.

Scenario	Subscriber ID	Last Name	First Name	Patient DOB
A-6		X	X	X

271 Response - AAA			
Possible Match Results	**Resulting AAA03 Response**	**Description of AAA03 Response**	**AAA04 Response**
Unique	None	None	None
*Multiple	72	Invalid/Missing Subscriber/Insured ID	C
None-Not Found	73	Invalid Missing Subscriber/Insured Name	C
No DOB	71	Patient DOB does not match that for the patient on the database	C

*Use 72 when there are no match errors on Name or Date of Birth

Scenario B - Patient is Dependent, Loop 2100D

Scenario B - Patient is Dependent, Loop 2100D

Scenario Options are indicated /displayed in order as referenced in 270/271 TR3, References: 5010 TR3 Section 1.4.8. Scenario A-1 is the required primary search options. Scenarios A2 and A3 are the required alternate search options. Support for Options A1-A3 is a best practice for all health plans.

Support for Options 4-6 is optional. However, when the option is supported, the best practice is outlined below.

Scenario B Options	2100C Subscriber ID	2100D Last Name	2100D First Name	2100D Patient DOB	TR3 Reference for Required Search Options for Maximum Data Elements to be used
1	X	X	X	X	Required **Primary** Search Options
2	X	X		X	Required **Alternate** Search Options
3	X	X	X		Required **Alternate** Search Options
4	X		X	X	Support is Optional
5	X			X	Support is Optional
6		X	X	X	Support is Optional

- **Required Primary Search Option** - If the **patient is a dependent** of a subscriber, the maximum data elements that can be required by an information source to identify a patient in loop **2100C and 2100D** are:

  Loop 2100C
  - Subscriber's Member ID Number

  Loop 2100D
  - Patient's Last Name
  - Patient's First Name
  - Date of Birth

  If all four of these elements are present the information source must generate a response provided the patient is in their database. All information sources are required to support the above search option if their system does not have unique Member Identifiers assigned to dependents.

  When the **patient is the dependent**, it is recommended that an Information Source use all four of these elements in locating the patient in their database; however Information Receivers should be aware that the Information Source might not have used all four of these elements.

Scenario	Loop 2100C Subscriber ID	Loop 2100D Last Name	Loop 2100D First Name	Loop 2100D Patient DOB
B-1	X	X	X	X

271 Response – AAA			
Possible Match Results	**Resulting AAA03 Response**	**Description of AAA03 Response**	**AAA04 Response**
Unique	None	None	None
Multiple	68	Duplicate Patient ID	C

Scenario B - Patient is Dependent, Loop 2100D

271 Response – AAA			
None-Not Found	64	Invalid Missing Patient ID	C
No Name	65	Invalid Missing Patient Name	C
No DOB	*58	Invalid/Missing Date-of-Birth	C

AAA04 - Description, C =Please Correct and Resubmit
*Code 71 must be returned when the transaction was rejected when the information source located an individual based on other information submitted, but the Birth Date does not match.

➢ Required Alternate Search Options - Patient is Dependent

If the patient is a dependent of a subscriber, the maximum data elements that can be required by an information source for a Required Alternate Search Option to identify a patient in Loop 2100C and 2100D are:

Loop 2100C
- Subscriber's Member ID Number

Loop 2100D
- Patient's Last Name
- Either Patient's First Name or Date of Birth

If all of the elements for one of the Required Alternate Search Options are present, the Information Source is required to search for the patient in their system and if a unique match for an individual can be made, the Information Source is required to return the appropriate eligibility response

Scenario	Loop 2100C Subscriber ID	Loop 2100D Last Name	Loop 2100D First Name	Loop 2100D Patient DOB
B-2	X	X		X

271 Response – AAA			
Possible Match Results	**Resulting AAA03 Response**	**Description of AAA03 Response**	**AAA04 Response**
Unique	None	None	None
*Multiple	65	Invalid/Missing Patient Name Required	C
None-Not Found	64	Invalid Missing Patient ID	C
No Name	65	Invalid Missing Patient Name	C
No DOB	58	Invalid/Missing Date of Birth	C

AAA04 Description, C =Please Correct and Resubmit
*Use 65 when there are no match errors on ID#, Last Name or DOB
Note: When No Date of Birth match, Code 71 must be returned when the transaction was rejected when the information source located an individual based on other information submitted, but the Birth Date does not match.

Scenario	Loop 2100C Subscriber ID	Loop 2100D Last Name	Loop 2100D First Name	Loop 2100D Patient DOB
B-3	X	X	X	

271 Response - AAA			
Possible Match	**Resulting**	**Description of AAA03 Response**	**AAA04**

Scenario B - Patient is Dependent, Loop 2100D

Results	AAA03 Response		Response
Unique	None	None	None
*Multiple	58	Invalid/Missing Date of Birth	C
None-Not Found	64	Invalid Missing Patient ID	C
No Name	65	Invalid Missing Patient Name	C

*Use 58 when there are no match errors on ID# or Name

➢ Optional Alternate Search Options - Patient is Dependent

If the patient is the dependent, the maximum data elements that can be required by an information source for an Optional Alternate Search Option to identify a patient in Loop 2100C and 2100D are:

- Patient Date of Birth-Loop 2100D
- 2 of 3 of (Subscriber's Member ID Number-Loop 2100C, Patient's First Name-Loop 2100D, Patient's Last Name-Loop 2100D

Scenario	Loop 2100C Subscriber ID	Loop 2100D Last Name	Loop 2100D First Name	Loop 2100D Patient DOB
B-4	X		X	X

271 Response - AAA			
Possible Match Results	**Resulting AAA03 Response**	**Description of AAA03 Response**	**AAA04 Response**
Unique	None	None	None
*Multiple	65	Invalid Missing Patient Name	C
None-Not Found	64	Invalid Missing Patient ID	C
No Name	65	Invalid Missing Patient Name	C
No DOB	*58	Invalid/Missing Date of Birth	C

*Code 71 must be returned when the transaction was rejected when the information source located an individual based on other information submitted, but the Birth Date does not match.

Scenario	Loop 2100C Subscriber ID	Loop 2100D Last Name	Loop 2100D First Name	Loop 2100D Patient DOB
B-5	X			X

271 Response - AAA			
Possible Match Results	**Resulting AAA03 Response**	**Description of AAA03 Response**	**AAA04 Response**
Unique	None	None	None
*Multiple	65	Invalid/Missing Patient Name	C
None-Not Found	64	Invalid Missing Patient ID	C
Name	65	Invalid/Missing Patient Name	C
DOB	*71	Patient Date of Birth Does Not Match That for the Patient on the Database	C

*Code 71 must be used when the Patient Date of Birth Does Not Match That for the Patient on the Database

Scenario B - Patient is Dependent, Loop 2100D

Note: Code 58 may not be returned if the information source has located an individual and the Birth Date does not match; use code 71 instead.

Scenario	Loop 2100C Subscriber ID	Loop 2100D Last Name	Loop 2100D First Name	Loop 2100D Patient DOB
B-6		X	X	X

271 Response – AAA			
Possible Match Results	**Resulting AAA03 Response**	**Description of AAA03 Response**	**AAA04 Response**
Unique	None	None	None
*Multiple	*64	Invalid/Missing Patient ID	C
None-Not Found	65	Invalid Missing Patient Name	C
No Name	73	Invalid/Missing Subscriber/Insured Name	C
No DOB	71	Patient Date of Birth Does Not Match That for the Patient on the Database	C

*Use code 64 when there are no errors on Name or Date of Birth

Note: Code 58 may not be returned if the information source has located an individual and the Birth Date does not match; use code 71 instead.

5. Service Types and associated information about Benefit Limitations

The table below identifies specific service types for which benefit information will be electronically provided by the health plan on their website and in their 270-271 transaction set. Over time, additional service types are likely to be added to this list.

This table also identifies those service types for which benefit limitation information is *typically* associated. *Typically* means that a number of health plans, though not all, have benefit limitations pertaining to those service types (as designated by a 'Y' in the table).

If a health plan's member has a benefit for one of the listed service types, deductible, copay and coinsurance information will be provided, as discussed in Section IV above. Benefit limitation information, if appropriate for that health plan, will also be provided. Note, health plans may not always provide benefit limitation information. They will only provide the information that is relevant to their member's specific policy. For example, one patient's policy may have a maximum number of visits for acupuncture and another patient's policy would not. As another example, a patient's policy may have Date Limitations pertaining to the benefit period and those limitations are different than the patient's general eligibility period. In this case, the Date Limitations specific to the benefit will be included in the 271 transaction. If the benefit's Date Limitations are the same as the patient's general eligibility period, then Date Limitations specific to the benefit will not be included.

			Possible Set of Benefit Limitations Information				
HIPAA Service Type Description	**Operational Description of Benefit**	**HIPAA Service Type Code**	**Need for Pre-Auth**	**Date Limita-tions pertain-ing to Benefit Period**	**Benefit Max-imums**	**Benefit Accum-ulators**	**Other**
Acupuncture	Services provided by a licensed acupuncturist.	64		Y	Y	Y	
Allergy Testing	Testing to determine the substance to which a person is allergic.	79					
Ambulatory Service Center Facility	Facility fee for services provided in a free standing ambulatory surgery center.	13					
Anesthesia	Local or general insensibility to pain with or without the	7	Y for				

				Possible Set of Benefit Limitations Information				
HIPAA Service Type Description	**Operational Description of Benefit**	**HIPAA Service Type Code**		**Need for Pre-Auth**	**Date Limita-tions pertain-ing to Benefit Period**	**Benefit Max-imums**	**Benefit Accum-ulators**	**Other**
	loss of consciousness induced by an anesthetic.			Dental				
Audiology Exam	Hearing exams by a licensed provider to determine the need for corrective treatment.	71			Y	Y	Y	
(Baby) Newborn Care	Medical facility and related professional charges for an infant during the initial period of confinement following birth.	65			Y	Y	Y	May be required to notify health plan w/in 24 hrs. of baby's birth
(Baby) Well Baby Care	Preventive office visits and immunizations during the first year of life.	68			Y	Y	Y	
Cardiac Rehabilitation	Rehabilitation therapy following an acute cardiac event.	BG				Y	Y	
Chemotherapy	The treatment of disease by chemical or biological antineoplastic agents.	78				Y	Y	May be required to notify health plan of drug type/dose
Chiropractic	Services provided by a licensed chiropractor.	33			Y	Y	Y	
Dental Care	The prevention and treatment of diseases of the teeth, gums, and related structures of the mouth.	35		Y	Y	Y	Y	
(Diagnostic) Diagnostic X-	Radiology to diagnose specific symptoms or rule out medical conditions.	4				Y	Y	

				Possible Set of Benefit Limitations Information				
HIPAA Service Type Description	**Operational Description of Benefit**	**HIPAA Service Type Code**		**Need for Pre-Auth**	**Date Limita-tions pertain-ing to Benefit Period**	**Benefit Max-imums**	**Benefit Accum-ulators**	**Other**
Ray								
(Diagnostic) Diagnostic Lab	Laboratory and pathology tests to diagnose specific symptoms or rule out medical conditions.	5				Y	Y	
(Diagnostic) MRI/Cat Scan	Testing used to diagnose or evaluate a condition. • A noninvasive procedure that causes magnets and radio waves to construct pictures of the body. • Computerized tomography of body imaging in which a thin x-ray beam rotates around the patient.	62		Y		Y	Y	
(Diagnostic) Diagnostic Medical	Tests/services used to diagnose specific symptoms or rule out medical conditions.	73				Y	Y	
Dialysis	Outpatient dialysis services furnished by a Hospital, Community Health Center, free-standing dialysis facility or physician. This coverage may also include dialysis services rendered on an inpatient basis or in the patient's home.	76						
DME - Purchase	The purchase of new medical equipment which can withstand repeated use, is not disposable, and is used to service a medically necessary therapeutic purpose.	12		Y	Y	Y	Y	
DME - Used	The purchase of previously used medical equipment which can withstand repeated use, is not disposable, and is used to service a medically necessary therapeutic purpose.	11		Y	Y	Y	Y	

			Possible Set of Benefit Limitations Information				
HIPAA Service Type Description	**Operational Description of Benefit**	**HIPAA Service Type Code**	**Need for Pre-Auth**	**Date Limita-tions pertain-ing to Benefit Period**	**Benefit Max-imums**	**Benefit Accum-ulators**	**Other**
DME – Rental	The rental of medical equipment which can withstand repeated use, is not disposable, and is used to service a medically necessary therapeutic purpose.	18	Y	Y	Y	Y	
Family Planning	Consultations, exams, procedures and medical services related to the use of contraceptive methods that have been approved by the US Food and Drug Administration.	82					
Home Health Care	Home care for homebound patients who require skilled care services. May include nursing services, physical therapy, occupational therapy, speech therapy, home health aide, and medical social worker.	42	Y		Y	Y	
Hospice	Care when a provider has determined that life expectancy is 6 months or less and a palliative, supportive care treatment approach has been chosen.	45	Y		Y		
Hospital - Ambulatory Surgical	Hospital billed surgery performed on a person who is admitted to and discharged from a hospital on the same day.	53					
Hospital - Emergency Accident	Hospital services for the treatment of a sudden and unexpected medical injury caused by an external force or element that requires immediate medical attention.	51					
Hospital - Inpatient	Care and services provided in a hospital setting after admission	48	Y		Y	Y	
Hospital - Outpatient	Care and services provided in a hospital setting without admission	50	Y				
Hospital – Emergency	Care and services provided in a hospital emergency department	52					

			Possible Set of Benefit Limitations Information				
HIPAA Service Type Description	**Operational Description of Benefit**	**HIPAA Service Type Code**	**Need for Pre-Auth**	**Date Limita-tions pertain-ing to Benefit Period**	**Benefit Max-imums**	**Benefit Accum-ulators**	**Other**
Medical							
Immunizations	Vaccination to prevent disease.	80			Y	Y	
Massage Therapy	Services provided by a licensed massage therapist.	BE		Y	Y	Y	
Maternity	Prenatal and postnatal visits as well as the facility fee for the delivery.	69			Y	Y	
Medical Care	Medical services and supplies to diagnose and/or treat medical condition, illness or injury. Medical services and supplies provided by physicians and other healthcare professionals	1					
Mental Health	Services provided by a physician and/or other healthcare providers who are trained and educated to perform services related to mental health and may be licensed to practice within the scope of licensure or training.	MH			1	1	
Occupational Therapy	Constructive activities designed and adapted to promote the functional restoration of the person's daily living abilities that are lost or impaired by disease or accidental injury.	AD	Y	Y	Y	Y	
Oral Surgery	Surgery to the jaw, sound natural teeth, mouth, or face.	40	Y		Y	Y	
Orthodontics	Treatment to correct and align irregularities of the teeth.	38	Y	Y	Y	Y	
Pediatric	Routine medical exams and related routine services, including immunizations, rendered to an infant, child or adolescent. Restrictions may apply due to age schedule and/or visit limits	BH					
Periodontics	Treatment of periodontal disease.	24			Y	Y	
Pharmacy	Coverage for prescription drugs and related supplies.	88					

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HIPAA Service Type Description	**Operational Description of Benefit**	**HIPAA Service Type Code**	**Need for Pre-Auth**	**Date Limita-tions pertain-ing to Benefit Period**	**Benefit Max-imums**	**Benefit Accum-ulators**	**Other**
Physical Medicine	Services provided by a licensed Physical Therapist.	AE	Y	Y	Y	Y	
Podiatry	Diagnosis, treatment, and prevention of diseases of the human foot.	93			Y	Y	
Professional (Physician) Visit - Inpatient	Medical services provided by physicians and/or other healthcare professionals to a patient admitted into the hospital staying overnight as inpatient (not for observation)	99					
Professional (Physician) Visit - Outpatient	Medical services provided by physicians and/or other healthcare professionals to a patient in the outpatient department of a hospital or other covered facility. (may be for observation)	A0					
Professional (Physician) Visit – Home	Medical services provided by physicians and/or other healthcare professionals to a patient at their home	A3					
Professional (Physician) Visit Office - *Sick*	An outpatient visit with a licensed care provider for treatment of an illness or condition when the patient is sick	BY					
Professional (Physician) Visit Office - *Well*	An outpatient visit with a licensed care provider for preventative care	BZ					
Professional (Physician) Visit-Office	An outpatient visit with a licensed care provider for treatment of an illness or condition	98					
TeleHealth		98					

HIPAA Service Type Description	Operational Description of Benefit	HIPAA Service Type Code	Possible Set of Benefit Limitations Information				
			Need for Pre-Auth	Date Limita-tions pertain-ing to Benefit Period	Benefit Max-imums	Benefit Accum-ulators	Other
		Place of Service = 02 in segment III					
	Optional Message (for health plans' 3rd party vendor): MSG: TELEHEATH						
Prosthetic Device	Artificial substitutes which replace parts of the human body.	75	Y		Y	Y	
Psychiatric - Inpatient	Inpatient facility treatment for psychiatric/mental conditions.	A7	Y	Y	Y	Y	
Psychiatric - Outpatient	Outpatient treatment for psychiatric/mental conditions.	A8	Y	Y	Y	Y	
Psychotherapy	Inpatient or outpatient professional services, including individual or group therapy by providers such as psychiatrists, psychologists, clinical social workers, or psychiatric nurses.	A6			1	1	
Radiation Therapy	Advanced imaging services, sometimes called radiotherapy, x-ray therapy radiation treatment, cobalt therapy, electron beam therapy, or irradiation uses high energy, penetrating waves or particles such as x rays, gamma rays, proton rays, or neutron rays, provided by or ordered and billed by a physician or other healthcare provider to destroy malignant cells and or tumors or keep them from reproducing	6			1	1	
Rehabilitation -	Inpatient rehabilitative treatment for patients recovering	AB	Y	Y	Y	Y	

				Possible Set of Benefit Limitations Information				
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Inpatient	from injuries or illnesses that severely impair their physical functioning or understanding.							
Rehabilitation - Outpatient	Outpatient therapy services to restore and significantly improve function that was previously present but lost due to acute injury or illness.	AC		Y	Y	Y	Y	
Respite Care	Temporary residential care for patients that provides relief for the permanent caregivers.	46		Y	Y	Y	Y	
Routine Physical	Exam to screen for diseases, assess risk of future medical problems, and update vaccinations.	81			Y	Y	Y	
Second Surgical Opinion	An additional professional opinion sought to verify or confirm the necessity of a surgical procedure.	20						
Skilled Nursing Care	Services provided in a licensed skilled nursing facility.	AG		Y	Y	Y	Y	
Smoking Cessation	Treatment to aid in quitting smoking.	67			Y	Y	Y	
Speech Therapy	Treatment of speech defects and disorders.	AF		Y	Y	Y	Y	
Substance Abuse	Treatment for the dependence of an addictive substance, including alcohol or a narcotic drug.	AI		Y	Y	Y	Y	
Surgical	Invasive procedure for diagnosis and treatment of injury, deformity, and disease.	2		Y				
Surgical Assistance	Assistant Surgeon/surgical assistance provided by a physician if required because of the complexity of the surgical procedures.	8						
TeleHealth	see above: Professional (Physician) Visit-Office (98)							
Transplants	The grafting of a tissue/organ.	70		Y	Y	Y	Y	
(Transportation)	Transportation by a licensed cabulance service.	58				Y	Y	

			Possible Set of Benefit Limitations Information				
HIPAA Service Type Description	**Operational Description of Benefit**	**HIPAA Service Type Code**	**Need for Pre-Auth**	**Date Limita-tions pertain-ing to Benefit Period**	**Benefit Max-imums**	**Benefit Accum-ulators**	**Other**
*C*abulance							
(Transportation) Licensed Ambulance	Transportation by a licensed ambulance service.	59			Y	Y	
(Transportation) Medically Related Transportation	Other medically related transportation.	56			Y	Y	
(Transportation) Air Transportation	Transportation via helicopter or plane in order to transport a sick or injured patient to the nearest appropriate hospital/facility.	57			Y	Y	
Urgent Care	Non-emergent episodic care that cannot be delayed until an appointment at a physician office is available. Care is provided by a physician and/or other healthcare providers on an outpatient basis in a fixed location or designated mobile unit that is not designated as an emergency department.	UC					
Vision (Optometry)	Eye examination, determination of visual abilities, diagnosis of eye diseases and conditions, and the prescription of lenses and other corrective measures.	AL		Y	Y	Y	

Legend:

- **HIPAA Service Type Description:** Description used in the HIPAA TR3. Organizational Categories (which are not included in the TR3) are denoted in *(italics)***.**
- **Operational Description of Benefit:** Best Practice Recommended description of the benefit to be used in common practice by health plans and providers.

- **HIPAA Service Type Code:** From the EQ01 field in the 270 or the EB03 field in the 271
- **Need for Pre-Authorization:** If 'Y' then services may need to be pre-authorized
- **Date Limitations pertaining to the Benefit Period:** If 'Y' then limitations pertaining to the benefit period may be different than the general eligibility period. For example, for a specific service, a member's policy may only allow a maximum of 4 visits for an episode of care.
- **Benefit Maximums:** If 'Y' then there may be specific benefit maximums for the service type**.** Benefit maximum information may include:
    - Maximum Dollar Amount
    - Maximum Number of Treatments/Visits
    - Maximum Number of Days
- **Benefit Accumulators**: If 'Y' then the benefit remaining may be tracked
- **Other:** Other types of benefit related information needed by providers. (There is currently not a place for this information in the 271 transaction.)