CORE 154: Eligibility and Benefits 270/271 Data Content Rule version 1.1.0

BACKGROUND

This CORE rule specifies the CORE minimum requirements for using the HIPAA-adopted ASC X12 005010X279A1 Eligibility Benefit Request and Response (270/271) (hereafter v5010 270) Eligibility Inquiry to inquire about health plan insurance coverage and to respond to such an inquiry using the HIPAA-adopted ASC X12 005010X279A1 Eligibility Benefit Request and Response (270/271) (hereafter v5010 271) Eligibility Response implementation guide. This CORE rule covers the following content in the v5010 270 inquiry and v5010 271 response:

1. *The required response to a inquiry when the individual is located in the health plan's system under the following conditions:*
   a) *A generic v5010 270 inquiry*
   b) *A specific inquiry for a Service Type not supported by the health plan*
   c) *A specific inquiry for one of the CORE required service types*
2. *The mandated response components include:*
   ~~a) *the status of eligibility (active, inactive, etc.) for both the health plan and benefits*~~
   b) *the dates of eligibility at the health plan (contract) level for past, ~~current~~ and future dates and the dates of eligibility at the benefit level if different from the contract level*
   c) *the patient financial responsibility for each specified benefit at the base contract amounts for both in-network and out-of-network*
   d) *the name of the health plan when it exists in the health plan's system*

The requirements specified in this CORE rule address certain situational elements and codes and are in addition to requirements contained in the HIPAA-adopted v5010 270/271 implementation guides.

RULE

~~**Section 1: 270 Eligibility Inquiry**[1]~~

~~**Subsection 1.1: HIPAA Requirements**~~

~~As specified in the HIPAA-adopted 270/271 Eligibility Inquiry implementation guide, a health plan (or information source) must support a generic request for eligibility. This is accomplished by the submission of service type Code "30" (Health Benefit Plan Coverage) in the "EQ" loops of the transaction.~~

~~Providers may also send inquiries for specific service type, identified by codes specified in the HIPAA Implementation Guide.~~

~~When a health plan (or information source) receives a generic request for eligibility or if the health plan (or information source) does not support the specific service type as indicated by the code submitted, and the individual is located in the system, the health plan must respond in the 271 as specified below in this CORE rule.~~

~~The HIPAA-adopted 270 Eligibility Inquiry implementation guide allows providers to submit an inquiry for three types of eligibility dates in the loops 2100C, 2110C, 2100D, and 2110D:~~

~~— code "307" Eligibility~~

~~[1] The language of the proposed CORE rule is adapted from the draft version 5010 270/271 guide currently being developed.~~

- code "435" Admission

- code "472" Service

Subsection 1.2: CORE Requirements

This CORE rule will further constrain these dates as specified herein. A date submitted in either the 2100C or 2100D loops is considered to apply globally to all of the service types specified in the EQ segment.

- When the 270 is a generic request for eligibility and a date is submitted in either or both of the 2100C or 2100D loops, all CORE-certified participants are required to submit only code "307" Eligibility.

- The use of code "307" in either loop 2100C or 2100D means the submitter is requesting the health plan (or information source) to respond with the date on which the health plan coverage begins.

A date submitted in either the 2110C or 2110D loop is considered to apply only to the benefit begin service date for the service type specified by each EQ01-1365 service type code. When a date is submitted in either or both of the 2110C or 2110D loops, all CORE-certified participants are required to submit only code "307" Eligibility.

- When code "307" is used in either loop 2110C or 2110D it means the submitter is requesting the health plan (or information source) to respond in the corresponding 2110C or 2110D loops in the 271 with the date on which the benefit eligibility covering the individual begins only if the benefit begin date is different from the plan begin date specified in either the 2100C or 2100D loops.

Section 2: v5010 271 Eligibility Inquiry Response [2,3]

The HIPAA Implementation Guide for the 270/271 Eligibility Inquiry implementation guide states: *"An information source must respond with either an acknowledgment that the individual has active or inactive coverage or that the individual was not found in their system."* The CORE rule for the 271 response imposes these additional requirements in the following sections. If the individual is located in the health plan's (or information source's) system, the following must be returned:

Subsection 2.1: Status

The status of the benefit in EB01-1390 using codes 1 through 8 (active through inactive status) or I (Non-covered) and using Code "30" in EB03-1365 as appropriate for the health plan covering the individual in either the 2110C or 2110D loop.

Subsection 2.2: Health Plan Name

When the individual is located in the health plan's (or information source's) system the health plan name must be returned (if one exists within the health plan's or information source's system) in EB05-1204 Plan Coverage Description. Neither the health plan or information source is required to obtain such a health plan name from outside its own organization.

[2] The language of the CORE rule is adapted from the draft version 5010 270/271 guide currently being developed.

[3] This CORE rule is not intended to be a comprehensive companion document specifying the complete content of either the v5010 270 Eligibility Inquiry or v5010 271 Eligibility Response transaction sets. The focus on this CORE rule is on specifications for the v5010 271 Eligibility Response to address the CORE Phase I data requirements for benefit coverage.

Subsection 2.3: Patient Financial Responsibility

The patient financial responsibility for co-insurance, co-payment and deductibles must be returned as specified below by a CORE-certified health plan (or information source) for each of the service type codes returned:[4]

Subsection 2.3.1: To specify the co-insurance responsibility

Use code "A" Co-Insurance in EB01-1390 Eligibility or Benefit Information data element and use EB08-954 Percent data element for each reported type of service. ~~The percent amount expressed is the portion that is the patient's responsibility. Negative numbers are prohibited. *Please refer to Subsection 2.5: Support Required for Generic Request for further detail.*~~

~~1. When the patient's portion of responsibility for a benefit is nothing, place zero (0) in data element EB08-954 and return this segment.~~

2. ~~When co-insurance does not apply to a benefit, do not return this segment.~~ If the patient financial responsibility amounts differ for in and out of network, two occurrences of the EB segment must be returned using EB12-1073 with codes N and Y as appropriate.

~~3.~~ The health plan (or information source) may, at its discretion, elect not to return co-insurance information for the following services specified in EB03-1365: 1 – Medical Care; 30 – Health Plan Benefit Coverage; 35 – Dental Care; 88 – Pharmacy; AL – Vision (Optometry); MH – Mental Health. This optional reporting does not preempt the health plan's (or information source's) requirement to report patient ~~co-payment~~ co-insurance responsibility for the remaining ~~5~~ 7 CORE required service types (33 – Chiropractic, 47 – Hospital; 48 – Hospital Inpatient, 50 – Hospital Outpatient, 86 – Emergency Services, 98 – Professional (Physician) Visit – Office, UC – Urgent Care), that must be reported in a generic request for eligibility (Service Type Code 30) or a service type not supported by the health plan. ~~This requirement is outlined in subsection 2.5 below.~~

Subsection 2.3.2: To specify the co-payment responsibility

Use code "B" Co-Payment in EB01-1390 Eligibility or Benefit Information data element and use EB07-782 Monetary Amount element for each reported type of service. ~~The dollar amount expressed is the portion that is the patient's responsibility. Negative numbers are prohibited. *Please refer to Subsection 2.5: Support Required for Generic Request for further detail.*~~

~~1. When the patient's portion of responsibility for a benefit is zero dollars, place zero (0) in data element EB07-782 and return this segment.~~

~~2. When a co-payment does not apply to a benefit, do not return this segment. If the patient financial responsibility amounts differ for in and out of network, two occurrences of the EB segment must be returned using EB12-1073 with codes N and Y as appropriate.~~

~~3.~~ The health plan (or information source) may, at its discretion, elect not to return co-payment information for the following services specified in EB03-1365: 1 – Medical Care; 30 – Health Plan Benefit Coverage; 35 – Dental Care; 88 – Pharmacy; AL –

[4] This CORE rule is not intended to be a comprehensive companion document specifying the complete content of either the v5010 270 Eligibility Inquiry or v5010 271 Eligibility Response transaction sets. The focus on this CORE rule is on specifications for the v5010 271 Eligibility Response to address the CORE Phase I data requirements for patient financial responsibility.

Vision (Optometry); MH – Mental Health. This optional reporting does not preempt the health plan's (or information source's) requirement to report patient co-payment responsibility for the remaining ~~5~~ 7 CORE required service types (33 – Chiropractic, 47 – Hospital, 48 – Hospital Inpatient, 50 – Hospital Outpatient, 86 – Emergency Services, 98 – Professional (Physician) Visit – Office, UC – Urgent Care), that must be reported in a generic request for eligibility (Service Type Code 30) or a service type not supported by the health plan. ~~This requirement is outlined in subsection 2.5 below.~~

Subsection 2.3.3: To specify the deductible responsibility

Use code "C" Deductible in EB01-1390 Eligibility or Benefit Information data element and use EB07-782 Monetary Amount to indicate the dollar amount of the deductible for the type of service specified in EB03-1365 service type code. ~~The dollar amount expressed is the portion that is the patient's responsibility. Negative numbers are prohibited. *Please refer to Subsection 2.5: Support Required for Generic Request for further detail.*~~

~~1. When the patient's portion of responsibility for a benefit is zero dollars, place zero (0) in data element EB07-782 and return this segment.~~

2. ~~When a deductible does not apply to a benefit, do not return this segment.~~ If the patient financial responsibility amounts differ for in and out of network, two occurrences of the EB segment must be returned using EB12-1073 with codes N and Y as appropriate.

3. If the deductible amount varies by the benefit coverage level specified in EB02-1207 Coverage Level Code, place the appropriate code in EB02 and use additional occurrences of the EB Eligibility or Benefit Information segment as necessary for each benefit coverage level for each type of service, e.g., individual or family coverage.

~~4.~~ The health plan (or information source) may, at its discretion, elect not to return deductible information for the following services specified in EB03-1365: 1 – Medical Care; 30 – Health Plan Benefit Coverage; 35 – Dental Care; 88 – Pharmacy; AL – Vision (Optometry); MH – Mental Health. This optional reporting does not preempt the health plan's (or information source's) requirement to report patient deductible responsibility for the remaining ~~5~~ 7 CORE required service types (33 – Chiropractic, 47 – Hospital, 48 – Hospital Inpatient, 50 – Hospital Outpatient, 86 – Emergency Services, 98 – Professional (Physician) Visit – Office, UC – Urgent Care), that must be reported in a generic request for eligibility (Service Type Code 30) or a service type not supported by the health plan. ~~This requirement is outlined in subsection 2.5 below.~~

Subsection 2.4: Eligibility Dates

~~If the individual has active coverage (codes 1 through 5 in EB01-1390), the code "307" Eligibility date (defined to mean health plan begin in the context of this CORE rule) must be returned in the DTP segment in either the 2100C or 2100D loops. The health plan or information source may alternately return a range of dates if known using code RD8 in DTP02-1250 Date Time Period Format Qualifier data element.~~

~~1. If the benefit begin dates are different from the health plan begin dates specified in the 2100C or 2100D loops, then code "348" Benefit Begin date must be returned in either the 2110C or 2110D loop with the associated EB03 benefit.~~

~~2. The response will be as of the date the transaction is processed as specified in the 271 BHT04 Transaction Set Creation Date, unless a specific date (prior, current or future) was used from the DTP segment in either the 2100C or 2100D loops of the 270 eligibility inquiry.~~

3. The v5010 270 eligibility inquiry 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 response 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.

~~Subsection 2.5: Support Required for Generic Request or Service Code not Supported.~~

~~If the 270 submitted is a generic request for eligibility (service type code "30" in the "EQ" loops of the transaction), or a request for a service type not supported by the health plan (or information source), the following CORE service type code values must be returned in EB03-1365 service type code in either the 2110C or 2110D loops:~~

~~CORE REQUIRED SERVICE TYPES~~	
~~CORE REQUIRED SERVICE TYPES (X12 270/271 Code Definition)~~[5]	**~~CORE DESCRIPTION~~**
~~1 – Medical Care~~	~~Medical care services to diagnose and/or treat medical condition, illness or injury. Medical services and supplies provided by physicians and other health care professionals.~~
~~30 – Health Benefit Plan Coverage~~	~~—~~
~~33 – Chiropractic~~	~~Professional services which may include office visits, manipulations, lab, x-rays, and supplies.~~
~~35 – Dental Care~~	~~Benefits for services, supplies or appliances for care of teeth.~~
~~48 – Hospital Inpatient~~	~~Hospital services and supplies for a patient who has been admitted to a hospital for the purpose of receiving medical care or other health services.~~
~~50 – Hospital Outpatient~~	~~Hospital services and supplies for a patient who has not been admitted to a hospital for the purpose of receiving medical care or other health services.~~
~~86 – Emergency Services~~	~~Medical services and supplies provided by physicians, Hospitals, and other healthcare professionals for the treatment of a sudden and unexpected medical condition or injury which requires immediate medical attention.~~
~~88 – Pharmacy~~	~~Drugs and supplies dispensed by a licensed Pharmacist, which may include mail order or internet dispensary.~~
~~98 – Professional (Physician) Visit - Office~~	~~Professional services of a Physician or other Health Care Professional during an office visit.~~
~~AL – Vision (Optometry)~~	~~Routine vision services furnished by an optometrist. May include coverage for eyeglasses, contact lenses, routine eye exams, and/or vision testing for the prescribing or fitting of eyeglasses or contact lenses.~~

1. ~~If the individual has active coverage and any of the above codes are not a covered benefit, then code "I" Not Covered must be returned in the EB01.~~

~~[5] CORE descriptions (clarification/meaning) are meant to provide a general understanding of the specific services which are included in each service type, but may not be all inclusive.~~

2. ~~If the health plan's (or information source's) plan benefits do not fall into any of the service type codes listed above, except service type code "30", the health plan must return the Active Status information as specified in Subsection 2.1 of this rule and whatever additional appropriate service type code does define the benefit.~~

3. ~~If no specific service type code exists, the health plan may return the appropriate procedure code(s) in EB13 or a description MSG01. EB03 and EB13 cannot both be used in the same EB segment.~~

Subsection 2.6: Support for CORE Required Service Types

The health plan (or information source) must support an explicit request for each of the CORE required service types. The CORE ~~corresponding~~ required service type codes are: "1", "33", "35", "47", "48", "50", "86", "88", "98", "AL", "MH", "UC" submitted in the v5010 270 EQ01 by providing the content identified in subsections 2.1 through 2.4 above for the submitted service type(s).

~~**Subsection 2.7: Support for Other Service Type Codes**~~

~~Additional covered service type codes may be returned at the health plan's (or information source's) discretion; however their absence does not imply that they are not covered.~~

CONFORMANCE

The CORE test suite for this rule includes the following types of tests:

1. *Receipt by a health plan or information source of a valid generic request for eligibility 270 transaction created using the CORE master test bed data.*
2. *The creation of an eligibility response v5010 271 transaction generated using the CORE master test bed data.*
   a) *The CORE master test bed data will contain all of the values necessary to generate a response transaction covering each of the requirements in the following paragraphs of the v5010 271 Eligibility Inquiry Response section of this rule:*
      i) *Subsection 2.2: health plan name*
      ii) ~~*Subsection 2.4: health plan begin date*~~
      iii) ~~*Subsection 2.4.(1): benefit begin date*~~
      iv) ~~*Sections 2.1 and 2.5: benefit coverage (service types) status, covered/non-covered benefits*~~
      v) *Subsection 2.3: patient financial responsibility for co-insurance, co-payment, and deductible, including in-network and out-of-network*

The CORE test suite will not include comprehensive testing requirements to test for all possible permutations of health plan benefit status or patient financial responsibility for all of the CORE required benefits addressed in the 271 response.

Conformance with this rule must be demonstrated through successful completion of the approved CORE test suite for this rule with a CORE-authorized testing vendor.