270/271 Health Care Eligibility Benefit Inquiry and Response

For AmeriHealth Administrators

Disclaimer

This AmeriHealth Administrators and Inter-County Health Plan (hereinafter referred to as AHA/ICHP) Companion Guide to EDI Transactions (the "Companion Guide") provides trading partners with guidelines for submitting electronic batch transactions. Because the HIPAA ASC X12N Implementation Guides require transmitters and receivers to make certain determinations/elections (e.g., whether, or to what extent, situational data elements apply), this Companion Guide documents those determinations, elections, assumptions, or data issues that are permitted to be specific to AHA/ICHP's business processes when implementing the HIPAA ASC X12N 4010A1 Implementation Guides.

This Companion Guide does NOT replace or cover all segments specified in the HIPAA ASC X12N Implementation Guides. It does not attempt to amend any of the requirements of the Implementation Guides, or impose any additional obligations on trading partners of AHA/ICHP that are not permitted to be imposed by the HIPAA Standards for Electronic Transactions. This Companion Guide provides information on AHA/ICHP specific codes relevant to AHA/ICHP's business processes and rules and situations that are within the parameters of HIPAA. Readers of this Companion Guide should be acquainted with the HIPAA Implementation Guides, their structure, and content.

This Companion Guide provides supplemental information to the Trading Partner Agreement that exists between AHA/ICHP and its trading partners. Trading partners should refer to their Trading Partner Agreement for guidelines pertaining to AHA/ICHP's legal conditions surrounding the implementation of the EDI transactions and code sets. However, trading partners should refer to this Companion Guide for information on AHA/ICHP's business rules or technical requirements regarding the implementation of HIPAA-complaint EDI transactions and code sets.

Nothing contained in this Companion Guide is intended to amend, revoke, contradict, or otherwise alter the terms and conditions of the Trading Partner Agreement. If there is an inconsistency between the terms of this Companion Guide and the terms of the Trading Partner Agreement, the terms of the Trading Partner Agreement will govern. If there is an inconsistency between the terms of this Companion Guide and any terms of one of the Implementation Guides, the relevant Implementation Guide will governs with respect to HIPAA edits, and this Companion Guide will control with respect to business edits.

270 Health Care Eligibility Benefit Inquiry

1.0 Overview of Document

This guide is to be used as a supplement to the 270/271 Health Care Eligibility Benefit Inquiry Implementation Guide, version 4010A1. It should be used to process eligibility requests for AmeriHealth Administrators and InterCounty Health Plan, Inc. (hereinafter referred to as AHA/ICHP).

The purpose of this document is to outline AHA/ICHP processes for handling the 270/271 Health Care Eligibility Benefit Implementation Guide (hereinafter referred to as the 270 or 271), and to delineate specific data requirements where that option is available within the 4010A1 Implementation Guide.

This Companion Document does not add, delete or change the name of any data element that is specified in the Implementation Guide. However, in order to meet the business objectives outlined above, it does recommend a number of conventions that are intended to clarify and standardize the usage of specific data elements.

2.0 General Information

This transaction set is used to inquire about the eligibility/benefits associated with a Subscriber's (or Dependent's) health plan coverage.

The Information Source is a Health Plan (AHA/ICHP) and the Information Receiver is a Provider organization.

The 270 transaction will be used to request eligibility information for a specific patient. That patient may be identified in the 270 as a subscriber or as a dependent.

Per the HIPAA implementation guide, the maximum set of fields that an Information Source can require for look-up are:

If Subscriber - Member ID, Patient First name, Last name and Date of Birth
Dependent – Subscriber Member ID, Patient First name, Last name and Date of Birth

AHA/ICHP prefers to receive all of the data elements listed above. However, if the name/birth date information is not available, AHA/ICHP will conduct the search using the Member ID# only. If the Member ID# is not available, then AHA/ICHP must have the first name, last name, and date of birth to conduct the search.

For the 270 transaction, if a service date is not provided, AHA/ICHP will use the current date to conduct the search. In addition, providers can submit a service date up to 1 year prior to the current date and up to 30 days after the current date.

3.0 Transmission Size and Type

Real time HIPAA (Addenda 1) ANSI X12 270 Health Care Eligibility Benefit Inquiry - As defined in the HIPAA Implementation Guide, a real time transaction contains an inquiry for no more than 1 patient. The Information Receiver, or their electronic intermediary, will send the 270 transaction to the Information Source through some means of telecommunications and will remain connected while the Information Source processes the transaction and returns a response.

This document considers a real time transaction to be a single transaction that contains a single inquiry for a single patient in a single envelope. As such, there will be one and only one of each of the following segments: ISA, GS, ST, SE, GE, IEA.

4.0 270 Data Elements

The following matrix identifies the recommended usage of the data elements when the trading partner submits 270 transactions to AHA/ICHP. Additional information about the data elements or HIPAA requirements can be found within the ASC X12N Health Care Eligibility Benefits Inquiry and Response Implementation Guide:

Segment: GS Functional Group Header

Loop: GS

Level: Header

Usage: Required – Provide control info.

Notes: Due to AHA/ICHP business practices, this information is needed on Inbound Functional Group Header Information for the 270 transaction sets.

Data Element Summary

Ref Des	Element Name	Element Note
GS-02	App Sender Id Code	**"R"** or **"B"** appended to Trading Partner FTIN (Federal TAX ID Number)
GS-03	App Receiver Id Code	Enter value: **54763** (AHA NAIC Number)

Segment: NM1 **Information Source Name**

Loop: 2100 A

Level: Detail

Usage: Required

Notes: Due to AHA/ICHP business practices, this information is needed for 270 transaction sets.

Data Element Summary

Ref Des	Element Name	Element Note
NM101	Entity Identifier Code	Enter code value: **PR** (Payer)
NM108	Identification Code Qualifier	Enter code value: **NI** (National Association of Insurance Commissioners (NAIC) Identification)
NM109	Identification Code	Enter code value: **54763**

Segment: NM1 **Information Receiver Name**

Loop: 2100 B

Level: Detail

Usage: Required

Notes: Due to AHA/ICHP business practices, this information is needed for 270 transaction sets.

Data Element Summary

Ref Des	Element Name	Element Note
NM108	Identification Code Qualifier	Enter code value: **FI** (Federal Taxpayer's Identification Number)
NM109	Identification Code	Enter value: **Federal Tax Identification Number**

Segment: NM1 **Subscriber Name**

Loop: 2100 C

Level: Detail

Usage: Required

Notes: Due to AHA/ICHP business practices, this information is needed for 270 transaction sets.

Data Element Summary

Ref Des	Element Name	Element Note
NM108	Identification Code Qualifier	Enter code value: **MI** (Member Identification)
NM109	Identification Code	Enter value: Subscriber's Member Identification Number on ID card

Segment: EQ **Service Type Code**

Loop: 2110 C (Subscriber Eligibility or Benefit Inquiry Information)

2110 D (Patient Eligibility or Benefit Inquiry Information)

Level: Detail

Usage: Required

Notes: AHA/ICHP integrates only the following HIPAA values 30,35 or AL. Other valid HIPAA values may be sent, but will be treated as a 30 value. Only 1 EQ loop is allowed per 270 transaction set.

Data Element Summary

Ref Des	Element Name	Element Note
EQ04	Insurance Type Code	Enter code value: **30 (Health Benefit Plan Coverage)** **35 (Dental Care)** **AL (Vision)**

271 Health Care Eligibility Benefit Response

Disclaimer

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This Companion Guide does NOT replace or cover all segments specified in the HIPAA ASC X12N Implementation Guides. It does not attempt to amend any of the requirements of the Implementation Guides, or impose any additional obligations on trading partners of AHA/ICHP that are not permitted to be imposed by the HIPAA Standards for Electronic Transactions. This Companion Guide provides information on AHA/ICHP specific codes relevant to AHA/ICHP's business processes and rules and situations that are within the parameters of HIPAA. Readers of this Companion Guide should be acquainted with the HIPAA Implementation Guides, their structure, and content.

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1.0 Overview of Document

This guide is to be used as a supplement to the 271 Health Care Eligibility Benefit Response Implementation Guide, version 4010A1. It should be used to process eligibility responses for AmeriHealth Administrators InterCounty Health Plan, Inc. (hereinafter referred to as AHA/ICHP).

The purpose of this document is to outline AHA/ICHP processes for handling the 270/271 Health Care Eligibility Response Implementation Guide (hereinafter referred to as the 271), and to delineate specific data requirements where that option is available within the 4010A1 Implementation Guide.

This Companion Document does not add, delete or change the name of any data element that is specified in the Implementation Guide. However, in order to meet the business objectives outlined above, it does recommend a number of conventions that are intended to clarify and standardize the usage of specific data elements.

2.0 General Information

This transaction set is used to respond to eligibility/benefits inquiries (270's) associated with a Subscriber's (or Dependent's) health plan coverage.

The Information Source is a Health Plan (AHA/ICHP) and the Information Receiver is a Provider organization.

This 271 eligibility response will include Eligibility Status, Eligibility Begin/End Dates, and Coverage description.

3.0 Transmission Size and Type

Real time HIPAA/ANSI X12 271 Health Care Eligibility Response – AHA/ICHP's real-time response transaction will contain information for only one patient. As such, there will be one and only one of each of the following segments: ISA, GS, ST, SE, GE, IEA.

4.0 271 Data Elements

The following matrix identifies the recommended usage of the data elements when the 271 transaction is being returned by AHA/ICHP to the submitter. Additional information about the data elements or HIPAA requirements can be found within the ASC X12N Health Care Eligibility Benefits Inquiry and Response Implementation Guide:

Segment: **NM1** **Information Source Name**

Loop: 2100 A

Level: Detail

Usage: Required

Notes: Due to AHA/ICHP business practices, this information is provided.

Data Element Summary

Ref Des	Element Name	Element Note
NM101	Entity Identification Code HL-1	Enter code value: **PR** (Payer)
NM102	Entity Type Qualifier	Expect Code value: **2** (Non Person Entity)
NM103	Last Name or Organization Name	Expect value: **AmeriHealth Administrators**
NM108	Identification Code Qualifier	Expect value: **NI** (National Association of Insurance (NAIC) Commissioners)
NM109	Primary Identification	Expect value: **54763**

Segment: **NM1** **Information Receiver Name**

Loop: 2100 B

Level: Detail

Usage: Required

Notes: Due to AHA/ICHP business practices, this information is provided.

Data Element Summary

Ref Des	Element Name	**Element Note**
NM101	Entity Identifier Code	Expect code value: **1P** (Provider)
NM102	Entity Type Qualifier	Expect value: **2** (Non Person Entity)
NM108	Identification Code Qualifier	Expect value: **SV** (Service Provider Number)
NM109	Identification Code	Expect value: Service Provider Number

Segment: NM1 **Subscriber Name**

Loop: 2100 C

Level: Detail

Usage: Required

Notes: Due to AHA/ICHP business practices, this information is provided.

Data Element Summary

Ref Des	Element Name	Element Note
NM101	Entity Identification Code	Expect value: **IL** (Insured or Subscriber)
NM102	Entity Type Qualifier	Expect value: **1** (Person)
NM108	Identification Code Qualifier	Expect value: **MI** (Member Identification Qualifier)
NM109	Identification Code	Expect value: **Member Identification Number**

Segment: DTP **Subscriber Date**

Loop: 2100 C

2100 D

Level: Detail

Usage: Required

Notes: Due to AHA/ICHP business practices, this information is provided.

Data Element Summary

Ref Des	Element Name	Element Note
DTP01	Date Time Qualifier	Expect value(s): **356** (Eligibility Begin) **357** (Eligibility End) **472** (Date of Service)
DTP02	Date Time Period Format Qualifier	Expect value: **D8** CCYYMMDD **RD8** CCYYMMDD-CCYYMMDD
DTP03	Date Time Period	Expect value: **Eligibility Begin Date** **Eligibility End Date** **Date of Service**

Segment: NM1 **Dependent Name**

Loop: 2100 D

Level: Detail

Usage: Required

Notes: Due to AHA/ICHP business practices, this information is provided

Data Element Summary

Ref Des	Element Name	Element Note
NM108	Dependent Identification Code Qualifier	Expect Value: **MI** (Member Identification Qualifier)
NM109	Identification Code	Expect Value**: Member Identification Number**

Segment: **EB Subscriber Eligibility or Benefit Information**

Loop: 2110 C

2110 D

Level: Detail

Usage: Required

Notes: Only 1 EB loop is allowed per 271.

Data Element Summary

Ref Des	Element Name	Element Note
EB01	Eligibility or Benefit Information	Expect code value: **1 (Active)** **6 (Inactive)** **U (Contact Following Entity)**
EB03	Service Type Code	Expect code value: **30 (Health Benefit Plan Coverage)** **35 (Dental Care)** **AL (Vision)**
EB05	Plan Coverage Description	Expect Value: **Contact Number**