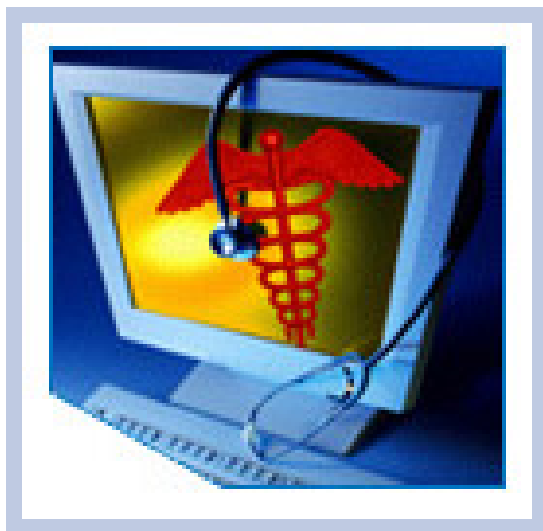


HITSP Medication Formulary and Benefits Information Transaction Package

HITSP/TP46



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TABLE OF CONTENTS

1.0	INTRODUCTION	5
1.1	Overview	5
1.2	Transaction Package Document Map	7
1.3	Copyright Permissions.....	7
1.4	Reference Documents.....	8
2.0	TRANSACTION PACKAGE DEFINITION.....	9
2.1	Context Overview	9
2.1.1	Transaction Package Constraints	10
2.1.2	Technical Actors	11
2.1.3	Actor Interactions.....	12
2.1.4	Pre-conditions.....	13
2.1.4.1	Process Triggers	14
2.1.5	Post-conditions	14
2.1.5.1	Required Outputs	14
2.1.6	Data Flows.....	14
2.2	List of Constructs.....	27
2.2.1	Construct Dependencies	27
2.2.2	Additional Constraints on Required Constructs.....	27
2.3	Standards	28
2.3.1	Regulatory Guidance.....	28
2.3.2	Selected Standards	29
2.3.3	Informative Reference Standards.....	30
3.0	TECHNICAL IMPLEMENTATION	31
3.1	Conformance	31
3.1.1	Conformance Criteria	31
3.1.2	Conformance Scoping, Subsetting and Options	31
4.0	APPENDIX	32
5.0	CHANGE HISTORY	33
5.1	December 7, 2007	33
5.2	March 19, 2008.....	33
5.3	March 27, 2008.....	33
5.4	August 20, 2008	33
5.5	August 27, 2008	34



FIGURES AND TABLES

Figure 2.1.3-1 Medication Formulary and Benefits Information Detailed Design	13
Table 1.4-1 Reference Documents	8
Table 2.1.1-1 Transaction Package Constraints.....	10
Table 2.1.2-1 Technical Actors	12
Table 2.1.4-1 Pre-conditions.....	13
Table 2.1.4.1-1 Process Triggers.....	14
Table 2.1.5-1 Post-conditions	14
Table 2.1.5.1-1 Required Outputs.....	14
Table 2.1.6-1 X12N 270/271 Data Mapping	15
Table 2.1.6-2 NCPDP Formulary and Benefit Data Load Data Mapping	27
Table 2.2-1 List of Constructs	27
Table 2.2.1-1 Construct Dependencies	27
Table 2.2.2-1 Additional Constraints on Required Constructs.....	28
Table 2.3.1-1 Regulatory Guidance	28
Table 2.3.2-1 Selected Standards	29
Table 2.3.3-1 Informative Reference Standards.....	30



1.0 INTRODUCTION

As an introduction to the HITSP Medication Formulary and Benefits Information Transaction Package, this section provides a high level overview of the information sharing scenario enabled by following this specification, provides a document map of the construct relationships for the HITSP specification, acknowledges the copyright protections that pertain and provides a list of key reference documents and background material. If you are already familiar with this information, proceed to Section 2.0 Transaction Package Definition.

1.1 OVERVIEW

This section describes the contents of this specification and provides a high level definition of this Transaction Package and background information about the underlying Transactions and Components that the Transaction Package is based on.

The HITSP Medication Formulary and Benefits Information Transaction Package addresses two tasks. The first task is to perform an eligibility check for a specific patient's pharmacy benefits. The eligibility check can be performed by a prescriber using ASC X12 270/271 transaction standards together with the X12 Insurance Subcommittee (X12N) Implementation Guides reference numbers 004010X92 and its addenda 004010X92A1. The eligibility response will tell the prescriber if the patient is eligible for retail and mail order pharmacy benefit. The eligibility response will also contain a set of IDs which link a given benefit to the associated formulary and benefits information. An eligibility check can also be performed by a pharmacy using NCPDP Telecommunication Standard transactions. Both of these methods of verification are done in real time. The second task of the HITSP Medication Formulary and Benefits Information Transaction Package is to obtain the medication formulary and benefit information.

The Accredited Standards Committee (ASC) X12 Insurance Subcommittee X12N Implementation Guides are used for various transactions, but specific to this Transaction Package, they are used by a prescriber system to obtain an individual's pharmacy benefit eligibility, coverage and benefits. They also provide the key identifiers that are used to obtain detailed formulary and benefits information. The eligibility response can contain single or multiple pharmacy benefit coverages.

Each of the formulary and benefits lists has a unique identifier (ID) that ties that specific formulary and benefit list to the patient benefit information returned in the ASC X12N 271 response. These formulary IDs are contained in the detail level of each formulary list type. The ID types are Formulary ID, Alternative ID, Classification ID, Coverage ID, and Copay ID. Once the appropriate eligibility is known and appropriate pharmacy plan parameters have been identified, the detailed formulary and benefits information can be obtained. This is accomplished using the NCPDP Formulary and Benefit Standard Implementation Guide Version 1.0 specification. This is accomplished in a batch mode.



Note: In the event that the eligibility information is not available (via the ASC X12N 270/271), a cross-reference file (obtained in the transmission of the NCPDP Formulary and Benefit Standard Implementation Guide file) can be utilized to link the individual to the appropriate formulary and benefit information that is applicable for their pharmacy coverage.

The eligibility checking is not a required prerequisite to the loading of formulary information. The Formulary Publisher develops their formulary and benefit file layout according to the NCPDP Formulary and Benefit Data Load specification. The Formulary Publisher sends a formulary and benefit message and file that contain one or more of the formulary and benefit list types (e.g., formulary status, alternative, coverage, copay, and classifications). The Formulary and Benefit Data are electronically transmitted to the Formulary Retriever. A physical validation of the file is done and a Formulary Response File is sent back to the Publisher indicating the Formulary and Benefit Data load status. The Response File indicates any errors encountered in the load process. Once the file is successfully processed and loaded, this information is stored locally in a formulary database. This database is queried to match a patient benefit to the appropriate formulary information based on the results of an eligibility query and the formulary IDs that are returned.

The NCPDP Telecommunication Standard is used by the pharmacy industry for various transactions, but specific to this Transaction Package it is used for the Eligibility Verification and Predetermination of Benefits transactions. The Eligibility Verification transaction is used by the Pharmacy to request that the Administrator, Processor or Reporting Entity verify the eligibility of a specific patient according to appropriate plan parameters. This transaction is used to request verification of a patient's or cardholder's status for a given benefit program. This is a real-time request/response transaction set. Eligibility Verification using the Telecommunication Standard for pharmacies is named in HIPAA and the Medicare Modernization Act of 2003 (MMA). The Pharmacy queries directly to the plan, through a switch/clearinghouse to the plan or the plan's agent (the Pharmacy Benefit Manager (PBM)) or in the case of Medicare Part D, to a Facilitator that holds past/current/future information about Medicare Part D beneficiaries. The Facilitator returns the identification for other plans if the patient has multiple coverages or has changed coverage.

The Predetermination of Benefits inquiry transaction is used by the Pharmacy to request the following:

- To determine if the patient is eligible for prescription coverage
- To determine if the submitted product is covered
- To identify the patient's financial responsibility at that point in time
- To potentially identify clinically relevant information

Conversely, the Predetermination of Benefits transaction response is used by the Processor to communicate the following:

- To identify if the patient is eligible for prescription coverage
- To identify if the submitted product is covered
- To identify the patient's financial responsibility at that point in time



- To potentially identify clinically relevant information that may influence the submission of a corresponding prescription claim request

1.2 TRANSACTION PACKAGE DOCUMENT MAP

Each HITSP specification describes how to integrate and constrain existing standards and specifications that will satisfy the requirements for the HITSP construct. There are four types of HITSP constructs called Interoperability Specifications (IS), Transaction Packages (TP), Transactions (T), and Components (C). Interoperability Specifications define the context(s) in which any other HITSP construct may be used. The current Medication Formulary and Benefits Information Transaction Package specification does not depend on any other HITSP constructs, however, it is used with other constructs to meet the requirements of one or more ISs. Review Section 1.2 Interoperability Specification Document Map from the relevant IS to better understand the context, dependencies, and relationships between the constructs used to meet the IS requirements.

1.3 COPYRIGHT PERMISSIONS

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NCPDP materials used in this document have been extracted from relevant copyrighted materials with permission of the National Council for Prescription Drug Programs (NCPDP). Copies of this standard are available from the NCPDP Web Site at www.ncdp.org.



1.4 REFERENCE DOCUMENTS

This section provides a list of key reference documents and background material. If you are already familiar with this information, proceed to Section 2.

A list of key reference documents and background material is provided in the table below. These documents can be retrieved from the www.hitsp.org Web Site.

Table 1.4-1 Reference Documents

Reference Document	Document Description
HITSP Interoperability Specification Overview	Provides background information about the HITSP and its role in the overall U.S. efforts to realize large scale interoperability of health information. The document also provides a description of the HITSP process for healthcare standards harmonization and explains how to use the Interoperability Specifications and other related documents to inform your health IT product development or product refinement.
HITSP Conventions List	Describes the conventions that are used to convey the full descriptions and usage of standards in the HITSP specifications
HITSP Acronyms List	Lists and defines the acronyms used in this document
HITSP Glossary	Provides definitions for relevant terms used by HITSP documents
HITSP Harmonization Framework	Describes the current framework within which the Interoperability Specifications are built
TN900 - Security and Privacy Technical Note	<p>Developed as a reference document to provide the overall context for use of the HITSP Security and Privacy constructs. It includes the following:</p> <ul style="list-style-type: none">• The scope, reference policy background, and Security and Privacy principles used in the development of the constructs• A detailed description and schematics of the conceptual relationship between the Security and Privacy constructs• A mapping of existing standards and constructs to be used in meeting the stated requirements of the AHIC Use Cases• A list of identified gaps and the recommended approaches to resolving those gaps• A roadmap for how the Security and Privacy constructs will evolve and eventually align with other HITSP Interoperability Specifications• A conceptual framework for Security and Privacy management, including reference information on privacy policies, risk assessment, and risk management• A glossary of terms used in all the Security and Privacy construct documents• A description of the application of the Security and Privacy constructs to the HITSP Interoperability Specifications for the three initial AHIC Use Cases – Biosurveillance, Electronic Health Records - Laboratory Results Reporting, and Consumer Empowerment <p>HITSP will periodically update this Technical Note as required by the introduction of new contexts for use.</p>



2.0 TRANSACTION PACKAGE DEFINITION

Transaction Packages define how two or more Transactions are used to support a stand-alone information exchange within a defined context between two or more systems.

2.1 CONTEXT OVERVIEW

This section provides a general description of the Transaction Package. It includes a detailed definition of the Transaction Package and the reason for its use. It also provides all the necessary background information that further describes the context in which the Transaction Package is needed and the independent Transactions and Components that the Transaction Package is based on.

The HITSP Medication Formulary and Benefits Information Transaction Package is used to accomplish two tasks. The first task is to perform an eligibility check for a specific patient's pharmacy benefits. The second is to obtain the medication formulary and benefit information. The eligibility checking is not a required prerequisite to the loading of formulary information. If the eligibility of a patient is already known or if the Formulary Retriever is updating their files, eligibility checking is not performed. The second task of the Medication Formulary and Benefits Information Transaction Package is to obtain the medication formulary and benefit information.

Implementations of this Transaction Package that support the prescriber performing a pharmacy benefit eligibility check shall support the specification as defined by the Accredited Standards Committee (ASC) X12 Insurance Subcommittee X12N Implementation Guides 004010X92 plus its Addenda 004010X92A1. Implementations shall also support the additional HITSP constraints as defined in Section 2.1.1.

Implementations of this Transaction Package that support the pharmacy performing a pharmacy benefit eligibility verification shall support the specification as defined by the NCPDP Telecommunication Standard Implementation Guide Version D.0 Eligibility Verification Transaction Section 6 and appropriate referenced sections. Additionally implementations shall support the additional HITSP constraints as defined in Section 2.1.1.

Implementations of this Transaction Package that support the pharmacy performing a pharmacy predetermination of benefits shall support the specification as defined by the NCPDP Telecommunication Standard Implementation Guide Version D.0 Predetermination of Benefits Transaction Section 8 and appropriate referenced sections. Implementations shall also support the additional HITSP constraints as defined in Section 2.1.1.

Implementations that support this Transaction Package shall support the NCPDP Formulary and Benefit Data Load specification as specified in the Formulary and Benefit Standard Implementation Guide Version 1.0, Sections 8 (request) and 9 (response) and their appropriate referenced sections. Implementations shall also support the additional HITSP constraints as defined in Section 2.1.1.



2.1.1 TRANSACTION PACKAGE CONSTRAINTS

This section describes the constraints that limit the context in which the Transaction Package construct may be used. A constraint describes a rule that limits the use of the actors, actions or data within the given context or to which the interactions must conform to be used within the described context. It is a description of the limits and scope of the interactions and can describe actions or events that are not part of the initial definition for the context.

The following table identifies the constraints for the X12N 270/271 Implementation Guides. The constraints are used to communicate if the patient is or is not eligible for pharmacy benefit. These constraints also link the eligibility to the appropriate Medication Formulary and Benefits Information Transaction Package. The table identifies the constraints at a high level; the actual requirements are in Section 2.1.6, Table 2.1.6-1 X12N 270/271 Data Mapping.

Note: The eligibility constraints also take into account the eligibility request flow between 1) Prescriber system and PBM/Data Source, and 2) Provider to Intermediary to PBM/Data Source.

No constraints are defined for the NCPDP Telecommunication Standard Eligibility Verification Transaction. The following table also identifies the constraints for the NCPDP Formulary and Benefit Data Load Specification.

Table 2.1.1-1 Transaction Package Constraints

Constraint
X12N 270/271 Implementation Guides
The GS01-479 Functional Identifier Code shall be "HS" Eligibility, Coverage or Benefit Inquiry for the 270 and the value of the GS08-480 Version/Release/Industry Identifier code shall be 004010X092A1
The GS01-479 Functional Identifier Code shall be "HB" Eligibility, Coverage or Benefit Inquiry for the 271 and the value of the GS08-480 Version/Release/Industry Identifier code shall be 004010X092A1
For 270 the BHT02-353 Transaction Set Purpose Code shall be "13" for Request
For both 270/271 the Information Source shall be the Third Party Administrator and shall be identified using either code "PI" for Payer Identification or code "XX" for Healthcare Financing Administration National Provider Identifier or "XV" for the Healthcare Financing Administration National Payer Identifier Number (which then requires the Identification Code)
For both 270/271 the Information Receiver shall be the Provider and shall be identified using code "XX" for the Healthcare Financing Administration National Provider Identifier (NPI) (which then requires the Identification Code)
The individual who is the subject of the 270 inquiry shall be identified in the Subscriber Loop 2100C using the individual's First Name, Last Name, Member Identifier and Date-of-Birth
For 270, the Subscriber Eligibility or Benefit Information Inquiry Information shall contain the values of "88" for Pharmacy and "90" for Mail Order Prescription Drug
For 271, the Subscriber Additional Identification shall use the follow identifiers to indicate formulary and benefits list IDs. Identifiers that will be utilized for the Reference Identification Qualifiers are "IF" for formulary status list ID and alternatives list id "1L" for coverage list ID, and "IG" for copay list ID
For 271, in Loop 2100C Subscriber Name, the NM101-1035 Name Last and NM104-1036 Name First shall contain a valid value



Constraint
For 271, the Subscriber Additional Identification. The Identifiers that shall be utilized for the Reference Identification Qualifiers are "18" for Plan Number, "6P" for Group Number, and "N6" for BIN/PCN
For 271, the Subscriber Eligibility/Benefit Date Information shall have a Date/Time qualifier of "472" for Service. The value for the Date Time Period Format Qualifier shall be "D8" for CCYYMMDD (which then requires Date/Time Period for the eligibility of service)
For 271, the Subscriber Eligibility/Benefit Information Inquiry Information shall contain the values of "88" for Pharmacy and "90" for Mail Order Prescription Drug. The eligibility or benefit information shall be "1" for Active Coverage or "6" for Inactive
For 271, the Dependent Additional Identification shall use the follow identifiers to indicate formulary and benefits list IDs. Identifiers that will be utilized for the Reference Identification Qualifiers are "IF" for formulary status list ID and alternatives list id "1L" for coverage list ID, and "IG" for copay list ID
For 271, the Dependent Additional Identification. The Identifiers that shall be utilized for the Reference Identification Qualifiers are "18" for Plan Number, "6P" for Group Number, and "N6" for BIN/PCN
For 271, the Dependent Eligibility/Benefit Date Information shall have a Date/Time qualifier of "472" for Service. The value for the Date Time Period Format Qualifier shall be "D8" for CCYYMMDD (which then requires Date/Time Period for the eligibility of service)
For 271, the Dependent Eligibility or Benefit Information Inquiry Information shall contain the values of "88" for Pharmacy and "90" for Mail Order Prescription Drug. The eligibility or benefit information shall be "1" for Active Coverage or "6" for Inactive
NCPDP Telecommunication Standard
N/A
NCPDP Formulary and Benefit Data Load Specification
A drug formulary is a list of prescription drugs published by a health plan, pharmacy benefit manager, payer, or provider. Coverage information qualifies the conditions under which the patient's pharmacy benefit covers a medication. When payers communicate the formulary and coverage factors, the Product/Service ID, the Drug Reference Number or the RxNorm Code shall be used consistently throughout the message transaction
For the Step Medications Segment, the "Diagnosis Code" field shall use SNOMED CT defined codes. Note: SNOMED CT defines mapping to ICD9 and ICD10 codes
For the Step Medications Segment, the "Diagnosis Code Qualifier" field shall be set to "SNOMED CT"

2.1.2 TECHNICAL ACTORS

This section describes the technical actors that need to be integrated in order to meet the interoperability requirements for this Transaction Package. A technical actor represents an entity internal to a software application, which is engaged in one or more specific Transactions to support a specific aspect of a real world information interchange (e.g., set of message exchanges). The table below lists the technical actors involved in the Transaction Package, a definition of their roles, an indication of their optionality, the specific Transactions and content with which they are involved and the optionality of the associated Transactions and/or content.



Table 2.1.2-1 Technical Actors

Actor	Description	Used in Component/ Standard	Transaction/Content	Optionality*
Eligibility Information Receiver	The system that initiates an inquiry to the Eligibility Information Source about an individual's insurance eligibility, coverage and benefits	Accredited Standards Committee (ASC) X12 Insurance Subcommittee X12N Implementation Guides Reference Number 004010X92 plus its Addenda 004010X92A1 Or NCPDP Telecommunication Standard Implementation Guide	Eligibility Information Request	R
Eligibility Information Source	The system which holds and maintains the information regarding the individual's insurance eligibility, coverage and benefits, and responds to the queries initiated by the Eligibility Information Receiver	Accredited Standards Committee (ASC) X12 Insurance Subcommittee X12N Implementation Guides Reference Number 004010X92 plus its Addenda 004010X92A1 Or NCPDP Telecommunication Standard Implementation Guide	Eligibility Information Request	R
Medication Formulary and Benefits Retriever	The entity that is asking about an individual's formulary and benefits information. It initiates queries to the Medication Formulary and Benefits Source	NCPDP Formulary And Benefit Standard Implementation Guide	Pharmacy Medication Formulary and Benefits Request	R
Medication Formulary and Benefits Source	The entity who maintains individual's formulary and benefits information. It responds to queries from the Medication Formulary and Benefits Retriever	NCPDP Formulary And Benefit Standard Implementation Guide	Pharmacy Medication Formulary and Benefits Request	R

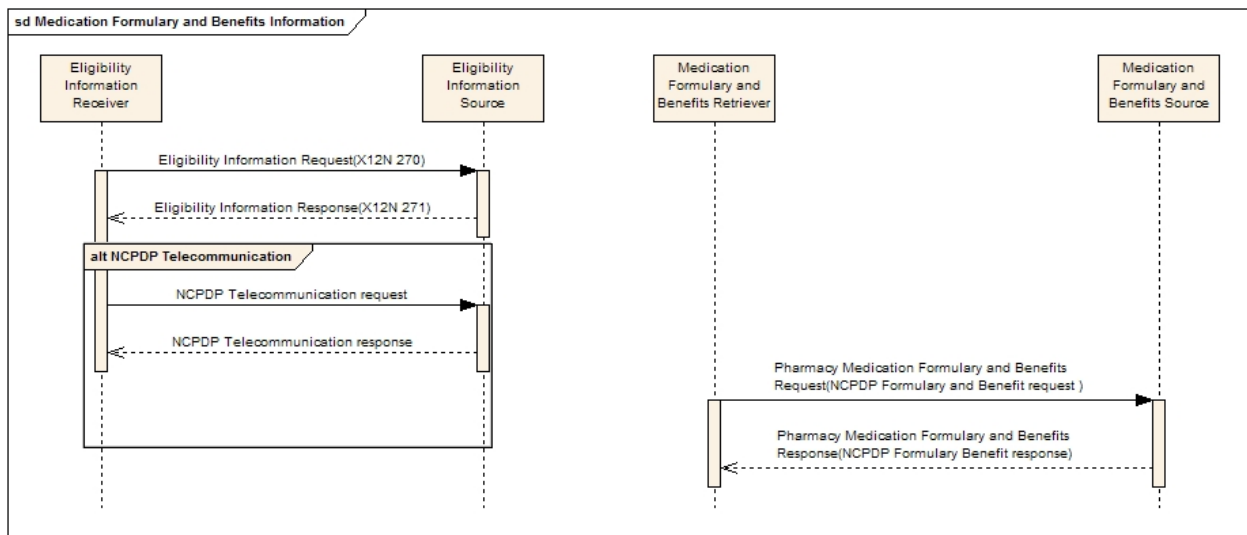
***NOTE:** Optionality = "R" for Required, "R2" for Required if known, "O" for Optional, or "C" for Conditional. If applicable, conditional footnotes are further described below.

2.1.3 ACTOR INTERACTIONS

This section uses a Unified Modeling Language (UML) workflow diagram to depict the business and technical actors, the relevant events or actions in which they are involved and a mapping to the Transactions and Components that encapsulate the defined events/actions. It describes the underlying events that fulfill the Transaction Package, the sequence and timing of the events and the specific actors involved. Process flow diagrams are also provided to illustrate the process relationships. A description of the UML diagram is also provided below the diagram.



Figure 2.1.3-1 Medication Formulary and Benefits Information Detailed Design



This Transaction Package is used to accomplish two tasks. The first task is to perform an eligibility check for a specific patient's pharmacy benefits. The second is to obtain the medication formulary and benefit information.

The eligibility check can be performed via two data flows:

- The eligibility request is initiated via the X12N 270 and the information is returned via the X12N 271 response
- The eligibility request is initiated via the NCPDP Telecommunication request and the information is returned via the NCPDP Telecommunication response

The medication formulary and benefits information query is performed via the NCPDP Formulary and Benefit request and the information is returned in the NCPDP Formulary Benefit response.

2.1.4 PRE-CONDITIONS

This section describes the necessary conditions that must be in place prior to the start of the workings of the Transaction Package. The pre-conditions are used to convey any conditions that must be true at the outset of a Transaction Package. They describe the context that must be established before the Transaction Package is executed. They are not however the triggers that initiate the Transaction Package. Where one or more pre-conditions are not met, the behavior of the Transaction Package should be considered uncertain.

Table 2.1.4-1 Pre-conditions

Pre-condition
It is expected that the security framework under which this Transaction Package operates is in accordance with the Interoperability Specification that references this construct. Therefore all applicable HITSP Security and Privacy constructs are implemented as required
Individuals are known to various health plans



Pre-condition
Individuals' formulary and benefits are known to various health care plans or their agents

2.1.4.1 Process Triggers

This section describes the triggers, including actors and/or processes, which are necessary to start the Transaction Package. They can invoke an automatic or manual process or result that in turn starts off the Transaction Package. A trigger is not the same as a pre-condition that describes a context that needs to be in place at the start of the event.

Table 2.1.4.1-1 Process Triggers

Process Trigger
Any Eligibility Information Requestor (physicians, clinics, medication prescribers, pharmacy, etc) requests patient pharmacy benefits verification
Any Medication Formulary and Benefits Retriever requests medication formulary and benefits information for a patient or plans

2.1.5 POST-CONDITIONS

This section provides an overview of the conditions or results that must occur at the end of the Transaction Package in order for the Transaction Package to be deemed successfully completed. This includes any required outputs from the Transaction Package or specific actor states.

Table 2.1.5-1 Post-conditions

Post-condition
The Eligibility Information Requestor processes the pharmacy benefit eligibility verification
The Medication Formulary and Benefits Retriever processes the medication formulary and benefits information

2.1.5.1 Required Outputs

This section identifies the required outputs that must be produced at the end of the Transaction Package in order for the Transaction Package to be deemed successfully completed. This includes the format and usage of the required output.

Table 2.1.5.1-1 Required Outputs

Required Output	Format/Usage
The Eligibility Information Requestor provides healthcare plan verification to the user of the system	Via User Interface
The Medication Formulary and Benefits Retriever updates its local data base with formulary and benefits information and provides this information to the user of the system	Via User Interface

2.1.6 DATA FLOWS

This section describes the basic data flows that are supported by this Transaction Package. It also describes the format of the data, the data sources, and the relevant actors involved in the successful flow of data for the Transaction Package.



Implementations of this Transaction Package that support the prescriber performing a pharmacy benefit eligibility check shall support the specification as defined by the Accredited Standards Committee (ASC) X12 Insurance Subcommittee X12N Implementation Guides 004010X92 plus its Addenda 004010X92A1. The additional HITSP constraints follow.

Below are the data mappings and constraints for the X12N 270/271 Eligibility and Benefits Inquiry and Response Transactions.

Note: This HITSP Transaction Package constrains certain portions of the X12N 270/271 implementation guide. The implementation guide contains other capabilities that are outside the scope of this transaction.

The legend for transaction set data element mapping follows the format below:

<transactionsetid>_<loopid>_<segment & data element position in segment>_X12 data element #>

For example:

271_2100A_NM101_98

Table 2.1.6-1 X12N 270/271 Data Mapping

Data Element	Description	Limit/Range of values	Data Source	Destination	Requirements/ Pre-conditions*	Additional Specification for Component
270 Request						
*_*_GS01_479	Functional Identifier Code	HS - Eligibility, Coverage, or Benefit Inquiry (270)	Eligibility Information Receiver	Eligibility Information Source	R	Shall be a value of HS
*_*_GS08_480	Version/Release/ Industry Identifier Code	004010X092A1 - Draft Standards approved for publication by ASC X12 Procedures Review Board through October 1991 as published	Eligibility Information Receiver	Eligibility Information Source	R	Shall be a value of 004010X092A1
270_*_BHT03_353	Transaction Set Purpose Code	13 - Request	Eligibility Information Receiver	Eligibility Information Source	R	Shall be a value of 13
270_2100A_NM101_98	Entity Identifier Code	2B - Third Party Administrator	Eligibility Information Receiver	Eligibility Information Source	R	Shall be a value of 2B
270_2100A_NM102_1065	Entity Type Qualifier	2 - Non Person Entity	Eligibility Information Receiver	Eligibility Information Source	R	Shall be a value of 2



Data Element	Description	Limit/Range of values	Data Source	Destination	Requirements/ Pre-conditions*	Additional Specification for Component
270_2100A_NM108_66	Identification Code Qualifier	PI - Payer Identification Or XV - Healthcare Financing Administration National Payer Identifier Number Or XX -Healthcare Financing Administration National Provider Identifier	Eligibility Information Receiver	Eligibility Information Source	R	Shall be a value of PI, XX, or XV Note: By requiring this data element, data element NM109 is required (Identification Code Description)
270_2100B_NM101_98	Entity Identifier Code	1P - Provider	Eligibility Information Receiver	Eligibility Information Source	R	Shall be a value of 1P
270_2100B_NM108_66	Identification Code Qualifier	XX - Healthcare Financing Administration National Provider Identifier	Eligibility Information Receiver	Eligibility Information Source	R	Shall be a value of XX Note: By requiring this data element, data element NM109 is required (Identification Code Description)
270_2100C_NM103_1035	Name Last		Eligibility Information Receiver	Eligibility Information Source	R	
270_2100C_NM104_1036	Name First		Eligibility Information Receiver	Eligibility Information Source	R2	



Data Element	Description	Limit/Range of values	Data Source	Destination	Requirements/ Pre-conditions*	Additional Specification for Component
270_2100C_NM108_66	Identification Code Qualifier	MI - Member Identification Number	Eligibility Information Receiver	Eligibility Information Source	R	<p>Shall be a value of MI</p> <p>This identification number shall be a unique identifier for each individual within the Information Source as identified in 270_2100A_NM108_66</p> <p>If the 270 is sent directly from a Provider to a PBM/Data Source, then the provider system shall populate this element. If the 270 is sent through an intermediary, then either the provider system or the intermediary shall populate this data element.</p> <p>Note: By requiring this data element, data element NM109 is required (Identification Code Description)</p>
270_2100C_DMG01_1250	Date Time Period Format Qualifier	D8-	Eligibility Information Receiver	Eligibility Information Source	R	Shall be a value of D8
270_2100C_DMG02_1251	Date Time Period (Subscriber Birth Date)		Eligibility Information Request	Eligibility Information Source	R	Shall be the Subscriber Birth Date
270_2110C1_EQ01_1365	Service Type Code	88 - Pharmacy	Eligibility Information Receiver	Eligibility Information Source	R	Shall be a value of 88
270_2110C2_EQ01_1365	Service Type Code	90 - Mail Order Prescription Drug	Eligibility Information Receiver	Eligibility Information Source	R	Shall be a value of 90
271 Response						
*_*_GS01_479	Functional Identifier Code	HB - Eligibility, Cover, or Benefit Inquiry (271)	Eligibility Information Source	Eligibility Information Receiver	R	Shall be a value of HB
*_*_GS08_480	Version/Release/ Industry Identifier Code	004010X092A1 - Draft Standards approved for publication by ASC X12 Procedures Review Board through October 1991 as published	Eligibility Information Source	Eligibility Information Receiver	R	Shall be a value of 004010X092A1



Data Element	Description	Limit/Range of values	Data Source	Destination	Requirements/ Pre-conditions*	Additional Specification for Component
271_2100A_NM101_98	Entity Identifier Code	2B - Third Party Administrator	Eligibility Information Source	Eligibility Information Receiver	R	Shall be a value of 2B
271_2100A_NM102_1065	Entity Type Qualifier	2 - Non Person Entity	Eligibility Information Source	Eligibility Information Receiver	Required to be supported for all Transactions	Shall be a value of 2
271_2100A_NM108_66	Identification Code Qualifier	PI - Payer Identification Or XV - Healthcare Financing Administration National Payer Identifier Number Or XX -Healthcare Financing Administration National Provider Identifier	Eligibility Information Source	Eligibility Information Receiver	Required to be supported for all Transactions	Shall be a value of PI, XX, or XV Note: By requiring this data element, data element NM109 is required (Identification Code Description)
271_2100B_NM101_98	Entity Identifier Code	1P - Provider	Eligibility Information Source	Eligibility Information Receiver	R	Shall be a value of 1P
271_2100B_NM108_66	Identification Code Qualifier	XX -Healthcare Financing Administration National Provider Identifier	Eligibility Information Source	Eligibility Information Receiver	Required to be supported for all Transactions	Shall be a value of XX Note: By requiring this data element, data element NM109 is required (Identification Code Description)
270_2100C_NM103 1035	Name Last		Eligibility Information Receiver	Eligibility Information Source	R	
270_2100C_NM104 1036	Name First		Eligibility Information Receiver	Eligibility Information Source	R2	
270_2100C_NM108 66	Identification Code Qualifier Description		Eligibility Information Receiver	Eligibility Information Source	R	Note: By requiring this data element, data element NM109 is required (Identification Code Description)
271_2100C_REF			Eligibility Information Source	Eligibility Information Receiver	C	This segment shall be sent if 271_2110C1_EB01_13 90 is set to 1 (Active Coverage)



Data Element	Description	Limit/Range of values	Data Source	Destination	Requirements/ Pre-conditions*	Additional Specification for Component
271_2100C_REF01_128	Reference Identification Qualifier	IF -Issue Number	Eligibility Information Source	Eligibility Information Receiver	R	Shall be a value of IF
271_2100C_REF02_127	Reference Identification		Eligibility Information Source	Eligibility Information Receiver	R	Shall be the ID which links the eligibility benefit to the appropriate the Formulary Status List
271_2100C_REF03_352	Description		Eligibility Information Source	Eligibility Information Receiver	R2	Shall be the ID which links the eligibility benefit to the appropriate Alternative List
271_2100C1_REF	Subscriber Additional Identification		Eligibility Information Source	Eligibility Information Receiver	R2	Note: This segment is sent if 271_2110C1_EB01_13 90 is set to 1 (Active Coverage) and the data source can provide this benefits information
271_2100C1_REF01_128	Reference Identification Qualifier	1L - Group or Policy Number	Eligibility Information Source	Eligibility Information Receiver	R	Shall be a value of 1L Note: This Data Element is sent only if the REF segment is sent
271_2100C1_REF02_127	Reference Identification		Eligibility Information Source	Eligibility Information Receiver	R	Shall be the ID which links the eligibility benefit to the appropriate the Coverage Note: This Data Element is sent only if the REF segment is sent
271_2100C2_REF	Subscriber Additional Identification		Eligibility Information Source	Eligibility Information Receiver	R2	Note: This segment is sent if 271_2110C1_EB01_13 90 is set to 1 (Active Coverage) and the data source can provide this benefits information
271_2100C2_REF01_128	Reference Identification Qualifier	IG -Insurance Policy Number	Eligibility Information Source	Eligibility Information Receiver	R	Shall be the value of IG Note: This Data Element is sent only if the REF segment is sent



Data Element	Description	Limit/Range of values	Data Source	Destination	Requirements/ Pre-conditions*	Additional Specification for Component
271_2100C2_REF02_127	Reference Identification		Eligibility Information Source	Eligibility Information Receiver	R	Shall be the ID which links the eligibility benefit to the appropriate Copay ID Note: This Data Element is sent only if the REF segment is sent
271_2100C3_REF	Subscriber Additional Identification		Eligibility Information Source	Eligibility Information Receiver	R2	Note: This segment is sent if 271_2110C1_EB01_13 90 is set to 1 (Active Coverage) and the data source can provide the benefits information
271_2100C3_REF01_128	Reference Identification Qualifier	18 -Plan Number	Eligibility Information Source	Eligibility Information Receiver	R	Shall be the value of 18be 18 Note: This Data Element is sent only if the REF segment is sent
271_2100C3_REF02_127	Reference Identification		Eligibility Information Source	Eligibility Information Receiver	R	Shall be the ID which links the eligibility benefit to the appropriate Plan Number Note: This Data Element is sent only if the REF segment is sent
271_2100C3_REF03_352	Description		Eligibility Information Source	Eligibility Information Receiver	R2	This is a free form text description of the Health Plan referenced in the REF02_127 Note: This Data Element is sent only if the REF segment is sent
271_2100C4_REF	Subscriber Additional Identification		Eligibility Information Source	Eligibility Information Receiver	R2	Note: This segment is sent if 271_2110C1_EB01_13 90 is set to 1 (Active Coverage) and the data source can provide the benefits information
271_2100C4_REF01_128	Reference Identification Qualifier	6P -Group Number	Eligibility Information Source	Eligibility Information Receiver	R	Shall be the value of 6P Note: This Data Element is sent only if the REF segment is sent



Data Element	Description	Limit/Range of values	Data Source	Destination	Requirements/ Pre-conditions*	Additional Specification for Component
271_2100C4_REF02_127	Reference Identification		Eligibility Information Source	Eligibility Information Receiver	R	Shall be the ID which links the eligibility benefit to the appropriate the Group Number Note: This Data Element is sent only if the REF segment is sent
271_2100C4_REF03_352	Description		Eligibility Information Source	Eligibility Information Receiver	R2	This is a free form text description of the Group referenced in the REF02_127 Note: This Data Element is sent only if the REF segment is sent
271_2100C5_REF	Subscriber Additional Identification		Eligibility Information Source	Eligibility Information Receiver	R2	Note: This segment is sent if 271_2110C1_EB01_13 90 is set to 1 (Active Coverage) and the data source can provide the benefits information
271_2100C5_REF01_128	Reference Identification Qualifier	N6 -Network Plan Identification Number	Eligibility Information Source	Eligibility Information Receiver	R	Shall be the value of N6 Note: This Data Element is sent only if the REF segment is sent
271_2100C5_REF02_127	Reference Identification Description		Eligibility Information Source	Eligibility Information Receiver	R	Shall be the Bank Identification Number (BIN) Note: This Data Element is sent only if the REF segment is sent
271_2100C5_REF03_352	Description		Eligibility Information Source	Eligibility Information Receiver	R	Shall be the Processor Control Number (PCN) Note: This Data Element is sent only if the REF segment is sent
271_2100C_DTP	Subscriber Date		Eligibility Information Source	Eligibility Information Receiver	R	This Segment is required to be sent
271_2100C_DTP01_374	Date/Time Qualifier	472 - Service	Eligibility Information Source	Eligibility Information Receiver	R	Shall be a value of 472



Data Element	Description	Limit/Range of values	Data Source	Destination	Requirements/ Pre-conditions*	Additional Specification for Component
271_2100C_DTP02_1250	Date Time Period Format Qualifier	D8 -CCYYMMDD	Eligibility Information Source	Eligibility Information Receiver	R	Shall be a value of D8 Note: Use of this field then requires DTP03 for the Eligibility or Benefit Date/Time Period
271_2110C1_EB	Subscriber Eligibility or Benefit Information		Eligibility Information Source	Eligibility Information Receiver	C	This segment shall be sent if the AAA (error condition) segment is not sent
271_2110C1_EB01_1390	Eligibility or Benefit Information	1 - Active Coverage Or 6 - Inactive	Eligibility Information Source	Eligibility Information Receiver	R	Shall be the value of 1 or 6
271_2110C1_EB03_1365	Service Type Code	88 - Pharmacy	Eligibility Information Source	Eligibility Information Receiver	R	Shall be a value of 88
271_2110C2_EB	Subscriber Eligibility or Benefit Information		Eligibility Information Source	Eligibility Information Receiver	C	This segment shall be sent if the AAA (error condition) segment is not sent
271_2110C2_EB01_1390	Eligibility or Benefit Information	1 - Active Coverage Or 6 - Inactive	Eligibility Information Source	Eligibility Information Receiver	R	Shall be the value of 1 or 6
271_2110C2_EB03_1365	Service Type Code	90 - Mail Order Prescription Drug	Eligibility Information Source	Eligibility Information Receiver	R	Shall be the value of 90
271_2100D_NM103 1035	Name Last		Eligibility Information Receiver	Eligibility Information Source	R	
271_2100D_NM104 1036	Name First		Eligibility Information Receiver	Eligibility Information Source	R2	
271_2100D_REF	Dependent Additional Identification		Eligibility Information Source	Eligibility Information Receiver	C	This segment shall be sent if 271_2110D1_EB01_13 90 is set to 1 (Active Coverage)
271_2100D_REF01_128	Reference Identification Qualifier	1F -Issue Number	Eligibility Information Source	Eligibility Information Receiver	R	Shall be a value of 1F



Data Element	Description	Limit/Range of values	Data Source	Destination	Requirements/ Pre-conditions*	Additional Specification for Component
271_2100D_REF02_127	Reference Identification		Eligibility Information Source	Eligibility Information Receiver	R	Shall be the ID which links the eligibility benefit to the appropriate Formulary Status List
271_2100D_REF03_352	Description		Eligibility Information Source	Eligibility Information Receiver	R2	Shall be the ID which links the eligibility benefit to the appropriate Alternative List
271_2100D1_REF	Dependent Additional Identification		Eligibility Information Source	Eligibility Information Receiver	R2	Note: This segment is sent if 271_2110D1_EB01_13 90 is set to 1 (Active Coverage) and the data source can provide the benefits information
271_2100D1_REF01_128	Reference Identification Qualifier	1L - Group or Policy Number	Eligibility Information Source	Eligibility Information Receiver	R	Shall be a value of 1L Note: This Data Element is sent only if the REF segment is sent
271_2100D1_REF02_127	Reference Identification		Eligibility Information Source	Eligibility Information Receiver	R	Shall be the ID which links the eligibility benefit to the appropriate Coverage Note: This Data Element is sent only if the REF segment is sent
271_2100D2_REF	Dependent Additional Identification		Eligibility Information Source	Eligibility Information Receiver	R2	Note: This segment is sent if 271_2110D1_EB01_13 90 is set to 1 (Active Coverage) and the data source can provide the benefits information
271_2100D2_REF01_128	Reference Identification Qualifier	IG -Insurance Policy Number	Eligibility Information Source	Eligibility Information Receiver	R	Shall be the value of IG Note: This Data Element is sent only if the REF segment is sent



Data Element	Description	Limit/Range of values	Data Source	Destination	Requirements/ Pre-conditions*	Additional Specification for Component
271_2100D2_REF02_127	Reference Identification		Eligibility Information Source	Eligibility Information Receiver	R	Shall be the ID which links the eligibility benefit to the appropriate Copay ID Note: This Data Element is sent only if the REF segment is sent
271_2100D3_REF	Dependent Additional Identification		Eligibility Information Source	Eligibility Information Receiver	R2	Note: This segment is sent if 271_2110D1_EB01_13 90 is set to 1 (Active Coverage) and the data source can provide the benefits information
271_2100D3_REF01_128	Reference Identification Qualifier	18 -Plan Number	Eligibility Information Source	Eligibility Information Receiver	R	Shall be the value of 18be 18 Note: This Data Element is sent only if the REF segment is sent
271_2100D3_REF02_127	Reference Identification		Eligibility Information Source	Eligibility Information Receiver	R	Shall be the ID which links the eligibility benefit to the appropriate Plan Number Note: This Data Element is sent only if the REF segment is sent
271_2100D3_REF03_352	Description		Eligibility Information Source	Eligibility Information Receiver	R2	This is a free form text description of the Health Plan referenced in the REF02_127 Note: This Data Element is sent only if the REF segment is sent
271_2100D4_REF	Dependent Additional Identification		Eligibility Information Source	Eligibility Information Receiver	R2	Note: This segment is sent if 271_2110D1_EB01_13 90 is set to 1 (Active Coverage) and the data source can provide the benefits information
271_2100D4_REF01_128	Reference Identification Qualifier	6P -Group Number	Eligibility Information Source	Eligibility Information Receiver	R	Shall be the value of 6P Note: This Data Element is sent only if the REF segment is sent



Data Element	Description	Limit/Range of values	Data Source	Destination	Requirements/ Pre-conditions*	Additional Specification for Component
271_2100D4_REF02_127	Reference Identification		Eligibility Information Source	Eligibility Information Receiver	R	Shall be the ID which links the eligibility benefit to the appropriate Group Number Note: This Data Element is sent only if the REF segment is sent
271_2100D4_REF03_352	Description		Eligibility Information Source	Eligibility Information Receiver	R2	This is a free form text description of the Group referenced in the REF02_127 Note: This Data Element is sent only if the REF segment is sent
271_2100D5_REF	Dependent Additional Identification		Eligibility Information Source	Eligibility Information Receiver	R2	Note: This segment is sent if 271_2110D1_EB01_13 90 is set to 1 (Active Coverage) and the data source can provide the benefits information
271_2100D5_REF01_128	Reference Identification Qualifier	N6 -Network Plan Identification Number	Eligibility Information Source	Eligibility Information Receiver	R	Shall be the value of N6 Note: This Data Element is sent only if the REF segment is sent
271_2100D5_REF02_127	Reference Identification Description		Eligibility Information Source	Eligibility Information Receiver	R	Shall be the Bank Identification Number (BIN) Note: This Data Element is sent only if the REF segment is sent
271_2100D5_REF03_352	Description		Eligibility Information Source	Eligibility Information Receiver	R	Shall be the Processor Control Number (PCN) Note: This Data Element is sent only if the REF segment is sent
271_2100D_DTP	Dependent Date		Eligibility Information Source	Eligibility Information Receiver	R	This Segment is required to be sent
271_2100D_DTP01_374	Date / Time Qualifier	472 - Service	Eligibility Information Source	Eligibility Information Receiver	R	Shall be a value of 472



Data Element	Description	Limit/Range of values	Data Source	Destination	Requirements/ Pre-conditions*	Additional Specification for Component
271_2100D_DTP02_1250	Date Time Period Format Qualifier	D8 -CCYYMMDD	Eligibility Information Source	Eligibility Information Receiver	R	Shall be a value of D8 Note: Used if this field then requires DTP03 for the Eligibility or Benefit Date/Time Period
271_2110D1_EB	Dependent Eligibility or Benefit Information		Eligibility Information Source	Eligibility Information Receiver	C	This segment shall be sent if the AAA (error condition) segment is not sent
271_2110D1_EB01_1390	Eligibility or Benefit Information	1 - Active Coverage Or 6 - Inactive	Eligibility Information Source	Eligibility Information Receiver	R	Shall be the value of 1 or 6
271_2110D1_EB03_1365	Service Type Code	88 - Pharmacy	Eligibility Information Source	Eligibility Information Receiver	R	Shall be a value of 88
271_2110D2_EB	Dependent Eligibility or Benefit Information		Eligibility Information Source	Eligibility Information Receiver	C	This segment shall be sent if the AAA (error condition) segment is not sent
271_2110D2_EB01_1390	Eligibility or Benefit Information	1 - Active Coverage Or 6 - Inactive	Eligibility Information Source	Eligibility Information Receiver	R	Shall be the value of 1 or 6
271_2110D2_EB03_1365	Service Type Code	90 - Mail Order Prescription Drug	Eligibility Information Source	Eligibility Information Receiver	R	Shall be the value of 90

***NOTE:** Optionality = “R” for Required, “R2” for Required if known, “O” for Optional, “C” for Conditional. If applicable, conditional footnotes are further described below.

Implementations of this Transaction Package that support the pharmacy performing a pharmacy benefit eligibility verification shall support the specification as defined by the NCPDP Telecommunication Standard Implementation Guide Version D.0 Eligibility Verification Transaction Section 6 and appropriate referenced sections.

Implementations that support this Transaction Package shall support the NCPDP Formulary and Benefit Data Load specification as specified in the Formulary and Benefit Standard Implementation Guide, Sections 8 (request) and 9 (response) and their appropriate referenced sections. The additional HITSP constraints are as follows:



Table 2.1.6-2 NCPDP Formulary and Benefit Data Load Data Mapping

Data Element	Description	Limit/Range of values	Data Source	Destination	Requirements/Pre-conditions	Additional Specification for Component
424-DO	Diagnosis Code	NA	Medication Formulary and Benefits Retriever	Medication Formulary and Benefits Source	Coverage Information Detail - Step Medications Segment	When used shall always be sent and filled in with the value "SNOMED CT." Note: SNOMED CT defines mapping to ICD9 and ICD10 codes.
492-WE	Diagnosis Code Qualifier	NA	Medication Formulary and Benefits Retriever	Medication Formulary and Benefits Source	Coverage Information Detail - Step Medications Segment	When used shall always be sent and filled in with the value "SNOMED CT"

Implementations of this Transaction Package that support the pharmacy performing a pharmacy predetermination of benefits shall support the specification as defined by the NCPDP Telecommunication Standard Implementation Guide Version D.0 Predetermination of Benefits transaction Section 8 and appropriate referenced sections. Additionally, implementations shall support the HITSP constraints as defined in Section 2.1.1.

2.2 LIST OF CONSTRUCTS

The following list of constructs and their definitions are used by the Transaction Package specification.

Table 2.2-1 List of Constructs

Construct Name	Technical Actor	Description	Event/Action Code	Content
No applicable constructs				

2.2.1 CONSTRUCT DEPENDENCIES

The following table shows a list of constructs with their existing dependencies. Dependencies usually exist when there are some additional pre-requisites for a specific Transaction Package specification.

Table 2.2.1-1 Construct Dependencies

Construct	Depends On (Name of Component that it depends on)	Dependency Type (Pre-condition, post-condition, general)	Purpose
No applicable construct dependencies			

2.2.2 ADDITIONAL CONSTRAINTS ON REQUIRED CONSTRUCTS

This section describes the constraints that further limit the constructs that are used by this Transaction Package.



Table 2.2.2-1 Additional Constraints on Required Constructs

Data Element	Construct	Constraint	Constraint Type (Pre-condition, post-condition, general)	Purpose (Reason for this constraint)
No applicable constraints				

2.3 STANDARDS

It is important to understand that the standards selected here are within the context of the specific Use Case requirements and do not necessarily reflect selection in other contexts. The standards used by this Transaction Package specification fall into the following categories:

- Regulatory guidance is a legal or other authoritative declaration that HITSP must abide by in standard selection (see Section 2.3.1)
- Selected standards are necessary for interoperability. These are standards that are used to meet information exchange requirements of associated constructs. For example, they are used to realize direct information exchange, to provide the transport mechanism, to specify the content, or to address security (see Section 2.3.2)
- Informative reference standards provide additional background information or guidance, and are not required for interoperability. These standards are not required to implement the Transaction Package specification (see Section 2.3.3)

2.3.1 REGULATORY GUIDANCE

The following table provides a list of legal or other authoritative guidelines that HITSP must abide by, or has agreed to use as guidance in the selection of standards. Note that only the referenced sections of the regulations are relevant to this Transaction Package specification.

Table 2.3.1-1 Regulatory Guidance

Standard	Description
Health Insurance Portability and Accountability Act (HIPAA) -- Administrative Simplification	A listing of national standards plus rules adopted by federal regulation for electronically communicating specified administrative and financial healthcare transactions, and protecting the security and privacy of healthcare information, as applied to the three types of defined covered entities: health plans, healthcare clearinghouses, and healthcare providers who conduct any of the specified healthcare transactions. See the Code of Federal Regulations, Title 45, Parts 160, et. seq. for more information
Medicare Prescription Drug Improvement and Modernization Act of 2003 (Pub.L. 108-173, 117 Stat. 2066, also called Medicare Modernization Act or MMA)	The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) initiated improvements in the Medicare system. The legislation provided a voluntary program for prescription drug coverage under Medicare. Additionally, the MMA allows a tax deduction to individuals for amounts contributed to health savings security accounts, provides the disposition of unused health benefits in cafeteria plans and flexible spending arrangements. For more information visit www.cms.hhs.gov



2.3.2 SELECTED STANDARDS

The following table provides a list of standards that are used to meet information exchange requirements of the Transaction Package specification, and a detailed description of each standard.

Table 2.3.2-1 Selected Standards

Standard	Description
Accredited Standards Committee (ASC) X12 270 and 271 transaction standards version 4010, using the Insurance Subcommittee (X12N) Implementation Guides Version Reference Numbers 004010X92	Detailed Implementation Guides based on release 004010 of the X12 standards. These Implementation Guides provide details on the use of X12 standards to accomplish specific transaction functions. Some of the version 004010 Implementation Guides, but not all, have been adopted as Implementation Specifications under HIPAA. This standard is required by regulatory guidance
Accredited Standards Committee (ASC) X12 270 and 271 transaction standards version 4010, using the Insurance Subcommittee (X12N) Addenda 004010X92A1	Many of the version X12N 004010 Implementation Guides, including all of those adopted under HIPAA, have Addenda that contain updates -- only -- to the original Implementation Guides. These Addenda are identified as version 004010A1. Implementation Guide 004010X092A1 describes transactions for Health Care Eligibility Benefit Inquiry and Response. Implementation Guides are published by Washington Publishing Company. For more information visit www.wpc-edi.com . This standard is required by regulatory guidance
Accredited Standards Committee (ASC) X12 270 Transaction Version Standards Release 004010	The objective of the Health Care Eligibility/Benefit Inquiry (270) is to provide for the exchange of eligibility inquiry to individuals within a health plan. This transaction can be used by health care providers to request coverage and payment information on the member/insured in a batch environment where real time processing is not required. This transaction is also used to provide additional patient eligibility information to support administrative reimbursement for health care products and services. This standard is required by HIPAA. This standard is required by regulatory guidance
Accredited Standards Committee (ASC) X12 271 Transaction Version Standards Release 004010	The objective of the Health Care Eligibility, Coverage, or Benefit Information (271) is to provide for the response to eligibility inquiries about individuals within a health plan. This transaction can be used to receive coverage and payment information on a member/insured in a batch environment where real time processing is not required. This transaction is also used to provide additional patient eligibility information to support administrative reimbursement for health care products and services. This standard is required by HIPAA. This standard is required by regulatory guidance
National Council for Prescription Drug Programs (NCPDP) Formulary and Benefits Standard Implementation Guide	Provides a standard means for pharmacy benefit payers (including health plans and Pharmacy Benefit Managers) to communicate formulary and benefit information to prescribers via technology vendor systems. The service enables technology vendors to receive a range of formulary and benefit information through the service: formulary status, preferred alternatives, benefit coverage and copay information. For more information visit www.ncdp.org
National Council for Prescription Drug Programs (NCPDP) Telecommunication Standard Implementation Guide	Provides prescription claim transactions between Providers and Adjudicators, and between Adjudicators (aka Payer-to-Payer). The Telecommunication Standard Implementation Guide supports the following processes: <ol style="list-style-type: none"> 1. Eligibility Verification 2. Claim 3. Service 4. Information Reporting 5. Prior Authorization 6. Predetermination of Benefits. For more information visit www.ncdp.org



2.3.3 INFORMATIVE REFERENCE STANDARDS

The following table lists standards that provide additional background information or guidance; however, they are not required for the implementation of the Transaction Package specification.

Table 2.3.3-1 Informative Reference Standards

Standard Name	Description/Reason for Use
No applicable informative reference standards	



3.0 TECHNICAL IMPLEMENTATION

3.1 CONFORMANCE

This section describes the conformance criteria, which are objective statements of requirements that can be used to determine if a specific behavior, function, interface or code set has been implemented correctly.

3.1.1 CONFORMANCE CRITERIA

In order to claim conformance to this construct specification, an implementation must satisfy all the requirements and mandatory statements listed in this specification, the associated HITSP Interoperability Specification, its associated construct specifications, as well as conformance criteria from the selected base and composite standards. A conformant system must also be constrained as specified in Table 2.1.1-1 and implement all of the required actors from Table 2.1.2-1 within the scope, subset or implementation option that is selected from the associated Interoperability Specification.

Claims of conformance may only be made for the overall HITSP Interoperability Specification with which this construct is associated.

3.1.2 CONFORMANCE SCOPING, SUBSETTING AND OPTIONS

A HITSP Interoperability Specification must be implemented in its entirety for an implementation to claim conformance to the specification. HITSP may define the permissibility for actor scoping, subsetting or implementation options by which the specification may be implemented in a limited manner. Such scoping, subsetting and options may extend to associated constructs, such as this construct. This construct must implement all requirements within the selected scope, subset or options as defined in the associated Interoperability Specification to claim conformance.



4.0 APPENDIX

The following sections include relevant materials referenced throughout this document.

No additional information at this time.

RELEASED FOR IMPLEMENTATION



5.0 CHANGE HISTORY

The following sections provide the history of all changes made to this document.

5.1 DECEMBER 7, 2007

No changes. This is the first published version of the document.

5.2 MARCH 19, 2008

The changes in this cycle address the following comments:

3004, 3005, 3032, 3033, 3047, 3066, 3220, 3221, 3232, 3233, 3244, 3246, 3247

The full text of the comments along with the Technical Committee's disposition can be reviewed on the HITSP Public Web Site.

The following changes have been made to the construct:

- Reworded overview to clarify usage of construct
- Identified UML changes
- Made editorial changes based on comments
- Defined all constraints for X12N 270/271 transactions
- Determined no constraints are needed for NCPDP Telecommunication standard
- Changed name of Medication Formulary and Benefits Publisher to Medication Formulary and Benefits Retriever
- Reworded pre-condition

5.3 MARCH 27, 2008

Upon approval by the HITSP Panel on March 27, 2008, this document is now Released for Implementation.

5.4 AUGUST 20, 2008

This document has been modified to reflect the updated HITSP approach to categorizing standards as Regulatory Guidance, Selected Standards, and Informative References.

The following standards were added as regulatory guidance:

- Health Insurance Portability and Accountability Act (HIPAA) -- Administrative Simplification
- Medicare Prescription Drug Improvement and Modernization Act of 2003 (Pub.L. 108-173, 117 Stat. 2066, also called Medicare Modernization Act or MMA)



5.5 AUGUST 27, 2008

Upon approval by the HITSP Panel on August 27, 2008, this document is now Released for Implementation.

RELEASED FOR IMPLEMENTATION

