

# HITSP Patient Health Plan Eligibility Verification Transaction

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HITSP/T40



Healthcare Information Technology Standards Panel

*Submitted to:*

**Healthcare Information Technology Standards Panel**

*Submitted by:*

**Administrative and Financial Domain Technical Committee**



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## 1.0 INTRODUCTION

### 1.1 OVERVIEW

The Healthcare Information Technology Standards Panel (HITSP) Patient Health Plan Eligibility Verification Transaction is intended to provide an individual's coverage status from a health plan, along with details regarding patient liability for deductible, co-pay and co-insurance amounts. It can be used for a defined base set of general benefits or services or for specific services based on service types, procedure codes, or diagnoses.

To support Patient Health Plan Eligibility Verification, HITSP is using the Accredited Standards Committee (ASC) X12 270 and 271 Transaction Sets Version 004010, and the Insurance Subcommittee X12N Implementation Guide reference number 004010X092 plus its Addenda reference number 004010X092A1. This X12N Implementation Guide is also being constrained by HITSP via the CAQH CORE Phase I and Phase II Operating Rules for the ASC X12 270/271 Eligibility and Benefits Inquiry and Response. The CAQH CORE Phase I and Phase II Operating Rules bring additional and other requirements permitted within the X12 standard for the exchange of the HIPAA-adopted X12N 270/271 Eligibility and Benefit Inquiry and Response Transaction Sets between a healthcare provider (information requester) and a health plan (information source). They are focused on providing operating rules for more useful and consistent conduct of the 270/271 between any information requester (such as a private physician office, a clinic or an acute care in-patient facility) and any information source (such as a health plan, an insurance company or a third-party administrator).

This HITSP Transaction may not define all functions, constructs and standards necessary to implement a conforming system in a real world environment. In particular, an implementer must provide the technical infrastructure and security framework necessary to support operations in accordance with law, regulation, best practices and business agreements.

### 1.2 COPYRIGHT PERMISSIONS

#### COPYRIGHT NOTICE

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### 1.3 REFERENCE DOCUMENTS

A list of key reference documents and background material is provided in the table below. These documents can be retrieved from [www.hitsp.org](http://www.hitsp.org) Web Site.

**Table 1-1 Reference Documents**

Reference Document	Document Description
<a href="#">HITSP Acronyms List</a>	Lists and defines the acronyms used in this document
<a href="#">HITSP Glossary</a>	Provides definitions for relevant terms used by HITSP documents
<a href="#">TN900 - Security and Privacy Technical Note</a>	TN900 is a reference document that provides the overall context for use of the HITSP Security and Privacy constructs
<a href="#">TN903 - Data Architecture</a>	TN903 is a reference document that provides the overall context for use of the HITSP Data Architecture constructs

### 1.4 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.



#### 1.4.1 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 implement all of the required interfaces 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 or Capability with which this construct is associated.

#### 1.4.2 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 interface 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.



## 2.0 TRANSACTION DEFINITION

### 2.1 CONTEXT OVERVIEW

This Patient Health Plan Eligibility Verification Transaction is used to provide the coverage status of an individual by a health plan along with details regarding patient liability for deductible, co-pay and co-insurance amounts for a defined base set of general or specific benefits or services.

Implementations of this HITSP Transaction support the specification as defined by the Accredited Standards Committee (ASC) X12 for the 270 and 271 Transaction Sets Version 004010, and the Insurance Subcommittee X12N Implementation Guide reference number 004010X092 plus its Addenda 004010X092A1. Implementations also support the additional HITSP constraints as defined in Section 2.1.

#### 2.1.1 INTERFACES

Table 2-1 Interfaces

Interface	Description	Used in Component/ Standard	Transaction/Content	T/C 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 270 and 271 Transaction Sets Version 004010, and the Insurance Subcommittee X12N Implementation Guide 004010X092 plus Addenda 004010X092A1	Eligibility Information Request	R
			Eligibility Information Response	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 270 and 271 Transaction Sets Version 004010, and the Insurance Subcommittee X12N Implementation Guide 004010X092 plus Addenda 004010X092A1	Eligibility Information Request	R
			Eligibility Information Response	R

Optionality Legend: "R" for Required, "O" for Optional, or "C" for Conditional

#### 2.1.2 INTERFACE INTERACTIONS

The following sections document the content of the Transaction and the basic process flows that are supported by the Transaction. They describe the underlying events that fulfill the Transaction, the sequence and timing of the events and the specific interfaces involved. Process flow diagrams are provided to illustrate the process relationships.

Figure 2-1 Eligibility Verification Flow Diagram



A patient needs a medication order and this Transaction is used to provide the status of a health plan covering the individual. The eligibility request is initiated via the X12N 270 and the information is returned via the X12N 271 response.

### 2.1.3 CONDITIONS AND ASSUMPTIONS

**Table 2-2 Context**

Assumptions, Pre-conditions, Post-conditions, and Triggers	Type of Context
Individuals are known to various health plans	Pre-condition
It is expected that the security framework under which this Transaction operates is in accordance with the Interoperability Specification that references this construct. Therefore all applicable HITSP Security and Privacy constructs are implemented as required	Pre-condition
Any Eligibility Information Receiver (systems used by physicians, clinics, medication prescribers, etc) that requires patient health plan benefits verification	Trigger
The Eligibility Information Receiver processes the response received from the Eligibility Information Source	Post-condition

#### 2.1.3.1 REQUIRED OUTPUTS

**Table 2-3 Required Output**

Required Output	Format/Usage
The Eligibility Information Receiver provides health plan benefit and coverage information to the user of the system	Via User Interface

### 2.1.4 DATA FLOWS<sup>1</sup>

This Transaction Package specifies one method of managing eligibility verification using the X12N 270/271 Eligibility and Benefits Inquiry and Response Transaction Sets 004010X092 and Addenda 004010X092A1.

TP40-[MSG-1-1]	Implementations of this Transaction <b>SHALL</b> support the specification as defined by the Accredited Standards Committee (ASC) X12 270 and 271 Transaction Sets Version 004010, and the Insurance Subcommittee X12N Implementation Guide reference number 004010X092 plus its Addenda reference number 004010X092A1.
TP40-[MSG-1-2]	Implementations of this Transaction Package <b>SHALL</b> conform to the specifications as defined by Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) <i>Phase I Operating Rules for the X12 270 Request and 271 Response</i>
TP40-[MSG-1-3]	Implementations of this Transaction <b>SHALL</b> conform to the specifications as defined by Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) <i>Phase II Operating Rules #258, <a href="#">Normalizing Patient Last Name Rule</a></i> , for the X12 270 Request and 271 Response
TP40-[MSG-1-4]	Implementations of this Transaction <b>SHALL</b> conform to the specifications as defined by Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) <i>Phase II Operating Rules #259, <a href="#">AAA Error Code Reporting Rule</a></i> for the X12 270 Request and 271 Response
TP40-[MSG-1-5]	Implementations of this Transaction <b>SHALL</b> conform to the specifications as defined by Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) <i>Phase II Operating Rules</i>

<sup>1</sup> This HITSP Transaction constrains certain portions of the X12N 270/271 Implementation Guide. The Implementation Guide contains other capabilities that are outside the scope of this HITSP Transaction.





#260, [Data Content \(270/271\) Rule](#), for the X12 270 Request and 271 Response

Tables below contain additional constraints for the X12N 270/271 Eligibility and Benefits Inquiry and Response Transaction Sets and when applicable a data mapping to HITSP/C154, Data Dictionary.

The ASC X12 Reference column in the tables below follow the format immediately below:

<Transaction Set ID>\_<Loop ID plus suffix>\_<Reference Designator >\_<Data Element Reference Number>

Examples:

270\_2110C\_EQ02-01\_235

270\_2100A\_NM101\_98

Not all segments are in a Loop and not all Loops have a suffix. This format uses an asterisk “\*” to indicate that the segment is not in a Loop.

For example:

270\_\*\_BHT02\_353

This use of an asterisk “\*” is also used for Control Segments ISA/IEA, GS/GE, ST/SE where HITSP constraints may be applied.

For example:

\*\_\*\_ISA05\_I05

**Table 2-4 X12N 270 Data Mapping**

Constraint ID	ASC X12 Reference X12N Industry Defined Name	HITSP Data Element Identifier and Name	Data Source	Destination	Optionality	Additional Specification
T40-[DET1-1]	*_*_GS01_479 Functional Identifier Code	Message Control, Code set N/A	Eligibility Information Receiver	Eligibility Information Source	R	T40-[MC-1-1] <b>SHALL</b> be a value of HS (Eligibility, Coverage or Benefit Inquiry (270))
T40-[DET1-2]	270_*_BHT02_353 Transaction Set Purpose Code	Message Control, Code set N/A	Eligibility Information Receiver	Eligibility Information Source	R	T40-[MC-1-2] <b>SHALL</b> be a value of 13 (Request)
T40-[DET1-3]	270_2100A_NM101_98 Entity Identifier Code	5.03 Health Plan Identification Code	Eligibility Information Receiver	Eligibility Information Source	R	T40-[DE-5.03-1] <b>SHALL</b> be a value of PR (Payer)
T40-[DET1-4]	270_2100A_NM102_1065 Entity Type Qualifier	5.03 Health Plan Identification Code	Eligibility Information Receiver	Eligibility Information Source	R	T40-[DE-5.03-2] <b>SHALL</b> be a value of 2 (Non Person Entity)
T40-[DET1-5]	270_2100A_NM108_66 Identification Code Qualifier	5.03 Health Plan Identification Code	Eligibility Information Receiver	Eligibility Information Source	R	T40-[DE-5.03-3] <b>SHALL</b> be a value of FI (Federal Tax Payer Identifier) or XV (Health Care Financing Administration National PlanID)
T40-[DET1-6]	270_2100B_NM101_98 Entity Identifier Code	4.10 Provider Identifier	Eligibility Information Receiver	Eligibility Information Source	R	T40-[DE-4.10-1] <b>SHALL</b> be a value of 1P (Provider)
T40-[DET1-7]	270_2100B_NM108_66	4.10	Eligibility	Eligibility	R	T40-[DE-4.10-2]



	Identification Code Qualifier	Provider Identifier	Information Receiver	Information Source		<b>SHALL</b> be a value of XX (Health Care Financing Administration National Provider Identifier)
T40-[DET1-8]	270_2100C_NM103_1035 Subscriber Last Name	5.18 Subscriber Name	Eligibility Information Receiver	Eligibility Information Source	R	
T40-[DET1-9]	270_2100C_NM104_1036 Subscriber First Name	5.18 Subscriber Name	Eligibility Information Receiver	Eligibility Information Source	R	
T40-[DET1-10]	270_2100C_NM108_66 Identification Code Qualifier	5.15 Subscriber ID	Eligibility Information Receiver	Eligibility Information Source	R	T40-[DE-5.15-1] <b>SHALL</b> be a value of MI (Member Identification Number)
T40-[DET1-11]	270_2100C_DM02_1251 Subscriber Birth Date	5.19 Subscriber Date of Birth	Eligibility Information Receiver	Eligibility Information Source	R	

Optionality Legend: "R" for Required, "O" for Optional, or "C" for Conditional

**Table 2-5 X12N 271 Data Mapping**

Constraint ID	ASC X12 Reference	HITSP Data Element Identifier and Name	Data Source	Destination	Optionality	Additional Specification
T40-[DET2-1]	*_*_GS01_479 Functional Identifier Code	Message Control, Code set N/A	Eligibility Information Receiver	Eligibility Information Source	R	T40-[MC-2-1] <b>SHALL</b> be a value of HB (Eligibility, Coverage or Benefit Information (271))
T40-[DET2-2]	271_2100A_NM101_98 Entity Identifier Code	5.03 Health Plan Identification Code	Eligibility Information Receiver	Eligibility Information Source	R	T40-[DE-5.03-4] <b>SHALL</b> be a value of PR (Payer)
T40-[DET2-3]	271_2100A_NM102_1065 Entity Type Qualifier	5.03 Health Plan Identification Code	Eligibility Information Receiver	Eligibility Information Source	R	T40-[DE-5.03-5] <b>SHALL</b> be a value of 2 (Non Person Entity)
T40-[DET2-4]	271_2100A_NM108_66 Identification Code Qualifier	5.03 Health Plan Identification Code	Eligibility Information Receiver	Eligibility Information Source	R	T40-[DE-5.03-6] <b>SHALL</b> be a value of FI (Federal Tax Payer Identifier) or XV (Health Care Financing Administration National PlanID)
T40-[DET2-5]	271_2100B_NM101_98 Entity Identifier Code	4.10 Provider Identifier	Eligibility Information Receiver	Eligibility Information Source	R	T40-[DE-4.10-3] <b>SHALL</b> be a value of 1P (Provider)
T40-[DET2-6]	271_2100B_NM108_66 Identification Code Qualifier	4.10 Provider Identifier	Eligibility Information Receiver	Eligibility Information Source	R	T40-[DE-4.10-4] <b>SHALL</b> be a value of XX (Health Care Financing Administration National Provider Identifier)

Optionality Legend: "R" for Required, "O" for Optional, or "C" for Conditional



## 2.2 LIST OF HITSP CONSTRUCTS

Table 2-6 List of HITSP Constructs

Construct Name	Description	Transaction/Content
No applicable constructs		

### 2.2.1 CONSTRUCT DEPENDENCIES

Table 2-7 Construct Dependencies

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

### 2.2.2 ADDITIONAL CONSTRAINTS ON REQUIRED CONSTRUCTS

Table 2-8 Additional Constraints on Required Constructs

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

## 2.3 STANDARDS

### 2.3.1 REGULATORY GUIDANCE

Table 2-9 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. For more information see the Code of Federal Regulations, Title 45, Parts 160, et. Seq

### 2.3.2 SELECTED STANDARDS

Table 2-10 Selected Standards

Standard	Description
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
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



Standard	Description
Accredited Standards Committee (ASC) X12 270 and 271 Transaction Sets Version 004010, and the Insurance Subcommittee X12N Implementation Guide 004010X092 plus Addenda 004010X092A1	Detailed Implementation Guides based on release 004010 of the X12 standard. These Implementation Guides provide details on the use of X12 standard to accomplish specific transaction functions. Some of the Version 004010 Implementation Guides, but not all, have been adopted as Implementation Specifications under HIPAA. 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 with the suffix "A1." Implementation Guide 004010X092A1 describes Transaction Sets for Health Care Eligibility Benefit Inquiry and Response. Implementation Guides are published by Washington Publishing Company. For more information visit <a href="http://www.wpc-edi.com">www.wpc-edi.com</a>
Council for Affordable Quality Health Care (CAQH) Committee on Operating Rules for Information Exchange (CORE) Phase I Operating Rules	Provide agreed-upon business rules and guidelines for using and processing eligibility inquiry and response transactions between providers and health plans; in particular those that have been adopted under HIPAA. For more information visit <a href="http://www.cagh.org">www.cagh.org</a>
Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) Phase II #258 Normalizing Last Name Rule v2.0.0	Provides agreed-upon business rules and guidelines for using and processing eligibility inquiry and response transactions between providers and health plans; in particular those that have been adopted under HIPAA. For more information visit <a href="http://www.cagh.org">www.cagh.org</a>
Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) Phase II #259 AAA Error Code Reporting Rule v2.0.0	Provides agreed-upon business rules and guidelines for using and processing eligibility inquiry and response transactions between providers and health plans; in particular those that have been adopted under HIPAA. For more information visit <a href="http://www.cagh.org">www.cagh.org</a>
Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) Phase II #260 Eligibility Data Content Rule v2.0.0	Provides agreed-upon business rules and guidelines for using and processing eligibility inquiry and response transactions between providers and health plans; in particular those that have been adopted under HIPAA. For more information visit <a href="http://www.cagh.org">www.cagh.org</a>

### 2.3.3 INFORMATIVE REFERENCE STANDARDS

**Table 2-11 Informative Reference Standards**

Standard	Reason for Use
No applicable informative reference standards	



### 3.0 APPENDIX

The following sections include relevant materials referenced throughout this document.

No additional information at this time.



## 4.0 DOCUMENT UPDATES

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

### 4.1 DECEMBER 7, 2007

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

### 4.2 MARCH 19, 2008

The changes in this cycle address the following comments:

- 3048, 3228, 3230, 3231, 3252

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:

- Identified updates to Unified Modeling Language (UML) diagrams
- Defined all constraints to CAQH CORE Phase I Operating Rules
- Added note regarding TP46 use for detailed pharmacy specific benefits
- Made editorial changes based on comments

### 4.3 MARCH 27, 2008

Upon approval by the HITSP Panel on March 27, 2008, this document is now Released for Implementation with one correction. Per the approved motion, the Technical Committee removed the constraint requiring the use of the Federal Tax Identification Number as identifiers in the X12 270/271 messages for the Sender and Receiver (ISA06 and ISA07). This occurred in Table 2-1 and Table 2-7.

### 4.4 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.

### 4.5 AUGUST 29, 2008

This document has been modified to accommodate the requirements specified in the HITSP RDSS56, 58, and 59 documents.

The following changes have been made to the construct:

- Removed "Generic" from all occurrences of construct name
- Modified Transaction Constraints Table 2-1 as follows:
  - Added CORE Phase II Operating Rules # 260, 258, and 259 as constraints
  - Replaced constraint to submit 270 Transaction as a generic health plan coverage inquiry with one requiring one or more EQ segments
- Modified X12N 270/271 Data Mapping Table 2-4 as follows:
  - Added CORE Phase II Operating Rules # 260, 258, and 259 as data mapping specifications
  - Removed requirement for data element 270\_2110C\_EQ01\_1365
  - Added requirement for data segment 270\_2110C\_EQ
- Added HIPAA to Regulatory Guidance Table 2-9
- Added CAQH CORE Phase II Operating Rules # 260, 259, and 258 to Selected Standards Table 2-10



#### **4.6 DECEMBER 10, 2008**

The changes in this construct address the following comments received during the Public Comment and Inspection Testing period (September 29 – October 24, 2008).

- 5046

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

- This document has been modified to add "or acknowledgements" to the 271 Transaction line in Figure 2-1 Eligibility Verification Flow Diagram

Minor editorial changes were made to this construct.

#### **4.7 DECEMBER 18, 2008**

Upon approval by the HITSP Panel on December 18, 2008, this document is now Released for Implementation.

#### **4.8 JUNE 30, 2009**

Minor editorial changes were made to this document. Removed boilerplate text for simplification. The term "actor" was replaced with "interface".

#### **4.9 JULY 8, 2009**

Upon approval by the HITSP Panel on July 8, 2009, this document is now Released for Implementation.

#### **4.10 JANUARY 18, 2010**

The document was updated to the HITSP Transaction Template Version 2.7.

In general, numerous modifications were made to be consistent with TN903 - Data Architecture.

- A reference was added in Table 1-1 for HITSP/TN903
- Globally changes were made to correct a typo where 004010X092A1 was incorrectly referenced as 004010X92A1. Additional global changes were made to be consistent with X12 nomenclature when that information speaks directly about X12 data elements and X12 structures.
- Deleted Table 2.1 as it became duplicative
- Moved the CAQH CORE constraints to become message constraints in section 2.1.5
- After removing Table 2-1 and moving the CAQH CORE constraints out of Table 2-6, split what had become Table 2-4 into two tables, one for the eligibility request, Table 2-4 and another for the response, Table 2-5
- Rows were removed from what are now Table 2-4 and Table 2-5. When the Harmonization Request changed from being rather narrow to an expansion to cover eligibility verification in general, there were fewer constraints necessary. Additionally, X12 syntax requires certain information based on the presence of other information. When HITSP requires, for example, the Subscriber's Date of Birth, it is not necessary for HITSP to also require the qualifier that specifies the date's format because X12 syntax does

#### **4.11 JANUARY 25, 2010**

Upon approval by the HITSP Panel on January 25, 2010, this document is now Released for Implementation.

