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HITSP Patient Health Plan Eligibility Verification Transaction

HITSP/T40

Submitted to:

Healthcare Information Technology Standards Panel

Submitted by:

Administrative and Financial Domain Technical Committee

DOCUMENT CHANGE HISTORY

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FIGURES AND TABLES

1.0 INTRODUCTION

1.1 OVERVIEW

The 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 standards version 4010, using the Insurance Subcommittee X12N Implementation Guides reference number 004010X92 plus an Addenda reference number 004010X92A1. 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 standards for the exchange of the HIPAA-adopted X12N 270/271 Eligibility and Benefit Inquiry and Response Transactions 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 transactions 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 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

1.3 REFERENCE DOCUMENTS

This section provides a list of key reference documents and background material.

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

Table 1-1 Reference Documents

Reference Document	Document Description
HITSP Acronyms List	Lists and defines the acronyms used in this document
HITSP Glossary	Provides definitions for relevant terms used by HITSP documents
TN900 - Security and Privacy Technical Note	TN900 is a reference document that provides the overall context for use of the HITSP Security and Privacy 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 a 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 Transaction shall support the specification as defined by the Accredited Standards Committee (ASC) X12 for the 270 and 271 transaction standards version 4010, using the Insurance Subcommittee X12N Implementation Guides reference number 004010X92 plus its Addenda 004010X92A1. Implementations also shall support the additional HITSP constraints as defined in Section 2.1.

2.1.1 TRANSACTION CONSTRAINTS[1]

The table identifies the constraints at a high level. The actual requirements are in Section 2.1.6, Table 2-7 X12N 270/271 Data Mapping.

Table 2-1 Transaction Constraints

Constraint	Constraint Section
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	
For 270 the BHT02-353 Transaction Set Purpose Code shall be "13" for Request	
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)	
For both 270/271 the Information Source shall be the Payer and shall be identified using either code "FI" for Federal Tax Payer Identifier or code "XV" for Healthcare Financing Administration Payer Identifier Number (which then requires the Identification Code)	
Shall be implemented as defined by the Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) Phase I Operating Rules, the Phase II #260 Eligibility Data Content Rule v2.0.0, the Phase II #259 AAA Error Code Reporting Rule v2.0.0, and the Phase II #258 Normalizing Last Name Rule v2.0.0	
The 270 shall contain one or more EQ segment each of which contains either EQ01 or EQ02	
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	
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	

[1] This Transaction is constrained to health plan benefits coverage, including whether or not a health plan covering the individual includes a pharmacy benefit. Detailed pharmacy specific benefits coverage is handled in the HITSP/TP46 Medication Formulary and Benefits Information Transaction Package.

2.1.2 INTERFACES

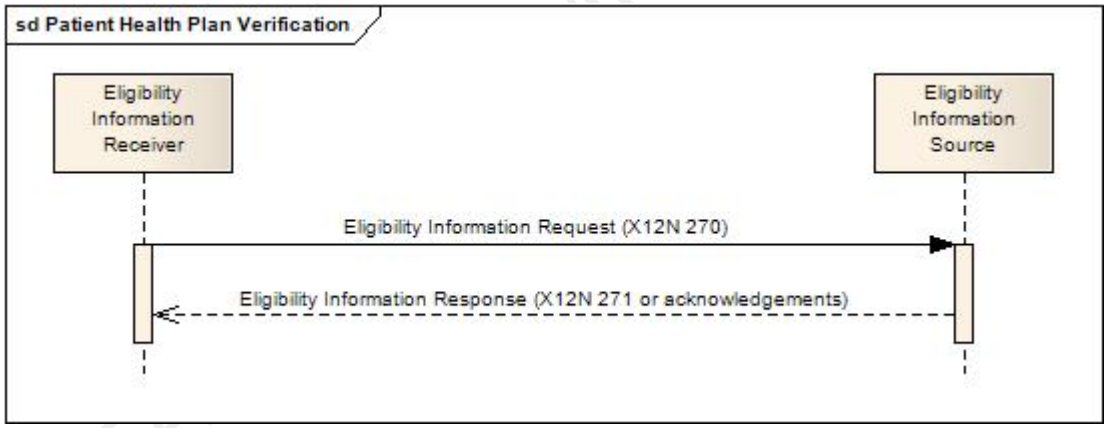
Table 2-2 Interfaces

Interface	Description	Used in Component/ Standard	Transaction/Content	Optionality[2]
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 standards version 4010, and the Insurance Subcommittee X12N Implementation Guides 004010X92 plus Addenda 004010X92A1	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 standards version 4010, and the Insurance Subcommittee X12N Implementation Guides 004010X92 plus Addenda 004010X92A1	Eligibility Information Request	R
			Eligibility Information Response	R

2.1.3 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] Optionality = "R" for Required, or "O" for Optional, or "C" for Conditional. If applicable, conditional footnotes are further described below.

2.1.4 PRE-CONDITIONS

Table 2-3 Pre-conditions

Pre-condition
Individuals are known to various health plans
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

2.1.4.1 PROCESS TRIGGERS

Table 2-4 Process Triggers

Process Trigger
Any Eligibility Information Receiver (systems used by physicians, clinics, medication prescribers, etc) that requires patient health plan benefits verification

2.1.5 POST-CONDITIONS

Table 2-5 Post-conditions

Post-condition
The Eligibility Information Receiver processes the response received from the Eligibility Information Source

2.1.5.1 REQUIRED OUTPUTS

Table 2-6 Required Outputs

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

2.1.6 DATA FLOWS[3]

Below are the data mappings and constraints for the X12N 270/271 Eligibility and Benefits Inquiry and Response Transactions 004010X92 and Addenda 004010X92A1. The first HITSP constraint is that transactions shall follow the CORE Phase I and Phase II Rules constraints as defined in the CORE Phase I and Phase II Operating Rules documents which are available at www.caqh.org. Additional HITSP constraints are also defined.

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

Not all segments are in a loop (segment group); thus <loopid> cannot always be specified. This legend uses an asterisk "*" to designate no <loopid> is applicable.

[3] 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 transaction.

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 2-7 X12N 270/271 Data Mapping

Category	Data Element	Description	Limit/Range of values	Data Source	Destination	Requirements / Pre-conditions[4]	Additional Specification for Component
NA	CORE Phase I Rules	Operating Rules	NA	Eligibility Information Receiver And Eligibility Information Source	Eligibility Information Receiver And Eligibility Information Source	R	As defined by Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) Phase I Operating Rules http://www.caqh.org Shall be applied for 270 Request and 271 Response
	CORE Phase II # 258	Normalizing Last Name Rule Version 2.0.0	NA	Eligibility Information Receiver And Eligibility Information Source	Eligibility Information Receiver And Eligibility Information Source	R	As defined by Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) Phase II Operating Rules http://www.caqh.org Shall be applied for 270 Request and 271 Response
	CORE Phase II # 259	AAA Error Code Reporting Rule Version 2.0.0	NA	Eligibility Information Receiver And Eligibility Information Source	Eligibility Information Receiver And Eligibility Information Source	R	As defined by Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) Phase II Operating Rules http://www.caqh.org Shall be applied for 270 Request and 271 Response
	CORE Phase II # 260	Eligibility Data Content Rule Version 2.0.0	NA	Eligibility Information Receiver And Eligibility Information Source	Eligibility Information Receiver And Eligibility Information Source	R	As defined by Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) Phase II Operating Rules http://www.caqh.org Shall be applied for 270 Request and 271 Response

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

Category	Data Element	Description	Limit/Range of values	Data Source	Destination	Requirements / Pre-conditions[4]	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	PR - Payer	Eligibility Information Receiver	Eligibility Information Source	R	Shall be a value of PR
	270_2100A_NM102 1065	Entity Type Qualifier	2 - Non Person Entity	Eligibility Information Receiver	Eligibility Information Source	R	Shall be a value of 2
	270_2100A_NM108_66	Identification Code Qualifier	FI - Federal Tax Payer Identifier or XV - Healthcare Financing Administration National Payer Identifier Number	Eligibility Information Receiver	Eligibility Information Source	R	Shall be a value of FI 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)

Category	Data Element	Description	Limit/Range of values	Data Source	Destination	Requirements / Pre-conditions[4]	Additional Specification for Component
	270_2100C_NM103 1035	Name Last	NA	Eligibility Information Receiver	Eligibility Information Source	R	NA
	270_2100C_NM104 1036	Name First	NA	Eligibility Information Receiver	Eligibility Information Source	R2	NA
	270_2100C_NM108 66	Identification Code Qualifier Description	MI - Member Identification Number	Eligibility Information Receiver	Eligibility Information Source	R	Shall be a value of MI NOTE: By requiring this data element, data element NM109 is required (Identification Code Description)
	270_2100C_DMG01 1250	Date Time Period Format Qualifier	D8 - CCYYMMDD	Eligibility Information Receiver	Eligibility Information Source	R	Shall be a value of D8
	270_2100C_DMG02 1251	Date Time Period (Subscriber Birth Date)	NA	Eligibility Information Receiver	Eligibility Information Source	R	Shall be the Subscriber Birth Date
	270_2110C_EQ	Subscriber Eligibility Information Segment	NA	Eligibility Information Receiver	Eligibility Information Source	R	Must contain one or more EQ segment each of which contains either EQ01 or EQ02
271 Response	*_ *_GS01_479	Functional Identifier Code	HB - Eligibility, Cover, or Benefit Information (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
	271_2100A_NM101 98	Entity Identifier Code	PR - Payer	Eligibility Information Source	Eligibility Information Receiver	R	Shall be a value of PR
	271_2100A_NM102 1065	Entity Type Qualifier	2 - Non Person Entity	Eligibility Information Source	Eligibility Information Receiver	R	Shall be a value of 2

Category	Data Element	Description	Limit/Range of values	Data Source	Destination	Requirements / Pre-conditions[4]	Additional Specification for Component
	271_2100A_NM108_66	Identification Code Qualifier	FI - Federal Tax Payer Identifier or XV - Healthcare Financing Administration National Payer Identifier Number	Eligibility Information Source	Eligibility Information Receiver	R	Shall be a value of FI 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 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)

2.2 LIST OF HITSP CONSTRUCTS

Table 2-8 List of HITSP Constructs

Construct Name	Interfaces	Description	Event/Action Code	Content
No applicable constructs				

2.2.1 CONSTRUCT DEPENDENCIES

Table 2-9 Construct Dependencies

Construct	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 2-10 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

2.3.1 REGULATORY GUIDANCE

Table 2-11 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 2-12 Selected Standards

Standard	Description
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
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. Implementation Guides are published by Washington Publishing Company. For more information visit www.wpc-edi.com

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 healthcare 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 healthcare 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 healthcare products and services. This standard is required by HIPAA
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 www.caqh.org
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 www.caqh.org
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 www.caqh.org
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 www.caqh.org

2.3.3 INFORMATIVE REFERENCE STANDARDS

Table 2-13 Informative Reference Standards

Standard	Description
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 2-7 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 2-11
- Added CAQH CORE Phase II Operating Rules # 260, 259, and 258 to Selected Standards Table 2-12

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.