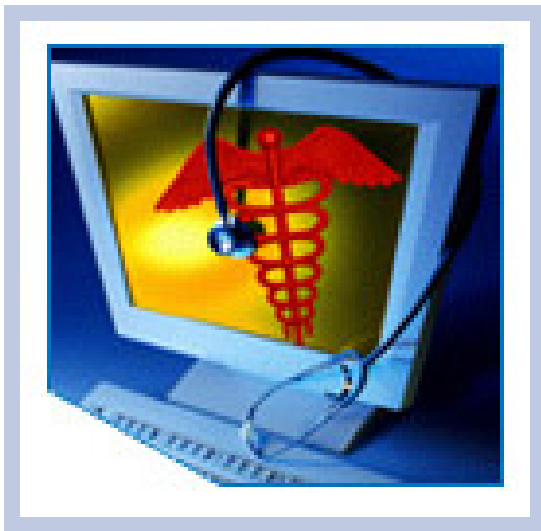


# HITSP Patient Generic Health Plan Eligibility Verification Transaction

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HITSP/T40



*Submitted to:*

**Healthcare Information Technology Standards Panel**

*Submitted by:*

**Care Delivery Technical Committee**



## DOCUMENT CHANGE HISTORY

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## 1.0 INTRODUCTION

As an introduction to the HITSP Patient Generic Health Plan Eligibility Verification Transaction, 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 this specification, acknowledges the copyright protections that pertain and provides links to key reference documents and background material. If you are already familiar with this information, proceed to Section 2.0 Transaction Definition.

### 1.1 OVERVIEW

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

This HITSP Patient Generic Health Plan Eligibility Verification Transaction is intended to provide the status of a health plan covering the individual, along with details regarding patient liability for deductible, co-pay and co-insurance amounts for a defined base set of Generic benefits or services. The base set of benefits includes, but is not limited to, coverage status and patient liability for medical, chiropractic, dental, hospital inpatient, hospital outpatient, emergency, professional physician office visit, pharmacy and vision services that are included in the patient's generic health plan benefit.

To support "Patient Generic Health Plan Eligibility Verification," HITSP is using the Accredited Standards Committee (ASC) X12 Insurance Subcommittee X12N Implementation Guides Version 004010 plus Addenda 004010A1. This X12N Implementation Guide is also being constrained by HITSP via the CAQH CORE Phase I Operating Rules for the ASC X12 270/271 Eligibility and Benefits Inquiry and Response. The CAQH CORE Phase I Operating Rules facilitate 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 the interoperable 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). The CAQH CORE Phase I Operating Rules include requirements for minimum 271 Eligibility and Benefit Response content, round-trip inquiry-to-response time, systems availability and the use of the ASC X12 Standard Acknowledgements for the Interchange (TA1) and Functional Group (997) to report errors and rejected transactions.

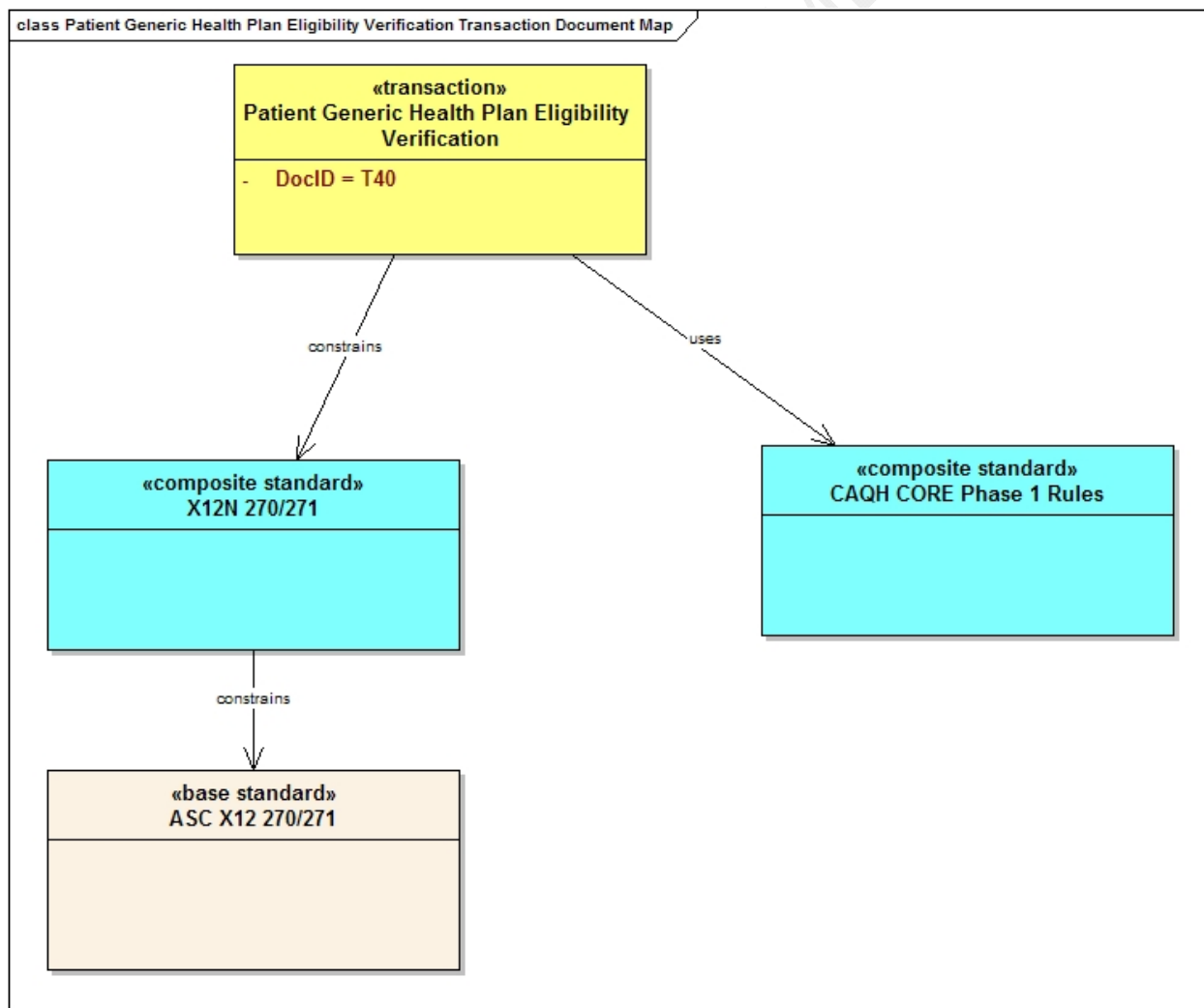
This Transaction may not define all functions, constructs and standards necessary to implement a conforming system in a real world environment. In particular, an implementer must provide the technical infrastructure and security framework necessary to support operations in accordance with law, regulation,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



## 1.2 TRANSACTION DOCUMENT MAP

Each HITSP Interoperability Specification (IS) is comprised of a suite of constructs that, taken as a whole, define how to integrate and constrain existing standards and specifications that will satisfy the requirements imposed by a given Use Case. There are four types of HITSP constructs called Interoperability Specifications (IS), Transaction Packages (TP), Transactions (T), and Components (C). The current Patient Generic Health Plan Eligibility Verification Transaction specification 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. The document map in Figure 1.2-1 depicts how this construct integrates and constrains HITSP constructs and existing standards selected, constrained, or referenced to support the logical grouping of actions that must all succeed or fail as a group, within the defined context of this document. Implementers should read the documents that describe the constructs represented in the diagram for their details and specific uses.

Figure 1.2-1 Transaction Document Map



## 1.3 COPYRIGHT PERMISSIONS

### COPYRIGHT NOTICE

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Materials reproduced from the Accredited Standards Committee (ASC) X12 Insurance Subcommittee (X12N) Implementation Guide entitled Healthcare Eligibility Benefit Inquiry and Response Version 004010 plus Addenda 004010A1 with permission of Washington Publishing Company (WPC). Copies of the Implementation Guide may be purchased from WPC at [www.wpc-edi.com](http://www.wpc-edi.com).

No part of the material may be copied or reproduced in any form outside of the Interoperability Specification documents, including an electronic retrieval system or made available on the Internet without the prior written permission of WPC. Material drawn from these standards is credited where used.

Committee on Operating Rules for Information Exchange (CORE) materials used in this document have been extracted from relevant copyrighted materials with permission of the Council for Affordable Quality Healthcare (CAQH). Copies of this standard are available from the CAQH Web Site at [www.caqh.org](http://www.caqh.org).

## 1.4 REFERENCE DOCUMENTS

This section contains links to key reference documents and background material.

The HITSP Interoperability Specification Overview provides the 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.

The conventions that are used to convey the full descriptions and usage of standards in the HITSP specifications are contained in the HITSP Conventions List.

The acronyms used in this document are contained in the HITSP Acronyms List.

The HITSP Glossary provides definitions for relevant terms used by HITSP documents.



The HITSP Harmonization Framework describes the current framework within which the Interoperability Specifications are built.

A Technical Note, TN900 - Security and Privacy, has been developed as a reference document to provide the overall context for use of the HITSP Security and Privacy constructs. It includes the following:

- 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

HITSP will periodically update this Technical Note as required by the introduction of new contexts for use.





## 2.0 TRANSACTION DEFINITION

Transactions are a logical grouping of actions, including necessary content and context that must all succeed or fail as a group.

### 2.1 CONTEXT OVERVIEW

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

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

Implementations of this Transaction shall support the specification as defined by the Accredited Standards Committee (ASC) X12 Insurance Subcommittee X12N Implementation Guides Version 004010 plus Addenda 004010A1. Additionally implementations shall support the additional HITSP constraints as defined in Section 2.1.1

#### 2.1.1 TRANSACTION CONSTRAINTS

This section describes the constraints that limit the context in which the Transaction 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 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: This Transaction is constrained to generic 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

**Table 2.1.1-1 Transaction Constraints**

Constraint	Constraint Section
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	



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	
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 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)	
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	
The 270 shall be submitted as a "generic" health benefit plan coverage inquiry by a single occurrence of the EQ segment in which the EA01-1365 shall contain the value "30" for Health Benefit Plan Coverage	

### 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. 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, 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 Version 004010 plus Addenda 004010A1.	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 Version 004010 plus Addenda 004010A1.	Eligibility Information Response	R

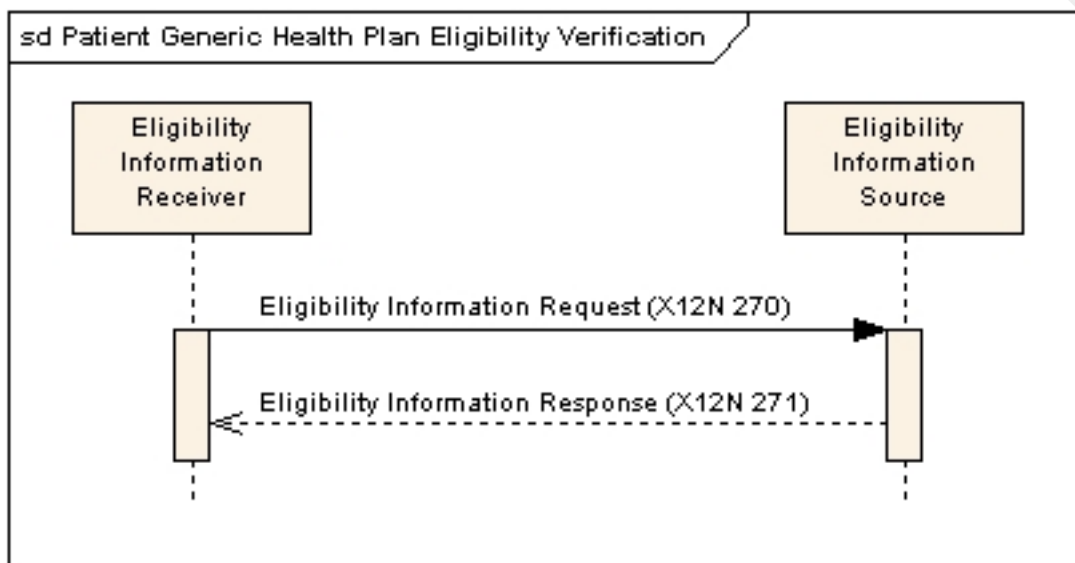
**NOTE:** \*Optionality = "R" for Required, or "O" for Optional, or "C" for Conditional. If applicable, conditional footnotes are further described below.



### 2.1.3 ACTOR 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 actors involved. Process flow diagrams are provided to illustrate the process relationships.

Figure 2.1.3-1 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.

### 2.1.4 PRE-CONDITIONS

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

Table 2.1.4-1 Pre-conditions

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.
Individuals are known to various health plans.



#### 2.1.4.1 Process Triggers

This section describes the process triggers, including actors and/or processes, which are necessary to start the Transaction. They can invoke an automatic or manual process or result that, in turn, starts off the Transaction. A process 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 Receiver (systems used by physicians, clinics, medication prescribers, etc) that requires patient generic health plan benefits verification.

#### 2.1.5 POST-CONDITIONS

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

**Table 2.1.5-1 Post-conditions**

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

##### 2.1.5.1 Required Outputs

This section identifies the required outputs that must be produced at the end of the Transaction in order for the Transaction 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 Receiver provides health plan benefit and coverage 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. It describes the specific data mapping requirements and constraints for the Transaction.

Below are the data mappings and constraints for the X12N 270/271 Eligibility and Benefits Inquiry and Response Transactions version 004010 and Addenda 004010A1. The first HITSP constraint is that transactions shall follow the CORE Phase I Rules constraints as defined in the CORE Phase I Operating Rules documents which are available at [www.caqh.org](http://www.caqh.org). Additional HITSP constraints are also defined.



Note: 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.

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.

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 2.1.6-1 X12N 270/271 Data Mapping**

Data Element	Description	Limit/Range of values	Data Source	Destination	Requirements/ Pre-conditions*	Additional Specification for Component
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 <a href="http://www.cagh.org">http://www.cagh.org</a>  Shall be applied for 270 Request and 271 Response
<b>270 Request</b>						
*_*_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



Data Element	Description	Limit/Range of values	Data Source	Destination	Requirements/ Pre-conditions*	Additional Specification for Component
* _ _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_NM10198	Entity Identifier Code	PR - Payer	Eligibility Information Receiver	Eligibility Information Source	R	Shall be a value of PR
270_2100A_NM1021065	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_NM10198	Entity Identifier Code	1P - Provider	Eligibility Information Receiver	Eligibility Information Source	R	Shall be a value of 1P
270_2100B_NM10866	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_NM1031035	Name Last		Eligibility Information Receiver	Eligibility Information Source	R	
270_2100C_NM1041036	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_NM10866	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_DMG011250	Date Time Period Format Qualifier	D8 - CCYYMMDD	Eligibility Information Receiver	Eligibility Information Source	R	Shall be a value of D8
270_2100C_DMG021251	Date Time Period (Subscriber Birth Date)		Eligibility Information Receiver	Eligibility Information Source	R	Shall be the Subscriber Birth Date
270_2110C_EQ01_1365	Service Type Code	30 - Health Benefit Plan Coverage	Eligibility Information Receiver	Eligibility Information Source	R	Shall be a value of 30
<b>271 Response</b>						
* _ _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_NM10198	Entity Identifier Code	PR - Payer	Eligibility Information Source	Eligibility Information Receiver	R	Shall be a value of PR
271_2100A_NM1021065	Entity Type Qualifier	2 - Non Person Entity	Eligibility Information Source	Eligibility Information Receiver	R	Shall be a value of 2



Data Element	Description	Limit/Range of values	Data Source	Destination	Requirements/ Pre-conditions*	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_NM10198	Entity Identifier Code	1P - Provider	Eligibility Information Source	Eligibility Information Receiver	R	Shall be a value of 1P
271_2100B_NM10866	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)

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

## 2.2 LIST OF HITSP CONSTRUCTS

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

**Table 2.2-1 List of HITSP Constructs**

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

### 2.2.1 CONSTRUCT DEPENDENCIES

The following table shows a list of Components with their existing dependencies. Dependencies usually exist when there are some additional prerequisites for a specific construct:

**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 (Reason for this dependency)
No applicable 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.

**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 LIST OF 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 following standards are used to implement this Transaction specification:

**Table 2.3-1 List of Standards**

Standard	Description
Accredited Standards Committee (ASC) X12 Insurance Subcommittee (X12N) Implementation Guides Version 004010 plus Addenda 004010A1	Detailed Implementation Guides based on release 004010 of the ASC 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. Many of the version 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 Guides 004010X092 and 004010X092A1 describe transactions for Healthcare 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> .
Accredited Standards Committee (ASC) X12 Standards Release 004010	Release (version) 004010 of the Accredited Standards Committee (ASC) X12 standards including the X12.5 Interchange Control, X12.6 Application Control Structure, 270 Eligibility, Coverage or Benefit Inquiry, 271 Eligibility, Coverage or Benefit Information and other control standards for the uniform electronic interchange of business transactions. Published by the Data Interchange Standards Association (DISA). For more information visit <a href="http://www.x12.org">www.x12.org</a> .
Council for Affordable Quality Healthcare (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.caqh.org">www.caqh.org</a> .



## 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.



## 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:

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 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

### 5.3 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 Tables 2.1.1-1 and 2.1.6-1.

