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HIPAA Eligibility Transaction System (HETS)
Health Care Eligibility Benefit Inquiry and Response
(270/271)
Companion Guide

Final

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DISCLOSURE STATEMENT

The Centers for Medicare & Medicaid Services (CMS) is committed to maintaining the integrity and security of health care data in accordance with applicable laws and regulations. Disclosure of Medicare Beneficiary eligibility data is restricted under the provisions of the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Provider Medicare Beneficiary eligibility transaction is to be used for conducting Medicare business only.

PREFACE

This companion guide to the Accredited Standards Committee (ASC) X12 270/271 version 004010X092A1 Implementation Guide (IG), adopted under HIPAA, clarifies and specifies the data content when exchanging Medicare Beneficiary eligibility data electronically with CMS utilizing the Health Insurance Portability and Accountability Act (HIPAA) Eligibility Transaction System (HETS) 270/271 application. Transmissions based on this companion guide, used in tandem with the X12 270/271 IG, are compliant with both X12 syntax and the IG. This companion guide is intended to convey information that is within the framework of the ASC X12 implementation guides adopted for use under HIPAA.

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1 INTRODUCTION

1.1 SCOPE

This document defines the Medicare HIPAA compliant eligibility request sent from Medicare authorized Submitters and the corresponding response from the Medicare Health Insurance Portability and Accountability Act (HIPAA) Eligibility Transaction System (HETS) 270/271 application. To implement the HIPAA administrative simplification provisions, the 270/271 transaction set has been named under 45 CFR 162 as the Electronic Data Interchange (EDI) standard for Health Care Eligibility Benefit Inquiry/Response.

The HETS 270/271 application is based on the ASC X12 270/271 version 004010X092A1 IG that can be found at the following web site: <http://www.wpc-edi.com/HIPAA>. The 270 request and the 271 response are "paired" transactions. The 270 is an inbound eligibility request; whereas, the 271 is an outbound eligibility response.

This companion guide has two purposes. The first purpose is to educate the user on how to access the HETS 270/271 application. The second purpose is to educate the user on how to send eligibility requests and interpret responses, using the 270/271 formats, as they relate to the applicable Medicare required business rules and information.

1.2 APPLICATION OVERVIEW

The HETS 270/271 application provides access to Medicare Beneficiary eligibility data in a real-time environment. Providers, Clearinghouses, and/or Third Party Vendors, herein referred to as "Trading Partners", may initiate a real-time 270 eligibility request to query coverage information from Medicare on patients for whom services are scheduled or have already been delivered. In real-time mode, the Trading Partner transmits a 270 request and remains connected while the receiver processes the transaction and returns a 271 response.

The HETS 270/271 application is located at a secure CMS data center, which is available via the CMS Extranet. This extranet is a secure closed private network currently used to transmit data between CMS and their authorized contractors. Trading Partners must not send User IDs and passwords within the 270 eligibility transaction.

For a real-time 270 request, the HETS 270/271 application translates the incoming 270 request, performs validations, requests Medicare Beneficiary eligibility data from the CMS eligibility database, and creates an Eligibility Response (271), a Functional Acknowledgement (997), an Interchange Acknowledgement (TA1), or a proprietary error response.

The information included in the 271 response is not intended to provide a complete representation of all benefits, but rather to address the status of eligibility (active or inactive) and patient financial responsibility for Medicare Part A and Part B.

The data included in a 271 response file is to be considered true and accurate only at the particular time of the transaction. Questions regarding eligibility/benefit data for Medicare Part A and Part B should be directed to the appropriate regional Medicare Administrative Contractor (MAC). Eligibility/benefit questions about Medicare Advantage (MA), Part D and Medicare Secondary Payer (MSP) should be directed to the appropriate plan(s) identified in the 271 response.

1.3 REFERENCES

- ASC X12 270/271 version 004010X092A1 IG – <http://www.wpc-edi.com>

Note: The ASC X12 270/271 version 004010X092A1 IG can be purchased from the publisher.

- Trading Partner Agreement and 270/271 Access Request Form can be completed by clicking “OK” at the following link and then following the instructions provided – http://www.cms.gov/AccessstoDataApplication/03_MedBenEligInq.asp

1.4 ADDITIONAL INFORMATION

CMS is committed to maintaining the integrity and security of health care data in accordance with applicable laws and regulations. Disclosure of Medicare Beneficiary eligibility data is restricted under the provisions of the Privacy Act of 1974 and HIPAA.

CMS implemented the HETS 270/271 application following a real-time request/response model (single response per request). The data available in this implementation allows a Provider to verify an individual’s Medicare eligibility and benefits. Medicare eligibility data is only to be used for the business of Medicare; such as preparing an accurate Medicare claim or determining eligibility for specific services. Providers’ authorized staff are expected to use and disclose protected health information according to the CMS regulations.

CMS monitors Medicare Beneficiary eligibility inquiries. Trading Partners identified as having aberrant behavior (e.g., high inquiry error rate or high ratio of eligibility inquiries to claims submitted) may be contacted to verify and/or address improper use of the system or, when appropriate, be referred for investigation.

1.4.1 Authorized Purposes for Requesting Medicare Beneficiary Eligibility Information

In conjunction with the intent to provide health care services to a Medicare Beneficiary, authorized purposes include to:

- Verify eligibility, after screening the patient to determine Medicare eligibility, for Part A and/or Part B coverage
- Determine Medicare Beneficiary payment responsibility with regard to deductible/co-payment
- Determine eligibility for other services, such as preventive
- Determine if Medicare is the primary or secondary payer
- Determine if the Medicare Beneficiary is in the original Medicare plan, MA plan or Part D plan
- Determine proper billing

1.4.2 Unauthorized Purposes for Requesting Medicare Beneficiary Eligibility Information

The following are examples of unauthorized purposes for requesting Medicare Beneficiary eligibility information:

- To determine eligibility for Medicare without first screening the patient to determine if they are Medicare eligible
- To acquire the Medicare Beneficiary's Health Insurance Claim Number (HICN)

1.4.3 Note to Medicare Providers/Suppliers:

The Medicare Beneficiary should be the first source of health insurance eligibility information. When scheduling a medical appointment for a Medicare Beneficiary, remind them to bring, on the day of their appointment, all health insurance cards showing their health insurance coverage. This will not only help you determine who to bill for services rendered, but also give you the proper spelling of the Medicare Beneficiary's first and last name and identify their HICN as reflected on the Medicare Health Insurance card. If the Medicare Beneficiary has Medicare coverage but does not have a Medicare Health Insurance card, encourage them to contact the Social Security Administration at 1-800-772-1213 to obtain a replacement Medicare Health Insurance card. Those beneficiaries receiving benefits from the Railroad Retirement Board (RRB) can call 1-800-808-0772 to request a replacement Medicare Health Insurance card from RRB.

It is assumed that the reader of this document is familiar with the X12 270/271 IG and the transaction format and content rules contained within it. This companion guide is intended to be a complement to the IG and not the sole authoritative source of data.

2 GETTING STARTED

2.1 WORKING WITH THE CMS HELP DESK

The Medicare Customer Assistance Regarding Eligibility (MCARE) Help Desk is available to assist with this process Monday – Friday, from 7:00 AM to 7:00 PM ET. MCARE is the single point of contact for all questions or concerns about the HETS 270/271 application. Potential Trading Partners must contact MCARE to initiate the registration process.

Please refer to [Section 5](#) of this companion guide for MCARE contact information.

2.2 TRADING PARTNER REGISTRATION

To obtain access to the HETS 270/271 application via the CMS Extranet, a potential Trading Partner must access the appropriate forms located on the CMS HETS Help website.

Instructions to complete the sign-up process can be found at the following link:

http://www.cms.gov/HETSHelp/05_HowtoGetConnectedHETS270271.asp

2.3 CERTIFICATION AND TESTING OVERVIEW

Trading Partners are required to submit test transactions to ensure that their systems are HIPAA and X12 compliant. Each Trading Partner may submit up to 50 test transactions during the testing phase. Trading Partners must contact MCARE to coordinate testing procedures.

Please refer to [Section 5](#) of this companion guide for MCARE contact information.

3 TESTING

CMS requires that all newly registered Trading Partners work with MCARE to complete basic transaction submission testing. Successful transaction submission and receipt of both valid and error responses is an indication to CMS that all systems involved can properly submit and receive transactions. MCARE is available to assist with new Trading Partner testing Monday – Friday, from 9:00 AM to 5:00 PM ET.

Trading Partners must send all test transactions with Usage Indicator (ISA15) = “T” until approved to submit production transactions with a Usage Indicator (ISA15) = “P”. The HETS 270/271 application will return a TA105 = “020” error for an Invalid Test Indicator Value if the incorrect value is included within this field.

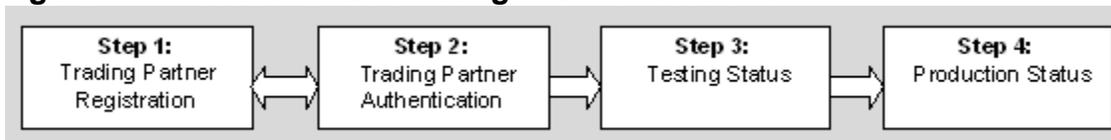
Please refer to [Section 5](#) of this companion guide for MCARE contact information.

4 CONNECTIVITY/COMMUNICATIONS

4.1 PROCESS FLOWS

To access the HETS 270/271 application via the CMS Extranet connection, potential Trading Partners need to obtain a Submitter ID through MCARE. Figure 1 illustrates the high level process for successfully registering as a Trading Partner and submitting 270 transactions:

Figure 1 – Process for Submitting 270 Transactions



Step 1: Trading Partner Registration

Complete and submit the Trading Partner Agreement and 270/271 Access Request Form for the Submitter ID Request. Refer to [Section 2.2](#) of this companion guide for the Trading Partner registration process.

Step 2: Trading Partner Authentication

MCARE will verify the information on the Trading Partner Agreement and 270/271 Access Request Form and approve or deny any Submitter ID requests.

Step 3: Testing Phase

MCARE will have a Trading Partner send up to 50 test transactions and verify that all systems involved can properly submit and receive HIPAA and X12 compliant transactions. The Usage Indicator (ISA15) must be “T”.

Step 4: Production Phase

Once testing is complete, a Trading Partner can begin to submit 270 transactions and receive 271 transactions in the Production environment. The Usage Indicator (ISA15) must be “P”.

4.2 TRANSMISSION ADMINISTRATIVE PROCEDURES

4.2.1 Schedule, Availability, and Downtime Notification

The HETS 270/271 application is available 24 hours a day, 7 days a week, with the exception of 12:00 AM – 5:00 AM Monday ET when system maintenance is performed. MCARE will notify the Trading Partners of any additional planned downtime. All current and archived downtime notifications are available via the CMS HETS Help website: <http://www.cms.gov/HETSHelp/>.

Any unplanned downtime with the HETS 270/271 application will also be communicated to the Trading Partners via email and posted to the HETS Status website:

<http://www.hetsstatus.com> as soon as MCARE is aware of the situation. A second

follow-up email will also be sent alerting the Trading Partners when the HETS 270/271 application becomes available.

Please refer to [Section 5](#) of this companion guide for MCARE contact information.

4.2.2 Re-Transmission Procedure

Trading Partners may call MCARE for assistance in researching problems with their transactions. However, MCARE will not edit Trading Partner eligibility data and/or resubmit transactions for processing on behalf of a Trading Partner. The Trading Partner must correct the file and resubmit, following the same processes and procedures of the original file.

4.3 COMMUNICATION PROTOCOL SPECIFICATIONS

Communications through the CMS Extranet to the HETS 270/271 application are via the TCP/IP transfer protocol. Trading Partners must initiate the TCP handshake to establish a TCP/IP socket connection at the CMS data center. Trading Partners should only request to open a TCP/IP socket connection as necessary to support their active eligibility requests.

The 270 transaction must be sent to the connected socket session immediately after Trading Partners have successfully negotiated the socket, and the 271 response will be received on the same socket connection. Trading Partners may choose to implement a client that can listen to the same socket session for a 271 response while 270 requests are being streamed. Trading Partners should monitor the TCP/IP socket connection while connected to ensure that the socket remains open and viable. Trading Partners should be able to determine if a socket has prematurely terminated for any reason.

Trading Partners should only submit one transaction concurrently per socket. Transactions process linearly; therefore, submitting more than one transaction per socket concurrently results in additional transactions queuing and delaying response time to the additional transactions.

CMS recommends that high volume Trading Partners send transactions asynchronously, that is, streaming multiple sequential requests via the single socket connection. If transactions are submitted asynchronously, Trading Partners should submit the next 270 request as soon as the response to the previous request is received. Asynchronous Trading Partners may open multiple sockets, if necessary, to support transaction volume during high volume periods.

Sending 270 requests asynchronously also improves socket efficiency. There are a finite number of available HETS 270/271 sockets, so Trading Partners should limit the number of simultaneous connections the HETS 270/271 application.

When the last requested 271 response has been received, Trading Partners should close the socket connection immediately using a TCP handshake. The HETS 270/271

application is configured to idle connections, but only after a 5-second delay to determine if additional requests will be sent. Trading Partners will greatly improve overall socket availability if they forcefully terminate all socket requests when their transactions are complete.

Each submitted transmission must contain one 270 request with only one Interchange Control Envelope, along with a transmission wrapper, around the 270 request. The purpose of the transmission wrapper is to communicate the length of the transaction message and to indicate the end of the transmission to the HETS 270/271 application.

The outbound response transaction wrapper has the same format as the inbound transmission wrapper. The 271 response to the Submitter will be returned in the same session in which the 270 request was submitted.

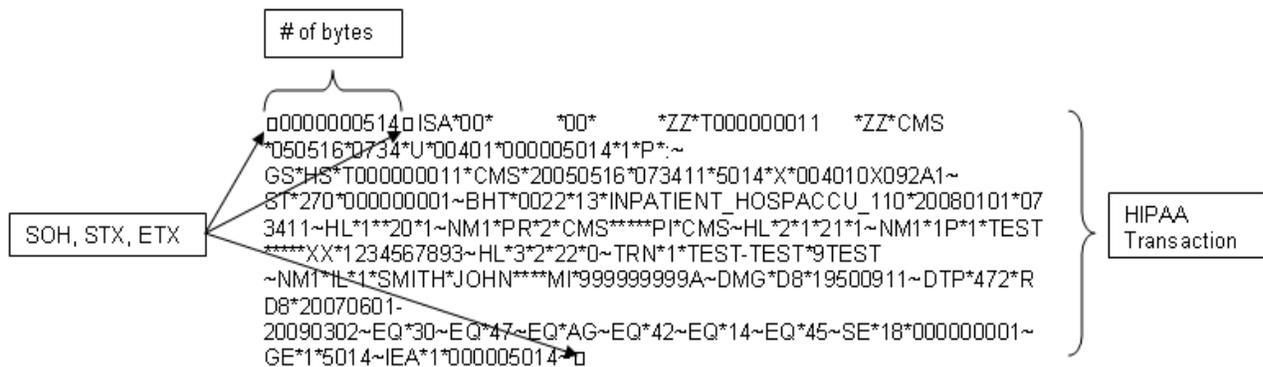
The standard format of the TCP/IP Communication Transport Protocol Wrapper, SOHLLLLLLLLLLLLSTX<HIPAA 270 Transaction>ETX, is represented in Table 1.

Table 1 – Standard Format of the TCP/IP Communication Transport Protocol Wrapper

Element	Description	Length	Hexadecimal Value	Note(s)
SOH	Start of header	1	01	This is a required element.
LLLLLLLLLLLL	# of bytes, including spaces, of the 270 request	10	N/A	Right justified, zero padded. This is a required element.
STX	Start of text	1	02	This is a required element.
HIPAA 270 Transaction	Eligibility request	variable	N/A	This is a required element.
ETX	End of text	1	03	This is a required element.

An illustration of the standard format of the TCP/IP Communication Transport Protocol Wrapper is represented by Figure 2.

Figure 2 – Example of TCP/IP Communication Transport Protocol Wrapper



Refer to the Extended Control Set matrix on page A.3 of the X12 270/271 IG for additional information about SOH, STX and ETX.

4.4 SECURITY

The HETS 270/271 application is located at a secure CMS data center, which is available via the CMS Extranet. This connection requires a password that is provided by the CMS-approved network reseller and features a variety of security measures to protect the integrity of the HETS 270/271 application. Additionally, the HETS 270/271 application authorizes Trading Partners based on their originating Internet Protocol (IP) address and their CMS issued HETS 270/271 Submitter ID.

All Trading Partners must assume full responsibility for the privacy and security of all Medicare Beneficiary data. Additionally, CMS holds Clearinghouse Submitters and Third Party Vendors responsible for the privacy and security of eligibility transactions sent directly to them from Providers, and requires them to be able to associate each inquiry with a Provider. Provider authentication must be established by the Clearinghouse or Third Party Vendor outside of the transaction.

5 MCARE CONTACT INFORMATION

All inquiries and comments regarding Trading Partner registration, connection set-up, transaction testing, and the submission of 270/271 transactions and interpretation of their data should be directed to MCARE.

MCARE is available at 1-866-324-7315 or at MCARE@cms.hhs.gov Monday through Friday, from 7:00 AM to 7:00 PM ET.

Note: The MCARE email address is monitored during normal business hours. Emails are typically answered within one business day.

MCARE cannot assist in the resolution of benefit-related discrepancies. Questions regarding eligibility/benefit data for Medicare Part A and Part B should be directed to the

appropriate regional MAC. Eligibility/benefit questions about MA, Part D and MSP should be directed to the appropriate plan(s) identified in the 271 response.

6 CONTROL SEGMENTS/ ENVELOPES

The following sections describe the HETS 270/271 transaction requirements to be used in conjunction with the requirements outlined in the IG. Adhering to these requirements will help to ensure that transactions received by the HETS 270/271 application will pass the specified business edits.

All references to the ASC X12 270/271 IG assume the version referenced in [Section 1.1](#) of this companion guide.

6.1 INTERCHANGE CONTROL STRUCTURE (ISA/IEA)

Table 2 describes the values specifically required by the HETS 270/271 application within the ISA Header of the 270 request transaction:

Table 2 – 270 ISA Segment Rules

IG Page #	Reference	X12 Element Name	Codes	Length	Notes/ Comments
B.3	ISA01	Authorization Information Qualifier	00	2	No authorization information must be present in ISA02
B.4	ISA02	Authorization Information	N/A	10	Must be Spaces
B.4	ISA03	Security Information Qualifier	00	2	N/A
B.4	ISA05	Interchange ID Qualifier	ZZ	2	N/A
B.4	ISA06	Interchange Sender ID	N/A	15	Must be Trading Partner Submitter ID assigned by CMS padded with trailing spaces to satisfy the minimum length requirements.
B.4	ISA07	Interchange ID Qualifier	ZZ	2	N/A
B.5	ISA08	Interchange Receiver ID	N/A	15	Must be "CMS" padded with trailing spaces to satisfy the minimum length requirement.

IG Page #	Reference	X12 Element Name	Codes	Length	Notes/ Comments
B.6	ISA14	Acknowledgment Requested	0,1	1	CMS will not return the TA1 acknowledgement receipt of a real time transaction even if acknowledgment is requested.

Note: The HETS 270/271 application does not require any custom values for the IEA segment within the 270 request. Please follow the rules as specified by the IG.

6.2 FUNCTIONAL GROUP STRUCTURE (GS/GE)

Table 3 describes the values required by the HETS 270/271 application within the GS Header of the 270 request transaction:

Table 3 – 270 GS Segment Rules

IG Page #	Reference	X12 Element Name	Codes	Length	Notes/ Comments
B.8	GS02	Application Sender's Code	N/A	8 or 10	Must be Trading Partner Submitter ID
B.8	GS03	Application Receiver's Code	N/A	3	Must be "CMS"

Note: The HETS 270/271 application does not require any custom values for the GE segment within the 270 request. Please follow the rules as specified by the IG.

6.3 TRANSACTION SET HEADER/TRAILER (ST/SE)

The HETS 270/271 application does not expect any custom values for the ST/SE segments within the 270 request. Please follow the rules as specified by the IG.

6.4 TRN, EQ and INS SEGMENTS

The HETS 270/271 application does not expect any custom values for the TRN, EQ and INS segments within the 270 request. Please follow the rules as specified by the IG.

7 PAYER SPECIFIC BUSINESS RULES AND LIMITATIONS

This section describes the business rules and limitations of the HETS 270/271 application.

All references to the X12 270/271 IG assume the version referenced in [Section 1.1](#) of this companion guide.

7.1 GENERAL STRUCTURAL NOTES

- Trading Partners should follow the ST/SE guidelines outlined in the 270 section of the IG.
- Trading Partners should follow the ISA/IEA, GS/GE, TA1, and 997 guidelines for HIPAA in Appendices A and B of the IG.
- Trading Partners must follow the character set guidelines as defined on page A.2 of the IG.
- CMS strongly recommends that Trading Partners use the preferred 270 request transaction delimiters in Table 4.

Table 4 – Preferred 270 Request Transaction Delimiters

Character	Name	Delimiter
*	Asterisk	Data Element Separator
	Pipe	Sub element Separator
~	Tilde	Segment Terminator

- Each transaction must contain only one Patient Request. Each 270 request must have only one ISA/IEA, one GS/GE, one ST/SE, and a single 2100C Subscriber Loop.

7.2 GENERAL TRANSACTION NOTES

- The HETS 270/271 application will perform X12 validation on the dependent segments within a 270 request. If dependent level data fails validation, then the HETS 270/271 application will return a 997 error acknowledgement. If dependent level data passes validation, this data will be ignored and only subscriber level information will be returned on the 271 response.
- The HETS 270/271 application will always return a basic set of eligibility information even if no Service Type Code (STC) is included on the 270 request.
- The HETS 270/271 application will return additional eligibility information along with the basic set of eligibility data for certain service type codes. Refer to [Section 10](#) of this companion guide, for a list of data elements included within the basic set and the additional eligibility data elements returned on the 271 response for each supported STC. Only the basic set of eligibility data will be returned for valid STCs that are not referenced in [Section 10](#) of this companion guide.
 - STCs specifically supported by the HETS 270/271 application include: 14, 15, 42, 45, 47 and AG.
- The HETS 270/271 application will accept multiple STCs on a 270 request transaction.

- The HETS 270/271 application may return multiple EB loops to reflect the Medicare Beneficiary's benefit and enrollment history and/or the STCs requested in the 270 request.
- Trading Partners will receive a AAA error in Loop 2100A with a reject reason code of AAA03 = "42" (Unable to Respond at Current Time) when the HETS 270/271 application is unable to process a single transaction in less than 60 seconds or when other system issues are encountered.
- The 271 response is based upon information obtained from the CMS database at the time of inquiry and is not considered a guarantee of payment.
- The HETS 270/271 application will construct 271 responses with the preferred delimiters as noted in Table 4 of this companion guide.
 - The sub element separator used in responses with a reject reason code of AAA03 = "42" (System Unable to Respond) is what was included in the in-bound ISA15.

7.3 MEDICARE BENEFICIARY MATCHING RULES

- The Subscriber Level (Loop 2100C) must contain the following data elements to search for and identify a Medicare Beneficiary:
 - Health Insurance Claim Number (HICN)
 - Medicare Beneficiary's Date of Birth (DOB)
 - Medicare Beneficiary's Full Last Name
 - Medicare Beneficiary's Full First Name
- If all four of these required elements are present in a 270 request that has passed X12 validation, the HETS 270/271 application will generate a 271 response.
- If the Medicare Beneficiary's submitted HICN is found but is not the Medicare Beneficiary's current number, the HETS 270/271 application will cross-reference the submitted HICN to the active HICN. The 271 response will include in the 2100C Loop the inactive HICN within a REF segment, the active HICN within NM109 field, and a AAA error with a reject reason code of AAA03 = "67" (Patient Not Found). The submitter may then send a new 270 request transaction with the active HICN.
- If the Medicare Beneficiary is not found, the HETS 270/271 application will generate the appropriate AAA03 error code in the 271 response. Refer to [Section 8.3](#) of this companion guide for additional information.
- If a Medicare Beneficiary's gender code is submitted on a 270 request, it must exactly match the current eligibility information.

7.4 DATE OF SERVICE RULES

- The HETS 270/271 application will respond with the benefits provided only for the specific service date or date range contained in Loop 2100C, element DTP03 (Date Time Period) of the 270 request. If no date is contained in the 270 request, the HETS 270/271 application will respond with current eligibility information.
- CMS will verify that the requested date(s) on the 270 request are within the HETS 270/271 application’s allowable date span. The allowable date span is up to 27 months in the past and up to four months in the future, based on the date the transaction was received. If requests are outside of this range, the HETS 270/271 application will return a AAA error in Loop 2100C with a reject reason code of AAA03 = “62” (Date of Service Not Within Allowable Inquiry Period).
- Table 5 illustrates the allowable request date ranges:

Table 5 – Request Date Calendar

If the Current Month Is:	Historical Requests Are Valid Through:	Future Requests Are Valid Through:
January	October, 3 years ago	May of the current year
February	November, 3 years ago	June of the current year
March	December, 3 years ago	July of the current year
April	January, 2 years ago	August of the current year
May	February, 2 years ago	September of the current year
June	March, 2 years ago	October of the current year
July	April, 2 years ago	November of the current year
August	May, 2 years ago	December of the current year
September	June, 2 years ago	January of the following year
October	July, 2 years ago	February of the following year
November	August, 2 years ago	March of the following year
December	September, 2 years ago	April of the following year

Example: If an eligibility request is sent on January 1, 2009, requests from October 1, 2006 through May 1, 2009 will be accepted.

7.5 MEDICARE PART A & PART B ELIGIBILITY BUSINESS RULES

- Trading Partners should review the entire 271 eligibility response to determine the appropriate eligibility status for the Medicare Beneficiary.
- To indicate periods of Medicare entitlement, the HETS 270/271 application will return Loop 2110C with element EB01 = “1” (Active Coverage) along with the Subscriber Eligibility/Benefit Date (DTP03) where DTP01 = “307” (Eligibility) with beginning and end dates, where appropriate, for each applicable entitlement period.

- The HETS 270/271 application will return Loop 2110C with element EB01 = “6” (Inactive) along with a DTP segment containing beginning and end dates for the period of inactivity when an individual entitled to Medicare is ineligible for Medicare benefits over a period of time for any one the following reasons:
 - The Medicare Beneficiary has been classified as an illegal alien in the United States.
 - The Medicare Beneficiary has been deported from the United States.
 - The Medicare Beneficiary has been incarcerated.

Note: Information specifying the reason for the period of ineligibility will not be released.
- The HETS 270/271 application will return a 2110C Loop with element EB01= “6” (Inactive) and no additional data, when the Medicare Beneficiary is deceased and the Date of Death is prior to the requested date(s) of service.
- The HETS 270/271 application will return a 2110C Loop with element EB01= “6” (Inactive) for Part A and/or Part B without the DTP segments for either of the following reasons:
 - The Medicare Beneficiary’s Part A and/or Part B entitlement had not yet begun as of the requested date(s) of service.
 - The Medicare Beneficiary’s Part A and/or Part B entitlement has terminated prior to the requested date(s) of service.
- The Insurance Type Code (EB04) will be omitted when periods of ineligibility apply to both Medicare Part A and Part B.
- The HETS 270/271 application will return Loop 2110C with element EB01 = “6” (Inactive) when an individual is entitled to one part of Medicare, but not the other. For example, when a Medicare Beneficiary is entitled to Part A but not Part B, the inactive EB segment would be returned for the Part B portion of the response.
- Multiple periods of a Medicare Beneficiary’s inactive Medicare enrollment may be returned in a 271 response if they occur during the requested date(s) of service.
- If a Medicare Beneficiary has died, but the requested date(s) of service are prior to the Date of Death, their Medicare Part A and/or Part B entitlement date(s) and other applicable eligibility data will be returned along with a separate DTP segment containing the Date of Death.
- Example segments returned in a 271 response:
 - Part A Entitlement

EB*1*IND**MA~

DTP*307*RD8*CCYYMMDD-CCYYMMDD~ (DTP03 = Entitlement and Termination Dates (where applicable))

- Part B Entitlement

EB*1*IND**MB~

DTP*307*RD8*CCYYMMDD-CCYYMMDD~ (DTP03 = Entitlement and Termination Dates (where applicable))

- Inactive Due to Date of Death

DTP*442*D8*CCYYMMDD~ (DTP01 = Date of Death)

EB*6~

- Entitled but Inactive Due to Incarceration, Deportation or Alien Status

EB*1*IND**MA~

DTP*307*D8*CCYYMMDD~ (DTP03 = Part A Entitlement Date(s))

EB*1*IND**MB~

DTP*307*D8*CCYYMMDD~ (DTP03 = Part B Entitlement Date(s))

...Benefit Information...

EB*6~

DTP*307*RD8*CCYYMMDD-CCYYMMDD~ (DTP03 = Inactive Date(s))

- For additional information, refer to Table 15.

7.6 PART A HOSPITAL AND SKILLED NURSING FACILITY (SNF) SPELLS BUSINESS RULES

- STC (Loop 2110C, Element EQ01) = “47” or “AG” must be included in the 270 request in order to receive Hospital Spell data in the 271 response.
- STC (Loop 2110C, Element EQ01) = “AG” must be included in the 270 request in order to receive SNF data in the 271 response.
- A SNF spell will always be accompanied by a prior Hospital stay.
- The dates of a Hospital/SNF spell (Loop 2110C, Element DTP01 = “435” (Admission)) will be returned as the Date of Earliest Billing Activity (DOEBA) through the Date of Latest Billing Activity (DOLBA) for the overall spell. Dates of individual Hospital/SNF stays within the complete spell will not be specified.
- All Hospital/SNF spells that fall within 60 days of the date or date range specified in the 270 request will be returned.
- If a single Hospital/SNF spell spans more than one calendar year, the HETS 270/271 application will return the daily copayment amounts associated with the beginning year of the spell.

- If there is no Hospital/SNF spell within 60 days of the requested date(s) of service, the HETS 270/271 application will return default values for Part A Spell data.
- The HETS 270/271 application will not generate a 2110C loop for future years that do not have default deductible or copayment per day values as published by CMS.
- Example 2110C loops returned in a 271 response:

- Hospital/SNF Spell

EB*K**47*MA**33***LA*60~ (EB10 = Part A Lifetime Days Remaining)
 EB*C**47*MA**29*150.25~ (EB07 = Part A Deductible Remaining)
 DTP*435*RD8*CCYMMDD-CCYMMDD~ (DTP03 = DOEBA-DOLBA)
 EB*F**47*MA**29***DY*43~ (EB10 = Hospital Full Days Remaining)
 DTP*435*RD8*CCYMMDD-CCYMMDD~
 EB*B**47*MA**29*248**DY*30~ (EB07 = Copayment Amount per Day,
 EB10 = Hospital Copayment Days Remaining)
 DTP*435*RD8*CCYMMDD-CCYMMDD~
 EB*F**AG*MA**29***DY*20~ (EB10 = SNF Full Days Remaining)
 DTP*435*RD8*CCYMMDD-CCYMMDD~
 EB*B**AG*MA**29*124**DY*80~ (EB07 = Copayment Amount per Day,
 EB10 = SNF Copayment Days Remaining)
 DTP*435*RD8*CCYMMDD-CCYMMDD~

- Default Hospital/SNF Spell

EB*K**47*MA**33***LA*60~ (EB10 = Part A Lifetime Days Remaining)
 EB*C**47*MA**29*1100~ (EB07 = Part A Default Deductible Amount)
 EB*F**47*MA**29***DY*60~ (EB10 = Default Hospital Full Days
 Remaining)
 EB*B**47*MA**29*275**DY*30~ (EB07 = Default Copayment Amount per
 Day, EB10 = Default Hospital Copayment Days Remaining)
 EB*F**AG*MA**29***DY*20~ (EB10 = Default SNF Full Days Remaining)
 EB*B**AG*MA**29*137.5**DY*80~ (EB07 = Default Copayment Amount
 per Day, EB10 = Default SNF Copayment Days Remaining)

- For additional information, refer to Table 16.

7.7 HOME HEALTH PERIODS BUSINESS RULES

- Home Health Period dates will be returned as part of the basic eligibility dataset for all periods that overlap the requested date(s) of service.
- Insurance Type Code (EB04) of "MA" is returned if beneficiary is only Medicare Part A entitled; Insurance Type Code (EB04) of "MB" is returned if beneficiary is Medicare Part B entitled or Medicare Part A and Part B entitled.

- Home Health Contractor and Provider information will only be returned on the 271 response when STC (Loop 2110C, element EQ01) = “42” is included in the 270 request.
- Example segments returned in a 271 response:
 - Home Health Periods if beneficiary is only Medicare Part A entitled
 - EB*X**42*MA**26~ (EB03 = Home Health Care)
 - DTP*193*D8*CCYYMMDD~ (DTP03 = Home Health Start Date)
 - DTP*194*D8*CCYYMMDD~ (DTP03 = Home Health End Date)
 - DTP*193*D8*CCYYMMDD~ (DTP03 = DOEBA)
 - DTP*194*D8*CCYYMMDD~ (DTP03 = DOLBA)
 - MSG*HHEH Start Date~
 - MSG*HHEH End Date~
 - MSG*HHEH DOEBA~
 - MSG*HHEH DOLBA~
 - LS*2120~
 - NM1*PR*2*Medicare MAC*****PI*12345~ (NM109 = Contractor Number)
 - PRV*HH*HPI*1234567890~ (PRV03 = Provider NPI)
 - LE*2120~
 - Home Health Periods if beneficiary is Medicare Part B entitled or Medicare Part A and Part B entitled
 - EB*X**42*MB**26~ (EB03 = Home Health Care)
 - DTP*193*D8*CCYYMMDD~ (DTP03 = Home Health Start Date)
 - DTP*194*D8*CCYYMMDD~ (DTP03 = Home Health End Date)
 - DTP*193*D8*CCYYMMDD~ (DTP03 = DOEBA)
 - DTP*194*D8*CCYYMMDD~ (DTP03 = DOLBA)
 - MSG*HHEH Start Date~
 - MSG*HHEH End Date~
 - MSG*HHEH DOEBA~
 - MSG*HHEH DOLBA~
 - LS*2120~
 - NM1*PR*2*Medicare MAC*****PI*12345~ (NM109 = Contractor Number)
 - PRV*HH*HPI*1234567890~ (PRV03 = Provider NPI)
 - LE*2120~
- For additional information, refer to Table 17.

7.8 PART B DEDUCTIBLE BUSINESS RULES

- The dollar amount remaining for the Medicare Beneficiary’s annual Part B deductible will be returned for all years within the requested Date(s) of Service, when the Medicare Beneficiary was also entitled to Part B at any time during those year(s). Annual Part B deductible will not be returned when:

- The Medicare Beneficiary was deceased prior to the start of that year.
- The Medicare Beneficiary had an inactive period of Part B entitlement that spanned the entire calendar year.
- The HETS 270/271 application will not generate a 2110C loop for future years that do not have default deductible values as published by CMS.
- Example 2110C loop returned in a 271 response:
 - Part B Deductible
 - EB*C**96*MB**29*0~ (EB07 = Part B Deductible Amount Remaining)
 - DTP*292*RD8*CCYY0101-CCYY1231~ (DTP03 = 01/01-12/31 of the deductible year that is represented)
- For additional information, refer to Table 18.

7.9 PREVENTIVE CARE BUSINESS RULES

- Eligibility for preventive services will be returned in multiple EB Loops as part of the basic eligibility information within every 271 response transaction for a Medicare Beneficiary that has active Part B entitlement and does not have a Date of Death on file at the time of the 270 request.
- Preventive services are described by the Healthcare Common Procedure Coding System (HCPCS). The following is a listing of the preventive categories and the associated HCPCS code(s) returned by the HETS 270/271 application:
 - Cardiovascular Disease Screening (CARD) includes codes 80061, 82465, 83718, and 84478.
 - Colorectal Cancer Screening (COLO) includes codes G0104, G0105, G0106, G0120 and G0121.
 - Fecal Occult Blood Test (FOBT) includes codes G0328 and 82270.
 - Diabetes Screening Tests (DIAB) includes codes 82947, 82950, and 82951.
 - Glaucoma Screening (GLAU) includes codes G0117 and G0118.
 - Initial Preventive Physical Examination (IPPE) includes codes G0402, G0403, G0404, and G0405.
 - Screening Mammography (MAMM) includes codes G0202 and 77057.
 - Screening Pelvic Exam (PCBE) includes code G0101.
 - Pneumococcal Vaccine (PPV) includes codes 90669, 90670 and 90732.
 - Prostate Cancer Screening (PROS) includes codes G0102 and G0103.
 - Screening Pap Test (PAPT) includes codes Q0091, P3000, G0123, G0143, G0144, G0145, G0147, and G0148.

- Ultrasound Screening for Abdominal Aortic Aneurysm (AAA) includes code G0389.
- Pharmacogenomic Testing for Warfarin Response (PTWR) includes code G9143.
- Annual Wellness Visit (AWV) includes codes G0438 and G0439.
- Preventive HCPCS codes may be returned twice in the 271 response if there are different dates for the technical and professional components of the service.
- Preventive care information displays current information only. No inference about historical eligibility can be made based on the returned next eligible dates. The next eligible date is the date on which the Medicare Beneficiary is/was eligible to receive services specified by the HCPCS.
- Example segments returned in a 271 response:
 - Preventive Care with the same Professional and Technical date
 - EB*D*IND**MB*****HC|82270~ (EB13-2 = HCPCS Code)
 - DTP*348*D8*CCYYMMDD~ (DTP03 = Next Eligible Date)
 - Preventive Care with different Professional and Technical dates for the HCPCS codes and Modifiers
 - EB*D*IND**MB*****HC|83718|26~ (EB13-2 = HCPCS Code, EB13-3 = HCPCS Modifier)
 - DTP*348*D8*20060701~ (DTP03 = Next Eligible Professional Date)
 - EB*D*IND**MB*****HC|83718|TC~ (EB13-2 = HCPCS Code, EB13-3 = HCPCS Modifier)
 - DTP*348*D8*20120601~ (DTP03 = Next Eligible Technical Date)
- For additional information, refer to Table 19.

7.10 SMOKING/TOBACCO CESSATION COUNSELING BUSINESS RULES

- Eligibility for smoking/ tobacco cessation counseling benefits will be returned as part of the basic eligibility information within every 271 response transaction for a Medicare Beneficiary that has active Part B entitlement and does not have a Date of Death on file at the time of the 270 request.
- Either the number of sessions remaining or next eligible date will be returned. If any sessions have been used in the applicable benefit period, the number of sessions remaining will be returned. Otherwise, the next date the Medicare Beneficiary is eligible to receive smoking/ tobacco cessation counseling will be returned.
- Example segments returned in a 271 response:
 - Smoking/Tobacco Cessation

EB*D*IND*67*MB~
DTP*348*D8*CCYYMMDD (DTP03 = Next Eligible Smoking/Tobacco
Cessation Counseling Date)

OR

EB*F*IND*67*MB**29***P6*6~ (EB10 = Number of Sessions Remaining)

- For additional information, refer to Table 20.

7.11 THERAPY CAPITATION BUSINESS RULES

- The dollar amount remaining for the Medicare Beneficiary's therapy capitation will be returned for all years within the requested Date(s) of Service, when the Medicare Beneficiary was also entitled to Part B at any time during those year(s). Therapy capitation information will not be returned when:
 - The Medicare Beneficiary was deceased prior to the start of that year.
 - The Medicare Beneficiary had an inactive period of Part B entitlement that spanned the entire calendar year.
- The HETS 270/271 application will not generate an EB segment for future years that do not have default capitation values as published by CMS.
- The HETS 270/271 application will return EB03 = "AE" to represent a combined capitation limit for Physical and Speech Therapy.
- Example segments returned in a 271 response:

- Therapy Capitation

EB*F*IND*AD*MB**29*1810~ (EB03 = Occupational Therapy; EB07 =
Therapy Capitation Amount Remaining)
DTP*292*RD8*CCYY0101-CCYY1231~ (DTP03 = 01/01-12/31 of the
Therapy Capitation year that is represented)

EB*F*IND*AE*MB***29*1810~ (EB07 = Therapy Capitation Amount
Remaining)
DTP*292*RD8*CCYYMMDD-CCYYMMDD~ (DTP03 = 01/01-12/31 of the
Therapy Capitation year that is represented)

- For additional information, refer to Table 21.

7.12 END STAGE RENAL DISEASE (ESRD) PERIODS BUSINESS RULES

- STC (Loop 2110C, element EQ01) = "14" or "15" must be included in the 270 request in order to receive ESRD dialysis method code, dialysis method start date, and kidney transplant hospital discharge date in a 271 response.

- Example segments returned in a 271 response:
 - ESRD – Renal Supplies in the Home
 - EB*D**14*MB~ (EB03 = 14 for Renal Supplies in the Home, EB04 = MB for Part B)
 - DTP*356*D8*CCYYMMDD~ (DTP01 = ESRD Dialysis Method Start Date)
 - DTP*198*D8*CCYYMMDD~ (DTP01 = Kidney Transplant Hospital Discharge Date)
 - MSG*Transplant Discharge Date~
 - ESRD – Alternative Method Dialysis
 - EB*D**15*MA~ (EB03 = 15 for Alternative Method Dialysis, EB04 = MA for Part A)
 - DTP*356*D8*CCYYMMDD~ (DTP01 = ESRD Dialysis Method Start Date)
 - DTP*198*D8*CCYYMMDD~ (DTP01 = Kidney Transplant Hospital Discharge Date)
 - MSG*Transplant Discharge Date~
- For additional information, refer to Table 22.

7.13 HOSPICE CARE PERIODS BUSINESS RULES

- The Hospice section provides eligibility information when the hospice benefit is effective and when it terminates. When Hospice coverage is elected, the beneficiary waives all rights to Medicare payments for services that are related to the treatment and management of their terminal illness during any period their hospice benefit election is in effect, unless the services are provided by the designated hospice or provided by another hospice under arrangements made by the designated hospice. The one exception is for professional services of an attending physician, which may include a nurse practitioner. If the attending physician, who may be a nurse practitioner, is an employee of the designated hospice provider, they may not receive compensation from the Hospice for those services under Part B. These physician professional services are billed to Medicare Part A by the Hospice.
- Hospice Period dates will be returned as part of the basic eligibility dataset for all periods that overlap the date(s) of service requested.
- Hospice Provider or Facility information will only be returned on the 271 response when STC (Loop 2110C, element EQ01) = "45" is included in the 270 request.
- If final claim billing has been received and Hospice care has been fully revoked, then a revocation date will be returned with the Hospice period.
- If Hospice care has not been fully revoked, the revocation date will be disregarded prior to determining which periods intersect the date(s) of service requested. For these Hospice periods, no revocation (or termination date) will be returned or applied to any internal logic. This can occasionally result in multiple open-ended Hospice

periods being returned when a Medicare Beneficiary has recently changed Hospice Providers.

- Example segments returned in a 271 response:
 - Hospice Care
 - EB*X**45*MA**26~ (EB03 = Hospice)
 - DTP*292*RD8*CCYMMDD-CCYMMDD~ (DTP03 = Hospice Effective and Revocation Dates)
 - Hospice Care with Facility information
 - EB*X**45*MA**26~ (EB03 = Hospice)
 - DTP*292*D8*CCYMMDD~ (DTP03 = Hospice Effective Date)
 - LS*2120~
 - NM1*1P*2*****XX*1234567890~ (NM109 = Provider NPI)
 - LE*2120~
- For additional information, refer to Table 23.

7.14 BLOOD DEDUCTIBLE BUSINESS RULES

- The number of units remaining for the Medicare Beneficiary's annual blood deductible will be returned for all years within the requested Date(s) of Service, when the Medicare Beneficiary was entitled to either Medicare Part A or Part B at any time during those year(s). Annual blood deductible will not be returned when:
 - The Medicare Beneficiary was deceased prior to the start of that year.
 - The Medicare Beneficiary had an inactive period that spanned the entire calendar year.
- The HETS 270/271 application will not generate an EB segment for future years that do not have default deductible values as published by CMS.
- Example segments returned in a 271 response:
 - Blood Deductible
 - EB*C*IND*10***29***DB*3 ~ (EB03 = Blood Charges; EB10 = Number of Units Remaining)
 - DTP*292*RD8*CCYMMDD-CCYMMDD~ (DTP03 = 01/01-12/31 of the Blood Deductible year that is represented)
- For additional information, refer to Table 24.

7.15 PART D PLAN ENROLLMENT BUSINESS RULES

- All Medicare Part D plans with enrollment periods that overlap the requested date(s) of service will be returned within the 271 response.

- Trading Partners are advised to contact the plans if there are any questions about the plan terms and conditions. In addition, indication of coverage does not imply or guarantee payment by the plan. Trading Partners should contact the plan for full benefit and billing information.
- For information on how to contact plans go to <http://www.cms.gov/MCRAdvPartDEnrolData/> and choose “PDP Plan Directory”.
- MA plans that offer Prescription Drug Coverage as a part of an HMO, PPO, POS, or Indemnity plan will be returned twice – once with the “OT” designation to indicate Prescription Drug Coverage and once with the appropriate qualifiers for their MA Plan Type.
- MA plans that only offer Prescription Drug Coverage will be returned once, with the “OT” designation.
- Example segments returned in a 271 response:
 - Part D
 - EB*R**88*OT~ (EB04 = OT – Prescription Drug Coverage)
 - REF*18*12345 001~ (REF02 = Contract Number followed by Plan Number)
 - DTP*292*RD8*CCYYMMDD-CCYYMMDD~ (DTP03 = Part D Enrollment and Disenrollment Dates)
 - LS*2120~
 - NM1*PR*2*ABC DRUG COMPANY~ (NM103 = Contract Name)
 - N3*PO BOX 123~ (N301 = Contract Street Address)
 - N4*ANYTOWN*MD*999999999~ (N401 = Contract City, N402 = Contract State, N403 = Contract Zip)
 - PER*IC**TE*8001234567~ (PER04 = Plan Telephone Number)
 - LE*2120~
- For additional information, refer to Table 25.

7.16 MA PLAN ENROLLMENT BUSINESS RULES

- All Medicare Beneficiary MA plans with enrollment periods that overlap the requested date(s) of service will be returned within the 271 response.
- The HETS 270/271 application will return one of the following qualifiers within Loop 2110C, element EB04, for each MA enrollment:
 - HM for Health Maintenance Organization (HMO) Medicare Non-Risk
 - HN for HMO Medicare Risk
 - IN for Indemnity

- PR for Preferred Provider Organization (PPO)
- PS for Point of Service (POS)

The HETS 270/271 application will return only the most recent plan designation (HMO, PPO, POS, Indemnity) for an MA contract, even if the contract's plan designation has changed since the Medicare Beneficiary originally enrolled in the contract.

- MCO Bill Option Code will be returned only for Insurance Type Code values “HM”, “HN”, “IN”, “PR” and “PS”. The MCO Bill Option Codes returned by the HETS 270/271 application are:

Beneficiary “locked in” to MCO

“A” – Fiscal Intermediary should process all claims

“B” – MCO should process only in-plan Part A claims and in-area Part B claims

“C” – MCO should process all claims

Beneficiary NOT “locked in” to MCO

“1” – Fiscal Intermediary should process all claims

“2” – MCO should process only in-plan Part A claims and in-area Part B claims

- Trading Partners are advised to contact the plans if there are any questions about the plan terms and conditions. In addition, indication of coverage does not imply or guarantee payment by the plan. Trading Partners should contact the plan for full benefit and billing information.
- For information on how to contact plans go to <http://www.cms.gov/MCRAAdvPartDENrolData/> and choose “MA Plan Directory”.
- MA plans that offer Prescription Drug Coverage as a part of an HMO, PPO, POS, or Indemnity plan will be returned twice – once with the “OT” designation to indicate Prescription Drug Coverage and once with the appropriate qualifiers for their MA Plan Type.
- Example segments returned in a 271 response:
 - MA

EB*R**30*HN~ (EB04 = Plan Type)

REF*18*12345 001~ (REF02 = Contract Number followed by Plan Number)

DTP*290*D8*CCYYMMDD~ (DTP03 = MA Enrollment Date)

MSG*MCO Bill Option Code – C~

LS*2120~

NM1*PRP*2*ABC HEALTHCARE~ (NM103 = Contract Name)

N3*PO BOX 123~ (N301 = Contract Street Address)

N4*ANYTOWN*MD*999999999~ (N401 = Contract City, N402 = Contract State, N403 = Contract Zip)

PER*IC**TE*8001234567~ (PER04 = Plan Telephone Number)
LE*2120~

- For additional information, refer to Table 26.

7.17 MEDICARE SECONDARY PAYER (MSP) ENROLLMENT BUSINESS RULES

- All Medicare Beneficiary insurance coverage policies that are primary to Medicare coverage will be returned within the 271 response, provided that the enrollment period overlaps the requested date(s) of service.
- Example segments returned in a 271 response:
 - MSP

EB*R*IND*30*12~(EB04 = MSP Insurance Type Code)
REF*IG*123456789~(REF02 = Insurance Policy Number)
DTP*290*D8*CCYYMMDD~ (DTP03 = MSP Effective Date(s))
LS*2120~
NM1*PRP*2*ABC HEALTHPLAN~ (NM103 = MSP Name)
N3*123 MAIN ST~ (N301 = MSP Street Address)
N4*ANYTOWN*MD*999999999~ (N401 = MSP City, N402=MSP State,
N403=MSP Zip)
LE*2120~

- For additional information, refer to Table 27.

8 ACKNOWLEDGEMENTS, ERROR CODES AND/OR REPORTS

Only one acknowledgement or response will be sent for each 270 request that is submitted – a TA1, a 997, a 271, or a proprietary error message.

8.1 TA1

The TA1 Interchange Acknowledgement is used by the HETS 270/271 application to communicate the rejection of a 270 request transaction based on errors encountered with X12 compliance, formatting, or CMS specific requirements of the ISA/IEA Interchange segments.

8.2 997

The 997 Functional Acknowledgement is used by the HETS 270/271 application to communicate the rejection of a 270 request transaction based on errors encountered with X12 compliance, formatting, or CMS specific requirements of the GS/GE Functional Group or ST/SE Transaction Set.

8.3 271

When the 270 request complies with the X12 standard syntax requirements and all additional formatting rules as specified by this companion guide, then a 271 response transaction is returned to the Submitter. If no error exists, the Medicare Beneficiary eligibility data will be returned within the 271 response. Refer to [Section 10.2](#) of this companion guide for more information.

The AAA error segment is utilized within the 271 response to communicate error conditions based on CMS business rules. The AAA error codes are specified in Table 6.

Table 6 – AAA Error Codes

Loop	AAA01 Yes/ No Condition ¹	AAA03 Reject Reason Code	AAA04 Follow-up Action Code ²
2100A	Yes	42 – When the system is unable to respond as a result of being unavailable.	R
2100A	No	79 – When 2100A NM103 or NM109 Source identification is other than “CMS”.	C
2100A	No	T4 – When 2100A NM109 or NM103 is missing data for Information Source.	C
2100B	No	41 – When the National Provider Identifier (NPI) located at 2100B NM109 is a valid FFS Medicare NPI and exists in HPG, but there is no current, valid relationship between the NPI and the provided HETS Submitter ID. Ensure that there is a relationship between your Submitter ID and the NPI in HPG.	C
2100B	No	43 – When the NPI located at 2100B NM109 is not a valid FFS Medicare provider or supplier. If you believe that the NPI is a valid FFS Medicare provider or supplier, contact your MAC for verification; OR – When 2100B NM101 is not equal to “1P”, “FA”, or “80”; OR – When NM108 is not “XX”.	C
2100B	No	50 – When the NPI located at 2100B NM109 is a valid, FFS Medicare provider or supplier but is not currently eligible to verify Medicare eligibility in HETS. Contact MCARE for further information.	C

¹ AAA01 Yes Condition means that the request is valid, but the transaction was rejected; AAA01 No Condition means that the request or an element in the request is not valid.

² AAA04 Follow-up Action code R means “Resubmission Allowed”; AAA04 Follow-up Action code C means “Please Correct and Resubmit”.

Loop	AAA01 Yes/ No Condition ¹	AAA03 Reject Reason Code	AAA04 Follow-up Action Code ²
2100B	No	51 – When the NPI located at 2100B NM109 is not on file with HETS. Verify that the NPI is a valid FFS Medicare provider and ensure that the NPI is added to your Submitter ID via HPG.	C
2100C	No	56 – When the 270 2100C DTP02 = RD8 and DTP03 contains a date range with a “from date” that is greater than the “to date”.	C
2100C	No	58 – When the 270 2100C DMG02 element is missing Subscriber DOB.	C
2100C	No	62 – When the 270 2100C DTP03 element request date is more than 27 months in the past, or more than 4 months in the future.	C
2100C	No	64 – When the 270 2100C NM109 element is missing Subscriber ID (HICN) or the Subscriber ID (HICN) is an invalid length.	C
2100C	No	65 – When the 270 2100C NM103 element is missing the Subscriber Last Name or the matching algorithm of the Medicare Beneficiary Last Name on the 270 does not match the matching algorithm of the Medicare Beneficiary Last Name in the database.	C
2100C	No	65 – When the 270 2100C NM104 element is missing the Subscriber First Name or the matching algorithm of the Medicare Beneficiary First Name on the 270 does not match the matching algorithm of the Medicare Beneficiary First Name in the database.	C
2100C	No	66 – When the 270 2100C DMG03 Subscriber Gender code does not match the Medicare Beneficiary Gender code on the database.	C
2100C	No	67 – When the 270 2100C NM109 Subscriber ID (HICN) cannot be found in the Medicare Beneficiary database or HICN is inactive.	C
2100C	No	71 – When the 270 2100C DMG02 Subscriber DOB does not match the Medicare Beneficiary DOB on the database.	C

8.4 PROPRIETARY ERROR MESSAGE

Proprietary error messages will be sent only when the ISA segment of the 270 request cannot be read, making it impossible to formulate an ISA segment for a 271 response. The proprietary message will return error codes and descriptions. Trading Partners may contact MCARE for assistance with Proprietary Errors. The format for the proprietary message is described in Table 7.

Table 7 – Proprietary Error Messages

Data Element	Description	Size	Comments
Transaction ID	Transaction ID	4	Data content will be “HETS”
Transaction Reference Number	Trace Identification Number or (ISA13)	30	Reference Number that Trading Partner should use to identify the transaction when calling MCARE
Date Stamp	System Date	8	CCYYMMDD
Time Stamp	System time	9	HHMMSSSSS
Response Code	ISA Formatting Error	2	“ I” – Incoming ISA cannot be read. OR “ D” – Delimiter cannot be identified.
Message Code	Error Code	8	Error code, refer to Table 8 of this companion guide
Message Text Description	Error Descriptions	500	“ – <i>Message Text Description</i> ”, refer to Table 8 of this companion guide

Table 8 describes the Proprietary Error Message Codes.

Table 8 – Proprietary Error Message Codes

Message Code	Message Text Description
HTS00101	Transmission Wrapper SOH (hex=01) is invalid or missing
HTS00102	Transmission Wrapper STX (hex=02) is invalid or missing
HTS00103	Transmission Wrapper ETX (hex=03) is invalid or missing
HTS00104	Transmission Wrapper Length is missing or not numeric
HTS00105	Transmission Wrapper Length is greater than the Transmission Length
HTS00106	Transmission data is invalid or not ASCII
HTS00107	HIPAA 270 transaction does not start with ISA (Segment ID)
HTS00111	Transmission Inbound Message was empty
HTS00115	Interchange Error - Message specific to the condition will also be included in the error message description.
HTS00116	Syntax Error - Message specific to the condition will also be included in the error message description.
HTS00117	Transmission Error - Message specific to the condition will also be included in the error message description.

8.5 REPORTS

There are no CMS reports regarding the 270/271 transactions available to Trading Partners.

9 TRADING PARTNER AGREEMENTS

The HETS 270/271 application will validate that the Clearinghouse or Provider has been established in the Trading Partner Management System (TPMS) prior to processing the

270 transaction. If the Trading Partner (ISA06) cannot be validated, the HETS 270/271 application will return a proprietary error message that states: “Authorization for this transaction cannot be validated”. Refer to [Section 8.4](#) of this companion guide for more information on Proprietary Error Messages.

Trading Partners may not send transactions to be executed as Usage Indicator (ISA15) = “P” until testing has been accomplished and approval to submit production transactions has been given. The HETS 270/271 application will return a TA105 = “020” error for an Invalid Test Indicator Value.

The Trading Partner Rules of Behavior are outlined within the Trading Partner Registration documentation. Please refer to [Section 1.3](#) of this companion guide for links to these documents.

10 TRANSACTION SPECIFIC INFORMATION

All references to the IG in this section assume the ASC X12 270/271 version referenced in [Section 1.1](#) of this companion guide.

- For the tables in sections 10.1 and 10.2, the “Length” column indicates field size limits of the HETS 270/271 application and may differ from the field lengths presented in the IG. A forward slash “/” between two numbers represents the minimum and maximum lengths for the element. For numeric fields, the minimum and maximum lengths allow for a decimal point, where applicable. Elements that include more than 1 distinct field length value will be displayed as the minimum length followed by “or” followed by the maximum length. For example, Postal Code can either be 5 digits or 9 digits; the length is displayed as “5 or 9”.
- The “270 Service Type Code (EQ01)” column indicates which STC must be requested in order to receive each listed element. “All” in this column indicates that the element will be returned regardless of the STC submitted.

10.1 270 ELIGIBILITY REQUEST TRANSACTION

This section describes the values required by CMS in the 270 eligibility request transaction.

10.1.1 Information Source Level Structures

CMS will be the Information Source for all Medicare Eligibility Transactions. Trading Partners must submit the BHT03 reference identification to uniquely identify each transaction. Trading Partners must follow the specific requirements for the BHT as illustrated Table 9.

Table 9 – Header and Information Source

IG Page #	Loop ID	Reference	X12 Element Name	Codes	Length	Notes/ Comments
39	Header	BHT02	Transaction Set Purpose Code	N/A	2	All codes are acceptable.
39	Header	BHT03	Reference Identification	N/A	1/30	Reference Identification is required for real-time inquiry.
44	2100A	NM101	Entity Identifier Code	PR	2	N/A
45	2100A	NM102	Entity Type Qualifier	2	1	N/A
45	2100A	NM103	Last/Organization Name	N/A	3	“CMS”
46	2100A	NM108	Identification Code Identifier	PI	2	N/A
46	2100A	NM109	Identification Code	N/A	3	“CMS”

10.1.2 Information Receiver Level Structures

Clearinghouses that submit transactions on behalf of the Provider must ensure that the correct, valid, and active Medicare Provider identification is submitted as the Information Receiver. Only National Provider Identifier (NPI) numbers are accepted. Trading Partners must follow the specific requirements for the Information Receiver data as illustrated in Table 10.

Table 10 – Information Receiver

IG Page #	Loop ID	Reference	X12 Element Name	Codes	Length	Notes/ Comments
50	2100B	NM101	Entity Identifier Code	1P, FA, or 80	2	N/A
52	2100B	NM108	Identification Code Identifier	XX	2	N/A
52	2100B	NM109	Identification Code	N/A	10	The Provider’s assigned NPI number.

10.1.3 Subscriber Level Structures

Trading Partners must ensure that only one Medicare Beneficiary request is submitted in the Subscriber Level for each transaction. Trading Partners must follow the specific requirements for the Subscriber Level data as illustrated in Table 11.

Table 11 – Subscriber

IG Page #	Loop ID	Reference	X12 Element Name	Codes	Length	Notes/ Comments
72	2100C	NM103	Subscriber Last Name	N/A	1/35	Last Name is required for Medicare Beneficiary Identification
72	2100C	NM104	Subscriber First Name	N/A	1/25	First name is required for Medicare Beneficiary Identification
72	2100C	NM107	Subscriber Name Suffix ¹	N/A	1/10	When the suffix is part of the Medicare Beneficiary's Last Name on the Medicare card, the suffix is required for Last Name matching.
73	2100C	NM108	Identification Code Identifier	MI	2	N/A
73	2100C	NM109	Identification Code	N/A	6/12	The HICN is required for Medicare Beneficiary Search. This element must exactly match the ID on the patient's Medicare card.
84	2100C	DMG02	Subscriber Date of Birth	N/A	8	Date of Birth is required for Medicare Beneficiary Identification.
88	2100C	DTP01	Date/Time Qualifier	N/A	3	All codes are accepted; the same eligibility data is returned regardless of code submitted.
90	2110C	EQ01 ²	Service Type Code	N/A	1/2	All codes are accepted. ³ For a complete list of codes, refer to page 90 of the IG.
95	2110C	EQ02-1 ¹	Service ID Qualifier	N/A	2	All codes are accepted.
96	2110C	EQ02-2 ¹	Procedure Code	N/A	1/48	N/A

¹ For convenience, a Medicare Beneficiary's name suffix can also be appended to the last name field in order to meet matching constraints.

² Either EQ01 or EQ02 is required, but not both.

³ While all STCs will be accepted by the HETS 270/271 application, only those specified by this companion guide will return explicit benefit information. All other codes will return only the basic set of eligibility data.

10.2 271 ELIGIBILITY RESPONSE TRANSACTION

This section describes the values returned by CMS in the 271 eligibility response transaction. The following tables describe the CMS utilization of segments and elements when there is a type of uniqueness or restriction. All other values comply with the IG.

Table 12 – Header and Information Source

IG Page #	Loop ID	Reference	X12 Element Name	Codes	Length	Notes/ Comments	270 Service Type Code (EQ01)
157	Header	BHT03	Reference Identification	N/A	1/30	Reference Identification is required for real-time inquiry.	All
157	Header	BHT04	Date	N/A	8	System Date	All
157	Header	BHT05	Time	N/A	8	System Time Stamp	All
165	2100A	NM109	Identification Code	N/A	3	“CMS”	All

Table 13 – Information Receiver

IG Page #	Loop ID	Reference	X12 Element Name	Codes	Length	Notes/ Comments	270 Service Type Code (EQ01)
180	2100B	NM108	Identification Code Qualifier	XX	2	N/A	All
181	2100B	NM109	Identification Code	N/A	10	The Provider’s assigned NPI number as submitted on the 270 request.	All

Table 14 – Subscriber Demographic Data

IG Page #	Loop ID	Reference	X12 Element Name	Codes	Length	Notes/ Comments	270 Service Type Code (EQ01)
194	2100C	NM103	Name Last	N/A	1/35	Subscriber Last Name ¹	All

¹ If there are errors in the transaction, these data elements will be the same as the 270. If a match is found, these data elements will be the values from the CMS Eligibility Database with the exception of Subscriber Name Suffix, which will be returned only in the event of an error. If there is a valid Subscriber Name Suffix, it will be appended to the Subscriber Last Name field.

IG Page #	Loop ID	Reference	X12 Element Name	Codes	Length	Notes/ Comments	270 Service Type Code (EQ01)
194	2100C	NM104	Name First	N/A	1/25	Subscriber First Name ¹	All
194	2100C	NM105	Name Middle	N/A	1	Subscriber Middle Initial ¹	All
194	2100C	NM107	Name Suffix	N/A	1/10	Subscriber Name Suffix ¹	All
195	2100C	NM108	Identification Code Qualifier	MI	2	N/A	All
195	2100C	NM109	Identification Code	N/A	6/12	This data element is the HICN submitted on the 270 request or the active cross-referenced HICN when an inactive HICN is submitted.	All
197	2100C	REF01	Reference Identification Qualifier	Q4	2	N/A	All
198	2100C	REF02 ¹	Reference Identification	N/A	6/12	Used to communicate the submitted HICN from the 270 when a cross-referenced HICN is located	All
200	2100C	N301	Address Information	N/A	1/40	Medicare Beneficiary Address Line 1	All
200	2100C	N302	Address Information	N/A	1/40	Medicare Beneficiary Address Line 2	All
201	2100C	N401	City Name	N/A	2/30	Medicare Beneficiary City Name	All
202	2100C	N402	State or Province Code	N/A	2	Medicare Beneficiary State Code	All
202	2100C	N403	Postal Code	N/A	5 or 9	Medicare Beneficiary Postal ZIP Code	All
211	2100C	DMG02	Date Time Period	N/A	8	Medicare Beneficiary Date of Birth	All
211	2100C	DMG03	Gender Code	F, M	1	Medicare Beneficiary Gender Code ²	All

¹ REF segment in the 2100C loop is returned containing the HICN submitted on the 270 when an active/cross-referenced HICN is found and returned in the NM109. REF segment in the 2100C loop is also returned if submitted on the 270 and REF02=EJ.

² If there are errors in the transaction, this data element will be the same as the 270. If a match is found, this data element will be the value from the CMS Eligibility Database.

IG Page #	Loop ID	Reference	X12 Element Name	Codes	Length	Notes/ Comments	270 Service Type Code (EQ01)
216	2100C	DTP01	Date/Time Qualifier	307	3	N/A	All
217	2100C	DTP02	Date Time Period Format Qualifier	D8 or RD8	2 or 3	N/A	All
217	2100C	DTP03	Date Time Period	N/A	8 or 17	Eligibility Request Start Date or Eligibility Request Start and End Dates	All
216	2100C	DTP01	Date/Time Qualifier	442	3	N/A	All
217	2100C	DTP02	Date Time Period Format Qualifier	D8	2	N/A	All
217	2100C	DTP03	Date Time Period	N/A	8	Date of Death	All

Table 15 – Medicare Part A and Part B Eligibility

IG Page #	Loop ID	Reference	X12 Element Name	Codes	Length	Notes/ Comments	270 Service Type Code (EQ01)
219	2110C	EB01	Eligibility or Benefit Information	1 or 6	1	N/A	All
221	2110C	EB02	Coverage Level Code	IND	3	N/A	All
226	2110C	EB04	Insurance Type Code	MA or MB	2	EB04 may be omitted ¹	All
240	2110C	DTP01	Date/Time Qualifier	307	3	N/A	All
241	2110C	DTP02	Date Time Period Format Qualifier	D8 or RD8	2 or 3	D8, if only entitlement date; RD8, if entitlement and termination dates exist	All

¹ EB04 will be omitted when periods of ineligibility apply to both Medicare Part A and Part B.

IG Page #	Loop ID	Reference	X12 Element Name	Codes	Length	Notes/ Comments	270 Service Type Code (EQ01)
241	2110C	DTP03 ¹	Date Time Period	N/A	8 or 17	Entitlement or Entitlement and Termination dates ²	All

Table 16 – Part A Hospital and SNF Data³

IG Page #	Loop ID	Reference	X12 Element Name	Codes	Length	Notes/ Comments	270 Service Type Code (EQ01)
219	2110C	EB01	Eligibility or Benefit Information	K	1	Lifetime Reserve EB Loop	47/AG
221	2110C	EB03	Service Type Code	47	2	N/A	47/AG
226	2110C	EB04	Insurance Type Code	MA	2	N/A	47/AG
228	2110C	EB06	Time Period Qualifier	33	2	N/A	47/AG
229	2110C	EB09	Quantity Qualifier	LA	2	N/A	47/AG
230	2110C	EB10	Quantity	N/A	1/2	Lifetime Reserve Days Remaining	47/AG
219	2110C	EB01	Eligibility or Benefit Information	C	1	Part A Deductible EB Loop	47/AG
221	2110C	EB03	Service Type Code	47	2	N/A	47/AG
226	2110C	EB04	Insurance Type Code	MA	2	N/A	47/AG
228	2110C	EB06	Time Period Qualifier	29	2	N/A	47/AG
229	2110C	EB07	Monetary Amount	N/A	1/7	Deductible Amount	47/AG

¹ For inactive periods, DTP will only be included for a specific date range.

² When multiple entitlements are returned, they will occur in descending order: future, current, past.

³ Hospital Days remaining, Hospital Copayment Days Remaining, SNF Days Remaining, SNF Copayment Days Remaining, DOEBA, and DOLBA are related to a single Inpatient Spell and NOT to the individual general benefit. DTP segments will not be returned accompanying default Part A Deductible, Hospital Days Remaining, or SNF Days Remaining data. For each Inpatient Spell, DTP segments will be returned for each occurrence of an EB segment. Part A and SNF deductible and copayment per day values will be returned for future calendar years only when CMS-published values are available.

IG Page #	Loop ID	Reference	X12 Element Name	Codes	Length	Notes/ Comments	270 Service Type Code (EQ01)
240	2110C	DTP01	Date/Time Qualifier	435	3	N/A	47/AG
241	2110C	DTP02	Date Time Period Format Qualifier	RD8	3	N/A	47/AG
241	2110C	DTP03	Date Time Period	N/A	17	DOEBA-DOLBA	47/AG
219	2110C	EB01	Eligibility or Benefit Information	F	1	Hospital Days Remaining EB Loop	47/AG
221	2110C	EB03	Service Type Code	47	2	N/A	47/AG
226	2110C	EB04	Insurance Type Code	MA	2	N/A	47/AG
228	2110C	EB06	Time Period Qualifier	29	2	N/A	47/AG
229	2110C	EB09	Quantity Qualifier	DY	2	N/A	47/AG
230	2110C	EB10	Quantity	N/A	1/2	Hospital Days Remaining	47/AG
219	2110C	EB01	Eligibility or Benefit Information	B	1	Hospital Copayment Days Remaining EB Loop	47/AG
221	2110C	EB03	Service Type Code	47	2	N/A	47/AG
226	2110C	EB04	Insurance Type Code	MA	2	N/A	47/AG
228	2110C	EB06	Time Period Qualifier	29	2	N/A	47/AG
229	2110C	EB07	Monetary Amount	N/A	1/5	Daily Copayment Amount	47/AG
229	2110C	EB09	Quantity Qualifier	DY	2	N/A	47/AG
230	2110C	EB10	Quantity	N/A	1/2	Hospital Copayment Days Remaining	47/AG
219	2110C	EB01	Eligibility or Benefit Information	F	1	SNF Days Remaining EB Loop	AG
221	2110C	EB03	Service Type Code	AG	2	N/A	AG

IG Page #	Loop ID	Reference	X12 Element Name	Codes	Length	Notes/ Comments	270 Service Type Code (EQ01)
226	2110C	EB04	Insurance Type Code	MA	2	N/A	AG
228	2110C	EB06	Time Period Qualifier	29	2	N/A	AG
229	2110C	EB09	Quantity Qualifier	DY	2	N/A	AG
230	2110C	EB10	Quantity	N/A	1/2	SNF Days Remaining	AG
219	2110C	EB01	Eligibility or Benefit Information	B	1	SNF Copayment Days Remaining EB Loop	AG
221	2110C	EB03	Service Type Code	AG	2	N/A	AG
226	2110C	EB04	Insurance Type Code	MA	2	N/A	AG
228	2110C	EB06	Time Period Qualifier	29	2	N/A	AG
229	2110C	EB07	Monetary Amount	N/A	1/5	Daily Copayment Amount	AG
229	2110C	EB09	Quantity Qualifier	DY	2	N/A	AG
230	2110C	EB10	Quantity	N/A	1/2	SNF Copayment Days Remaining	AG

Table 17 – Home Health Data¹

IG Page #	Loop ID	Reference	X12 Element Name	Codes	Length	Notes/ Comments	270 Service Type Code (EQ01)
219	2110C	EB01	Eligibility or Benefit Information	X	1	N/A	All
221	2110C	EB03	Service Type Code	42	2	N/A	All

¹ Home Health Data will be returned only for episodes with end dates.

IG Page #	Loop ID	Reference	X12 Element Name	Codes	Length	Notes/ Comments	270 Service Type Code (EQ01)
226	2110C	EB04	Insurance Type Code	MA or MB	2	"MA" is returned if beneficiary is only Medicare Part A entitled; "MB" is returned if beneficiary is Medicare Part B entitled or Medicare Part A and Part B entitled.	All
228	2110C	EB06	Time Period Qualifier	26	2	N/A	All
240	2110C	DTP01	Date/Time Qualifier	193 or 194	3	N/A	All
241	2110C	DTP02	Date Time Period Format Qualifier	D8	2	N/A	All
241	2110C	DTP03 ¹	Date Time Period	N/A	8	Start Date, End Date, DOEBA or DOLBA	All
244	2110C	MSG01 ¹	Free-Form Message Text	N/A	10/15	"HHEH Start Date", "HHEH End Date", "HHEH DOEBA" or "HHEH DOLBA"	All
250	2120C	NM101	Entity Identifier Code	PR	2	N/A	42
251	2120C	NM102	Entity Type Qualifier	2	1	N/A	42
251	2120C	NM103	Name Last or Organization Name	N/A	10/30	"Cahaba GBA", "National Government Services, Inc.", "National Heritage Insurance Company", "Palmetto GBA" or "United Government Services, CA"	42
252	2120C	NM108	Identification Code Qualifier	PI	2	N/A	42
253	2120C	NM109	Identification Code	N/A	5	00011, 00180, 00380, 00450, 00454, 00456, 11004, 14004 or 15004	42

¹ All applicable dates pertaining to a Home Health episode will be returned along with their corresponding MSG segment.

IG Page #	Loop ID	Reference	X12 Element Name	Codes	Length	Notes/ Comments	270 Service Type Code (EQ01)
262	2120C	PRV01	Provider Code	HH	2	N/A	42
262	2120C	PRV02	Reference Identification Qualifier	HPI	2/3	N/A	42
263	2120C	PRV03	Reference Identification	N/A	10	NPI	42

Table 18 – Part B Deductible Data¹

IG Page #	Loop ID	Reference	X12 Element Name	Codes	Length	Notes/ Comments	270 Service Type Code (EQ01)
219	2110C	EB01	Eligibility or Benefit Information	C	1	N/A	All
221	2110C	EB03	Service Type Code	96	2	N/A	All
226	2110C	EB04	Insurance Type Code	MB	2	N/A	All
228	2110C	EB06	Time Period Qualifier	29	2	N/A	All
229	2110C	EB07	Monetary Amount	N/A	1/5	Deductible Amount	All
240	2110C	DTP01	Date/Time Qualifier	292	3	N/A	All
241	2110C	DTP02	Date Time Period Format Qualifier	RD8	3	N/A	All
241	2110C	DTP03	Date Time Period	N/A	17	CCYY0101-CCYY1231	All

¹ Part B Deductible values will be returned for future calendar years only when CMS-published values are available.

Table 19 – Preventive Data

Page #	Loop ID	Reference	X12 Element Name	Codes	Length	Notes/ Comments	270 Service Type Code (EQ01)
219	2110C	EB01	Eligibility or Benefit Information	D	1	Preventive Services EB Loop(s)	All
221	2110C	EB02	Coverage Level Code	IND	3	N/A	All
226	2110C	EB04	Insurance Type Code	MB	2	N/A	All
231	2110C	EB13-1	Product/ Service ID Qualifier	HC	2	N/A	All
231	2110C	EB13-2	Product/ Service ID	N/A	5	HCPCS Code	All
231	2110C	EB13-3	Procedure Modifier	26 or TC	2	HCPCS Modifier 26 (Professional Component) or TC (Technical Component) Omit EB13-3 if the dates are the same.	All
240	2110C	DTP01	Date/Time Qualifier	348	3	N/A	All
241	2110C	DTP02	Date Time Period Format Qualifier	D8	2	N/A	All
241	2110C	DTP03	Date Time Period	N/A	8	Next Eligible Date	All

Table 20 – Smoking/Tobacco Cessation Data

Page #	Loop ID	Reference	X12 Element Name	Codes	Length	Notes/ Comments	270 Service Type Code (EQ01)
219	2110C	EB01 ¹	Eligibility or Benefit Information	F	1	Smoking/Tobacco Cessation Sessions Remaining EB Loop	All

¹ Smoking/Tobacco Cessation Counseling Sessions Remaining will be returned when the Beneficiary is eligible for Smoking/Tobacco Cessation Counseling with no waiting period; next eligible date will not be returned.

Page #	Loop ID	Reference	X12 Element Name	Codes	Length	Notes/ Comments	270 Service Type Code (EQ01)
221	2110C	EB02	Coverage Level Code	IND	3	N/A	All
221	2110C	EB03	Service Type Code	67	2	N/A	All
226	2110C	EB04	Insurance Type Code	MB	2	N/A	All
228	2110C	EB06	Time Period Qualifier	29	2	N/A	All
229	2110C	EB09	Quantity Qualifier	P6	2	N/A	All
230	2110C	EB10	Quantity	N/A	1/2	Sessions remaining	All
219	2110C	EB01 ¹	Eligibility or Benefit Information	D	1	Smoking/Tobacco Cessation Next Eligible Date EB Loop	All
221	2110C	EB02	Coverage Level Code	IND	3	N/A	All
221	2110C	EB03	Service Type Code	67	2	N/A	All
226	2110C	EB04	Insurance Type Code	MB	2	N/A	All
240	2110C	DTP01	Date/Time Qualifier	348	3	N/A	All
241	2110C	DTP02	Date Time Period Format Qualifier	D8	2	N/A	All
241	2110C	DTP03	Date Time Period	N/A	8	Next Eligible Date	All

¹ Smoking/Tobacco Cessation Counseling Next Eligible Date will be returned when no Smoking/Tobacco Cessation Counseling sessions remain; sessions remaining will not be returned.

Table 21 – Therapy Cap Data¹

IG Page #	Loop ID	Reference	X12 Element Name	Codes	Length	Notes/ Comments	270 Service Type Code (EQ01)
219	2110C	EB01	Eligibility or Benefit Information	F	1	Occupation Therapy Capitation EB Loop	All
221	2110C	EB02	Coverage Level Code	IND	3	N/A	All
221	2110C	EB03	Service Type Code	AD	2	N/A	All
226	2110C	EB04	Insurance Type Code	MB	2	N/A	All
228	2110C	EB06	Time Period Qualifier	29	2	N/A	All
229	2110C	EB07	Monetary Amount	N/A	1/7	Therapy Capitation Amount	All
240	2110C	DTP01	Date/Time Qualifier	292	3	N/A	All
241	2110C	DTP02	Date Time Period Format Qualifier	RD8	3	N/A	All
241	2110C	DTP03	Date Time Period	N/A	17	CCYY0101-CCYY1231	All
219	2110C	EB01	Eligibility or Benefit Information	F	1	Physical/Speech Therapy Capitation EB Loop	All
221	2110C	EB02	Coverage Level Code	IND	3	N/A	All
221	2110C	EB03	Service Type Code	AE	2	N/A	All
226	2110C	EB04	Insurance Type Code	MB	2	N/A	All
228	2110C	EB06	Time Period Qualifier	29	2	N/A	All
229	2110C	EB07	Monetary Amount	N/A	1/7	Physical/Speech Therapy Capitation Amount	All
240	2110C	DTP01	Date/Time Qualifier	292	3	N/A	All

¹ Therapy Caps values will be returned for future calendar years only when CMS-published values are available.

IG Page #	Loop ID	Reference	X12 Element Name	Codes	Length	Notes/ Comments	270 Service Type Code (EQ01)
241	2110C	DTP02	Date Time Period Format Qualifier	RD8	3	N/A	All
241	2110C	DTP03	Date Time Period	N/A	17	CCYY0101-CCYY1231	All

Table 22 – ESRD Data

IG Page #	Loop ID	Reference	X12 Element Name	Codes	Length	Notes/ Comments	270 Service Type Code (EQ01)
219	2110C	EB01	Eligibility or Benefit Information	D	1	N/A	14/15
221	2110C	EB03	Service Type Code	14 or 15	2	N/A	14/15
226	2110C	EB04	Insurance Type Code	MA or MB	2	N/A	14/15
240	2110C	DTP01	Date/Time Qualifier	356	3	N/A	14/15
241	2110C	DTP02	Date Time Period Format Qualifier	D8	2	N/A	14/15
241	2110C	DTP03	Date Time Period	N/A	8	ESRD Effective Date	14/15
240	2110C	DTP01	Date/Time Qualifier	198	3	N/A	14/15
241	2110C	DTP02	Date Time Period Format Qualifier	D8	2	N/A	14/15
241	2110C	DTP03	Date Time Period	N/A	8	Transplant Discharge Date	14/15
244	2110C	MSG01	Free-Form Message Text	N/A	24	“Transplant Discharge Date”	14/15

Table 23 – Hospice Data

IG Page #	Loop ID	Reference	X12 Element Name	Codes	Length	Notes/ Comments	270 Service Type Code (EQ01)
219	2110C	EB01	Eligibility or Benefit Information	X	1	N/A	All
221	2110C	EB03	Service Type Code	45	2	N/A	All
226	2110C	EB04	Insurance Type Code	MA	2	N/A	All
228	2110C	EB06	Time Period Qualifier	26	2	N/A	All
240	2110C	DTP01	Date/Time Qualifier	292	3	N/A	All
241	2110C	DTP02	Date Time Period Format Qualifier	D8 or RD8	2 or 3	N/A	All
241	2110C	DTP03	Date Time Period	N/A	8 or 17	Effective Date or Effective and Revocation Dates	All
250	2120C	NM101	Entity ID Code	1P	2	N/A	45
251	2120C	NM102	Entity Type Qualifier	2	1	N/A	45
252	2120C	NM108	Identification Code Qualifier	XX	2	N/A	45
253	2120C	NM109	Identification Code	N/A	10	NPI	45

Table 24 – Blood Deductible Data¹

IG Page #	Loop ID	Reference	X12 Element Name	Codes	Length	Notes/ Comments	270 Service Type Code (EQ01)
219	2110C	EB01	Eligibility or Benefit Information	C	1	N/A	All
221	2110C	EB02	Coverage Level Code	IND	3	N/A	All
221	2110C	EB03	Service Type Code	10	2	N/A	All

¹ Blood Deductible Units will be returned for future calendar years only when CMS-published values are available.

IG Page #	Loop ID	Reference	X12 Element Name	Codes	Length	Notes/ Comments	270 Service Type Code (EQ01)
228	2110C	EB06	Time Period Qualifier	29	2	N/A	All
229	2110C	EB09	Quantity Qualifier	DB	2	N/A	All
230	2110C	EB10	Quantity	N/A	1	Number of Units	All
240	2110C	DTP01	Date/Time Qualifier	292	3	N/A	All
241	2110C	DTP02	Date Time Period Format Qualifier	RD8	3	N/A	All
241	2110C	DTP03	Date Time Period	N/A	17	CCYY0101-CCYY1231	All

Table 25 – Part D Enrollment Data

IG Page #	Loop ID	Reference	X12 Element Name	Codes	Length	Notes/ Comments	270 Service Type Code (EQ01)
219	2110C	EB01	Eligibility or Benefit Information	R	1	Part D Enrollment EB Loop	All
221	2110C	EB03	Service Type Code	88	2	N/A	All
226	2110C	EB04	Insurance Type Code	OT	2	N/A	All
238	2110C	REF01	Part D Data	18	2	N/A	All
239	2110C	REF02	Part D Data	N/A	5 or 9	Contract Number and Plan Number separated by a space. If a Plan Number is unavailable only the Contract Number will be in this element.	All
240	2110C	DTP01	Date/Time Qualifier	292	3	N/A	All
241	2110C	DTP02	Date Time Period Format Qualifier	D8 or RD8	2 or 3	N/A	All

IG Page #	Loop ID	Reference	X12 Element Name	Codes	Length	Notes/ Comments	270 Service Type Code (EQ01)
241	2110C	DTP03	Date Time Period	N/A	8 or 17	Part D Enrollment Date or Part D Enrollment and Disenrollment Dates	All
250	2120C	NM101	Entity Identifier Code	PR	2	N/A	All
251	2120C	NM102	Entity Type Qualifier	2	1	N/A	All
251	2120C	NM103	Name Last or Organization Name	N/A	1/35	Plan Name	All
254	2120C	N301	Address Information	N/A	1/55	Payer Address Line 1	All
254	2120C	N302	Address Information	N/A	1/55	Payer Address Line 2	All
255	2120C	N401	City Name	N/A	2/30	Payer City	All
256	2120C	N402	State or Province Code	N/A	2	Payer State Code	All
256	2120C	N403	Postal Code	N/A	5 or 9	Payer ZIP Code	All
258	2120C	PER01	Contact Function Code	IC	2	N/A	All
258	2120C	PER03	Communication Number Qualifier	TE	2	N/A	All
259	2120C	PER04	Communication Number	N/A	10	Telephone Number (format AAABBBCCCC)	All

Table 26 – MA Enrollment Data

IG Page #	Loop ID	Reference	X12 Element Name	Codes	Length	Notes/ Comments	270 Service Type Code (EQ01)
219	2110C	EB01	Eligibility or Benefit Information	R	1	MA EB Loop	All
221	2110C	EB03	Service Type Code	30	2	N/A	All

IG Page #	Loop ID	Reference	X12 Element Name	Codes	Length	Notes/ Comments	270 Service Type Code (EQ01)
226	2110C	EB04	Insurance Type Code	HM, HN, IN, PR, or PS	2	N/A	All
238	2110C	REF01	Reference Identification Qualifier	18	2	N/A	All
239	2110C	REF02	Reference Identification	N/A	5 or 9	Contract Number and Plan Number separated by a space. If a Plan Number is unavailable only the Contract Number will be in this element.	All
240	2110C	DTP01	Date/Time Qualifier	290	3	N/A	All
241	2110C	DTP02	Date Time Period Format Qualifier	D8 or RD8	2 or 3	N/A	All
241	2110C	DTP03	Date Time Period	N/A	8 or 17	MA Enrollment Date or MA Enrollment and Disenrollment Dates	All
244	2110C	MSG01	Free Form Message Text	N/A	1/264	"MCO Bill Option Code – (code value)". Code values returned are: A, B, C, 1 and 2.	All
250	2120C	NM101	Entity Identifier Code	PR or PRP	3	N/A	All
251	2120C	NM102	Entity Type Qualifier	2	1	N/A	All
251	2120C	NM103	Name Last or Organization Name	N/A	1/35	Insurer Name	All
254	2120C	N301	Address Information	N/A	1/55	MA Address Line 1	All
254	2120C	N302	Address Information	N/A	1/55	MA Address Line 2	All

IG Page #	Loop ID	Reference	X12 Element Name	Codes	Length	Notes/ Comments	270 Service Type Code (EQ01)
255	2120C	N401	City Name	N/A	2/30	MA City	All
256	2120C	N402	State or Province Code	N/A	2	MA State Code	All
256	2120C	N403	Postal Code	N/A	5 or 9	MA ZIP Code	All
258	2120C	PER01	Contact Function Code	IC	2	N/A	All
258	2120C	PER03	Communication Number Qualifier	TE	2	N/A	All
259	2120C	PER04	Communication Number	N/A	10	Telephone Number (format AAABBBCCCC)	All

Table 27 – MSP Enrollment Data

IG Page #	Loop ID	Reference	X12 Element Name	Codes	Length	Notes/ Comments	270 Service Type Code (EQ01)
219	2110C	EB01	Eligibility or Benefit Information	R	1	N/A	All
221	2110C	EB02	Coverage Level Code	IND	3	N/A	All
221	2110C	EB03	Service Type Code	30	2	N/A	All
226	2110C	EB04	Insurance Type Code	N/A	2	MSP Code: 12, 13, 14, 15, 16, 41, 42, 43, 47, or WC	All
238	2110C	REF01	Reference Identification Qualifier	IG	2	N/A	All
239	2110C	REF02	Reference Identification	N/A	1/17	Policy Number	All
240	2110C	DTP01	Date/Time Qualifier	290	3	N/A	All
241	2110C	DTP02	Date Time Period Format Qualifier	D8 or RD8	2 or 3	N/A	All

IG Page #	Loop ID	Reference	X12 Element Name	Codes	Length	Notes/ Comments	270 Service Type Code (EQ01)
241	2110C	DTP03	Date Time Period	N/A	8 or 17	MSP Effective Date or MSP Effective and Termination Dates	All
250	2120C	NM101	Entity Identifier Code	PRP	3	N/A	All
251	2120C	NM102	Entity Type Qualifier	2	1	N/A	All
251	2120C	NM103	Name Last or Organization Name	N/A	1/32	Insurer Name	All
254	2120C	N301	Address Information	N/A	1/32	MSP Address Line 1	All
254	2120C	N302	Address Information	N/A	1/32	MSP Address Line 2	All
255	2120C	N401	City Name	N/A	2/15	MSP City	All
256	2120C	N402	State or Province Code	N/A	2	MSP State Code	All
256	2120C	N403	Postal Code	N/A	5 or 9	MSP ZIP Code	All

APPENDIX A – SAMPLE 270 ELIGIBILITY REQUEST TRANSACTION

□0000000494□
ISA*00* *00* *ZZ*T000000011 *ZZ*CMS
*050516*0734*U*00401*000005014*1*P*:~
GS*HS*T000000011*CMS*20050516*073411*5014*X*004010X092A1~
ST*270*000000001~
BHT*0022*13*ALL*20080101*073411~
HL*1**20*1~
NM1*PR*2*CMS*****PI*CMS~
HL*2*1*21*1~
NM1*1P*1*TEST*****XX*9999999999~
HL*3*2*22*0~
TRN*1*TEST-TEST*9TEST ~
NM1*IL*1*SMITH*MARY****MI*123456789A~
DMG*D8*19240901~
DTP*472*RD8*20070101-20090330~
EQ*30~
EQ*47~
EQ*AG~
EQ*42~
EQ*14~
EQ*45~
SE*18*000000001~
GE*1*5014~
IEA*1*000005014~
□

APPENDIX B – SAMPLE 271 ELIGIBILITY RESPONSE TRANSACTION

□0000003878□
 ISA*00* *00* *ZZ*CMS *ZZ*T000000011
 *090326*1705*U*00401*002417703*0*P*|~
 GS*HB*CMS*T000000011*20090326*1705*2381770*X*004010X092A1~
 ST*271*2377396~
 BHT*0022*11*ALL*20090326*17055389~
 HL*1**20*1~
 NM1*PR*2*CMS*****PI*CMS~
 HL*2*1*21*1~
 NM1*1P*2*TEST*****XX*1234567893~
 HL*3*2*22*0~
 TRN*2*TEST-TEST*9TEST ~
 NM1*IL*1*SMITH*MARY****MI*123456789A~
 N3*123 MAIN STREET*~
 N4*ANYTOWN*MD*999999999~
 DMG*D8*19240901*F~
 INS*Y*18*001*25~
 DTP*307*RD8*20070101-20090325~
 EB*1*IND**MA~
 DTP*307*D8*19890801~
 EB*K**47*MA**33***LA*60~
 EB*C**47*MA**29*992~
 EB*F**47*MA**29***DY*60~
 EB*B**47*MA**29*248**DY*30~
 EB*F**AG*MA**29***DY*20~
 EB*B**AG*MA**29*124**DY*80~
 EB*1*IND**MB~
 DTP*307*D8*19890801~
 EB*C**96*MB**29*0~
 DTP*292*RD8*20090101-20091231~
 EB*C**96*MB**29*0~
 DTP*292*RD8*20080101-20081231~
 EB*C**96*MB**29*0~
 DTP*292*RD8*20070101-20071231~
 EB*D*IND**MB*****HC|G0389~
 DTP*348*D8*20070701~
 EB*D*IND**MB*****HC|77057~
 DTP*348*D8*20070101~
 EB*D*IND**MB*****HC|82270~
 DTP*348*D8*20070101~
 EB*D*IND**MB*****HC|Q0091~
 DTP*348*D8*20050701~
 EB*D*IND**MB*****HC|82951~
 DTP*348*D8*20050101~
 EB*D*IND**MB*****HC|84478~
 DTP*348*D8*20050101~
 EB*D*IND**MB*****HC|82950~
 DTP*348*D8*20050101~
 EB*D*IND**MB*****HC|82947~
 DTP*348*D8*20050101~
 EB*D*IND**MB*****HC|82465~

DTP*348*D8*20050101~
EB*D*IND**MB*****HC | 80061~
DTP*348*D8*20050101~
EB*D*IND**MB*****HC | 83718~
DTP*348*D8*20050101~
EB*D*IND**MB*****HC | G0202~
DTP*348*D8*20040201~
EB*D*IND**MB*****HC | G0328~
DTP*348*D8*20040101~
EB*D*IND**MB*****HC | G0118~
DTP*348*D8*20020101~
EB*D*IND**MB*****HC | G0117~
DTP*348*D8*20020101~
EB*D*IND**MB*****HC | G0101~
DTP*348*D8*20010701~
EB*D*IND**MB*****HC | P3000~
DTP*348*D8*20010701~
EB*D*IND**MB*****HC | G0148~
DTP*348*D8*20010701~
EB*D*IND**MB*****HC | G0147~
DTP*348*D8*20010701~
EB*D*IND**MB*****HC | G0145~
DTP*348*D8*20010701~
EB*D*IND**MB*****HC | G0144~
DTP*348*D8*20010701~
EB*D*IND**MB*****HC | G0143~
DTP*348*D8*20010701~
EB*D*IND**MB*****HC | G0121~
DTP*348*D8*20010701~
EB*D*IND**MB*****HC | G0123~
DTP*348*D8*20010701~
EB*D*IND**MB*****HC | G0105~
DTP*348*D8*19980101~
EB*D*IND**MB*****HC | G0106~
DTP*348*D8*19980101~
EB*D*IND**MB*****HC | 82270~
DTP*348*D8*19980101~
EB*D*IND**MB*****HC | G0104~
DTP*348*D8*19980101~
EB*D*IND**MB*****HC | G0120~
DTP*348*D8*19980101~
EB*D*IND**MB*****HC | 90732~
DTP*348*D8*19890801~
EB*F*IND*67*MB**29***P6*8~
EB*F*IND*AD*MB**29*1840~
DTP*292*RD8*20090101-20091231~
EB*F*IND*AE*MB***29*1840~
DTP*292*RD8*20090101-20091231~
EB*F*IND*AD*MB**29*1810~
DTP*292*RD8*20080101-20081231~
EB*F*IND*AE*MB***29*1810~
DTP*292*RD8*20080101-20081231~
EB*F*IND*AD*MB**29*1780~
DTP*292*RD8*20070101-20071231~
EB*F*IND*AE*MB***29*1780~
DTP*292*RD8*20070101-20071231~

EB*X**45*MA**26~
DTP*292*RD8*20080208-20081217~
LS*2120~
NM1*1P*2*****XX*1427038314~
LE*2120~
EB*X**45*MA**26~
DTP*292*D8*20061016~
LS*2120~
NM1*1P*2*****SV*031549~
LE*2120~
EB*C*IND*10***29***DB*3~
DTP*292*RD8*20090101-20091231~
EB*C*IND*10***29***DB*3~
DTP*292*RD8*20080101-20081231~
EB*C*IND*10***29***DB*3~
DTP*292*RD8*20070101-20071231~
EB*R**88*OT~
REF*18*H9999 999~
DTP*292*D8*20070801~
LS*2120~
NM1*PR*2*ABC HEALTH PLAN~
N3*123 MAIN STREET~
N4*ANYTOWN*MD*999999999~
PER*IC**TE*999999999~
LE*2120~
EB*R**88*OT~
REF*18*S9999 999~
DTP*292*RD8*20070101-20070731~
LS*2120~
NM1*PR*2*ABC INSURANCE COMPANY~
N3*123 MAIN STREET~
N4*ANYTOWN*MD*999999999~
PER*IC**TE*999999999~
LE*2120~
EB*R**30*HN~
REF*18*H9999 999~
DTP*290*D8*20070801~
MSG*MCO Bill Option Code - C~
LS*2120~
NM1*PRP*2*ABC HEALTH PLAN~
N3*123 MAIN STREET~
N4*ANYTOWN*MD*999999999~
PER*IC**TE*999999999~
LE*2120~
EB*R*IND*30*14~
DTP*290*D8*19960912~
LS*2120~
NM1*PRP*2*SMITH~
LE*2120~
SE*156*2377396~
GE*1*2381770~
IEA*1*002417703~

□

APPENDIX C – ACRONYMS

The acronyms in Table 28 are used in this document.

Table 28 - Acronyms

Acronym	Definition
ASC	Accredited Standards Committee
CMS	Centers for Medicare & Medicaid Services
DOB	Date of Birth
DOEBA	Date of Earliest Billing Activity
DOLBA	Date of Latest Billing Activity
EDI	Electronic Data Interchange
ESRD	End Stage Renal Disease
HCPCS	Healthcare Common Procedure Coding System
HETS	HIPAA Eligibility Transaction System
HICN	Health Insurance Claim Number
HIPAA	Health Insurance Portability and Accountability Act of 1996
HMO	Health Maintenance Organization
IG	ASC X12 270/271 Implementation Guide
IP	Internet Protocol
MA	Medicare Advantage
MAC	Medicare Administrative Contractor
MCARE	Medicare Customer Assistance Regarding Eligibility
MDCN	Medicare Data Communication Network
MSP	Medicare Secondary Payer
NPI	National Provider Identifier
POS	Point of Service
PPO	Preferred Provider Organization
RRB	Railroad Retirement Board
SNF	Skilled Nursing Facility
STC	Service Type Code
TPMS	Trading Partner Management System

APPENDIX D – REVISION HISTORY

Table 29 provides a summary of changes made to this document.

Table 29 – Document Revision History

Version	Date	Description of Changes
1.0	03/31/2009	Baseline Version
1.1	04/28/2009	<p>R2009Q200 changes:</p> <p>Section 4.3 – Added information regarding socket connection closure after 5 seconds has elapsed since the last transaction.</p> <p>Section 7.6 and Table 16 – Updated “co-insurance” to “co-payment” for Part A Hospital and SNF.</p> <p>Section 7.9 – Added HCPCS code 90669 for Pneumococcal (PPV) category.</p> <p>Section 7.13 – Added bullet item to address the change that all hospice periods that intersect the requested date(s) of service will be returned.</p>
1.2	12/15/2009	<p>R2009Q400 changes:</p> <p>Table 27 – Added “WC” to list of values for MSP Insurance Type Code.</p> <p>Table 3 – Updated length for element GS02 to “8 or 10” to eliminate confusion with the new 8 character Submitter IDs.</p>
1.3	04/19/2010	<p>Changes include:</p> <p>Section 4.2.1 – Updated date and time for system maintenance.</p> <p>Updated CMS website addresses to the new standard (cms.gov instead of cms.hhs.gov).</p>
1.4	05/03/2010	<p>Changes include:</p> <p>Section 7.11 – Added bullet regarding the use of EB03 = “AE”; updated example segments.</p> <p>Table 6 – Added AAA Error Code “56”.</p> <p>Table 7 – Updated length of Proprietary</p>

Version	Date	Description of Changes
		<p>Error Message Text Description</p> <p>Table 8 – Updated Proprietary Error Message Codes and Descriptions.</p> <p>Table 21 – Updated for element EB03.</p> <p>Appendix B – Updated Sample 271 Eligibility Response Transaction with changes associated with Therapy Capitation.</p>
1.5	06/08/2010	<p>Changes include:</p> <p>Table 6 – Added AAA Error Codes “41”, “50” and “51” and updated description for AAA Error Code “43”.</p>
1.6	11/30/2010	<p>Changes include:</p> <p>Section 7.5 – Updated example for Inactive.</p> <p>Section 7.6 – Updated examples with co-payment explanations.</p> <p>Section 7.7 – Added bullet for Insurance Type Codes “MA” and “MB”; added example for Insurance Type Code “MB”.</p> <p>Section 7.9 – Added HCPCS code G9143 and changed Diabetes Self-Management Training to Diabetes Screening Tests.</p> <p>Section 7.11 – Removed not about 2007 since it is not within 27 months.</p> <p>Section 7.13 – Added bullet for additional Hospice verbiage.</p> <p>Section 7.16 – Added bullet for explanation of MCO Bill Option Code and added this element to the example.</p> <p>Table 7 – Added Data Element Response Code “ D”.</p> <p>Table 17 – Added Insurance Type Code “MB” and Note/Comment; removed PRV02 value “9K”, PRV03 value “Legacy Provider ID” and PRV03 field length “6”.</p> <p>Table 23 – Removed NM108 value “SV”, NM109 value “Legacy Provider ID” and NM109 field length “6”.</p>

Version	Date	Description of Changes
		<p>Table 26 – Added IG page 322 2110C MSG01="MCO Bill Option Code – (code value)" and values.</p> <p>Appendix B – Added MSG*MCO Bill Option Code – C~.</p> <p>Appendix C – Added ESRD to list of acronyms.</p>
1.7	03/21/2011	<p>Changes include:</p> <p>General – removed references to AGNS/MDCN and AT&T</p> <p>Section 4.3 – Updated with CMS Best Practices for HETS Connections</p> <p>Section 7.9 – Added HCPCS code 90670.</p> <p>Section 7.10 and Table 20 – Added tobacco cessation counseling.</p> <p>Table 17 – Updated values for NM103 and NM109.</p>
1.8	06/13/2011	<p>Changes include:</p> <p>Section 7.9 – Added HCPCS codes G0438 and G0439.</p>
1-9	12/20/2011	<p>Changes include:</p> <p>Sections 2.1 and 5 – Updated MCARE hours of operation.</p>