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HIPAA Eligibility Transaction System (HETS)
Health Care Eligibility Benefit Inquiry and Response (270/271)
5010 Companion Guide Supplement for Disproportionate Share Hospital (DSH) Submitters

FINAL

Version: 3-5

Last Updated: November 2017

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1 INTRODUCTION

CMS permits the use of the HETS 270/271 application by Medicare Disproportionate Share Hospital (DSH) Submitters and their agents (independent auditors related to DSH fraud, waste and abuse investigations) to receive a limited subset of eligibility data. This data assists DSH Submitters with the:

- Verification of CMS' determination of the hospital's Supplemental Security Income (SSI) ratio (the total number of Medicare days compared to the number of Medicare/SSI days);
- Calculation of the Medicare disproportionate patient percentage (DPP);
- Preparation for Medicare DSH audits by simulating auditor practices, such as mass eligibility checks for all hospital patients; or
- Investigation of DSH fraud, waste and abuse by independent auditors.

Sections 1.1 - 1.3 of this document are intended to replace Sections 1.1 - 1.3 of the HETS 270/271 5010 Companion Guide. Section numbering in this document corresponds to the HETS 270/271 5010 Companion Guide; any gaps in numbering are intentional.

1.1 SCOPE

This document is intended as a supplement for Medicare authorized DSH Submitters interested in exchanging eligibility transactions with the Medicare Health Insurance Portability and Accountability Act (HIPAA) Eligibility Transaction System (HETS) 270/271 application that has been modified to return limited data. It is to be used in conjunction with the ASC X12 270/271 version 005010X279A1, the ASC X12 999 version 005010X231A1 TR3s and the HETS 270/271 5010 Companion Guide. This document contains information about specific Medicare requirements for processing the DSH 270/271 transactions.

1.2 OVERVIEW

This supplement to the HETS 270/271 5010 Companion Guide is applicable to DSH Submitters.

The information included in the DSH 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 limited patient financial responsibility for Medicare Part A.

The data included in a DSH 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 should be directed to the appropriate regional Medicare Administrative Contractor (MAC). Eligibility/benefit questions

about Medicare Advantage (MA) and Medicare Secondary Payer (MSP) should be directed to the appropriate plan(s) identified in the DSH 271 response.

1.3 REFERENCES

- The ASC X12 270/271 version 005010X279A1 and the ASC X12 999 version 005010X231A1 TR3s can be purchased from the publisher, Washington Publishing Company, at their website: http://store.x12.org/store/
- HETS 270/271 5010 Companion Guide - https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp/Downloads/HETS270271CompanionGuide5010.pdf
- The HETS Trading Partner Agreement (TPA) form to request access to the HETS 270/271 application is available for download from the CMS HETS Help website. Use the following link to display the “How to Get Connected - HETS 270/271” page: http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp/HowtoGetConnectedHETS270271.html.

7 PAYER SPECIFIC BUSINESS RULES AND LIMITATIONS

This section describes the business rules and limitations of the HETS 270/271 application for DSH transactions and is intended to replace Section 7 of the HETS 270/271 5010 Companion Guide.

All references to the ASC X12 270/271 version 005010X279A1 TR3 assume the version referenced in Section 1.1 of this document.

7.1 GENERAL STRUCTURAL NOTES

- Trading Partners should follow the ST/SE guidelines outlined in the 270 section of the ASC X12 270/271 version 005010X279A1 TR3.
- Trading Partners should follow the ISA/IEA and GS/GE guidelines for HIPAA in Appendix C of the ASC X12 270/271 version 005010X279A1 TR3 and follow the 999 and TA1 guidelines outlined in the ASC X12 version 005010X231A1 TR3.
- Trading Partners must follow the character set guidelines as defined in the Appendix of the ASC X12 270/271 version 005010X279A1 TR3.
- CMS strongly recommends that Trading Partners use the preferred 270 request transaction delimiters in Table 1. HETS will utilize these delimiters for all 271 responses (regardless of the delimiters the Trading Partner sent in the 270 request).

Table 1 - Preferred 270 Request Transaction Delimiters

Character	Name	Delimiter
*	Asterisk	Data Element Separator
|	Pipe	Component Element Separator
~	Tilde	Segment Terminator
^	Carat	Repetition Separator

- 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 data is updated once daily (early in the morning, Eastern Time). The HETS 271 response will not be updated further during the course of a day. Trading Partners should not resubmit the same transaction multiple times during the course of a day expecting to receive different results.
- The HETS 270/271 application will return benefit data if the Medicare Beneficiary is entitled to Medicare Part A. The HETS 270/271 application will not return Medicare Part B eligibility data within a DSH 271 response.
- The HETS 270/271 application will return a 999 response if dependent level data is sent within a 270 request.
- The HETS 270/271 application will always return a basic set of eligibility information regardless of the Service Type Code (STC) submitted on the 270 request.
- 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.
- The DSH 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 DSH 271 responses with the preferred delimiters as noted in Table 1 of this document.
- Trading Partners will receive a AAA error in the 2100A Loop with a reject reason code of AAA03 = "42" 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.

7.3 MEDICARE BENEFICIARY MATCHING RULES

- The HETS 270/271 application applies search logic that uses a combination of the following data elements: Health Insurance Claim Number (HICN) or Medicare Beneficiary Identifier (MBI)[1], Medicare Beneficiary's Date of Birth (DOB), Medicare Beneficiary's Full Last Name, and Medicare Beneficiary's Full First Name. Trading Partners should not submit any additional Beneficiary data elements in an attempt to generate a match. Table 2 describes the necessary data elements for the required primary and alternate search options supported by the HETS 270/271 application.

Table 2 - HETS 270/271 Search Options

Search	HICN or MBI[2]	Last Name	First Name	DOB
Primary	X	X	X	X
Alternate 1	X	X		X
Alternate 2	X	X	X	

- The HETS 270/271 application only accepts HICNs through March, 2018. Effective April 1, 2018 and continuing through the New Medicare Card transition period the HETS 270/271 application will accept either the HICN or MBI on 270 requests. HETS Submitters will submit either the MBI or HICN in the 270 2100C NM109 element, and will use the identical 270 2100C NM108 qualifier. HETS will continue to accept either the HICN or the MBI until December 31, 2019. Effective January 1, 2020, HETS will only accept the MBI. Table 3 outlines HETS 270/271 HICN and MBI processing during the transition period.

[1] Effective April 1, 2018
[2] Effective April 1, 2018

Table 3 - HETS HICN & MBI Processing During the New Medicare Card Transition Period[3]

Subscriber Primary Identifier Sent on 270 Request	HETS 271 Response	Comments
Medicare HICN	Medicare HICN	If a HICN is sent on the 270 request, HETS will return a HICN in the 271 response. Additionally, if certain criteria are met, HETS will return a 2110C MSG segment of "CMS mailed a Medicare card with a new Medicare Beneficiary Identifier (MBI) to this beneficiary. Medicare providers, please get the new MBI from your patient and save it in your system(s)." This additional MSG segment will be returned when: • A new Medicare card with an MBI number has been mailed to the Medicare Beneficiary. AND • The Medicare Beneficiary is currently enrolled in traditional Medicare and not a Medicare Advantage plan. Medicare Advantage plans will continue to assign and use their own identifiers on their health insurance cards. For patients in these plans, Medicare providers/suppliers should continue to ask for and use the Medicare Advantage plans' health insurance cards. AND • The Medicare Beneficiary does not have a Date of Death on file.
MBI	MBI	If an MBI is sent on the 270 request, HETS will return an MBI in the 271 response. Additionally, If the individual qualifies for Medicare under RRB, HETS will return a 2110C MSG segment of "Railroad Retirement Medicare Beneficiary."

- CMS encourages all HETS Submitters to migrate their systems to submit the MBI as soon as the new Medicare card and number is available.
- Medicare Beneficiary MBI numbers can be replaced in specific circumstances. If a Medicare Beneficiary's MBI number has been changed, then HETS will[4] accept historical 270 requests with either a) the new MBI or b) the old MBI number only if the old MBI was active during the Date(s) of Service submitted on the request.

[3] Effective April 1, 2018
[4] Effective April 1, 2018

- If the Medicare Beneficiary's submitted HICN or MBI is found but is not the Medicare Beneficiary's active number, the HETS 270/271 application will cross-reference the submitted HICN to the active HICN or[5] submitted MBI to the active MBI. The 271 response will include in the 2100C Loop the inactive HICN or MBI within a REF segment, the active HICN or MBI within NM109, and a AAA error with a reject reason code of AAA03 = "72". The Trading Partner may then send a new 270 request with the active HICN or MBI.
- If the Trading Partner submits a Beneficiary's Middle Name or Initial in the 270 2100C NM105 or a Gender Code in the 270 2100C DMG03 then HETS will return a 999 response. Additionally, HETS will reject any requests where the 270 2100C REF01 contains a value of 'SY'. Trading Partners should not submit any additional Beneficiary data elements outside of those listed above in Table 2.
- If the search criteria do not produce a match to a Medicare Beneficiary, the HETS 270/271 application will generate the appropriate AAA03 error code in the DSH 271 response. Refer to Section 8.3 of this document for additional information.

7.4 DATE REQUEST RULES

- The HETS 270/271 application will respond with current eligibility information if no date is contained in the 270 request.
- CMS will verify that the requested date(s) on the DSH 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 the 2100C Loop with a reject reason code of AAA03 = "62".

Table 4 illustrates the allowable request date ranges:

Table 4 - 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

[5] Effective April 1, 2018

If the Current Month Is:	Historical Requests Are Valid Through:	Future Requests Are Valid Through:
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 February 1, 2018, requests from November 1, 2015 through June 1, 2018 will be accepted.

7.5 MEDICARE PART A & PART B ELIGIBILITY BUSINESS RULES

- The HETS 270/271 application will not return Medicare Part B eligibility data within a DSH 271 response.
- Trading Partners should review the entire DSH 271 eligibility response to determine the appropriate eligibility status for the Medicare Beneficiary.
- To indicate periods of Medicare Part A entitlement, the HETS 270/271 application will return a 2110C Loop with element EB01 = “1” along with the DTP03 where DTP01 = “291” with beginning and end dates, where appropriate, for each applicable entitlement period.
- The HETS 270/271 application will return a 2110C Loop with element EB01= “6” for Part A without the DTP segments for either of the following reasons:
  - The Medicare Beneficiary’s Part A entitlement had not yet begun as of the requested date(s) of service.
  - The Medicare Beneficiary’s Part A entitlement has terminated prior to the requested date(s) of service.
- Multiple periods of a Medicare Beneficiary’s Medicare enrollment may be returned in a DSH 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 on or prior to the Date of Death, their Medicare Part A Entitlement date(s) and other applicable eligibility data will be returned along with a separate DTP segment containing the Date of Death. Date of Death will be returned on the 2100C DTP segment. Example segments returned in a 271 response:
  - Part A Entitlement

    EB*1**30*MA~
    DTP*291*RD8*CCYYMMDD-CCYYMMDD~ (DTP03 = Entitlement and Termination Dates (where applicable))
  - Inactive Due to Date of Death

    DTP*442*D8*CCYYMMDD~ (DTP03 = Date of Death)

EB*6**30~

- For additional information, refer to Table 12.

7.19 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 DSH 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/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/index.html and choose “MA Plan Directory”.

- Example segments returned in a DSH 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*UR*www.plan.com~ (PER04 = Plan Telephone Number, PER06 = Contract Website Address)
    LE*2120~

- For additional information, refer to Table 13.

7.20 MEDICARE SECONDARY PAYER (MSP) ENROLLMENT BUSINESS RULES

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

    EB*R**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 14.

7.21 QUALIFIED MEDICARE BENEFICIARY (QMB) PERIOD BUINESS RULES

- HETS will return a 271 2110C loop for applicable Beneficiaries to indicate periods where the Beneficiary is enrolled in the Qualified Medicare Beneficiary (QMB) program. QMB-enrolled Beneficiaries are dually-eligible for both Medicare and Medicaid. Beneficiaries who are enrolled in the QMB program are not liable for Medicare co-insurance, co-payments or deductible payments. Note that QMB status may fluctuate for a minority of Beneficiaries. If the HETS response indicates that the Beneficiary QMB enrollment has terminated, please verify the patient's QMB status through State online Medicaid eligibility systems or other documentation, including Medicaid Identification cards and documents issued by the State proving the patient qualifies for the QMB program.
- QMB Periods will only be returned in the 271 when the Beneficiary has the appropriate Medicare entitlement and the QMB enrollment intersects at least one of the following:
  - One day within a calendar year contained in the request date(s)
  - The current date
- Example of a QMB Enrollment Period returned in a 271 2110C loop:
  - EB*R***QM*State QMB Plan~ (EB05 = State Code + "QMB Plan")
    DTP*290*RD8*CCYYMMDD-CCYYMMDD~ (DTP02 = D8 if the QMB Period is ongoing, RD8 if the QMB period has an end date)

8 ACKNOWLEDGEMENTS, ERROR CODES AND/OR REPORTS

Section 8.3 of this document replaces Section 8.3 of the HETS 270/271 5010 Companion Guide.

8.3 DSH 271

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

The AAA error segment is utilized within the DSH 271 response to communicate error conditions based on CMS business rules. The HETS 270/271 application will return the invalid or non-matching data element(s) from the 270 request for 2100C Loop AAA error codes 58, 62, 71, 72, and 73. The AAA error codes applicable to DSH Submitters are specified in Table 5.

Table 5 - AAA Error Codes

Loop	AAA01 Yes/ No Condition	AAA03 Reject Reason Code	AAA04 Follow-up Action Code
2100A	No	04 - When multiple Medicare Beneficiaries are included on a single 270 request.	C
2100A	Yes	42 - When the system is unable to respond as a result of being unavailable or when a HIPAA compliant 271 cannot be formatted.	R
2100A	No	79 - When 2100A NM103 or NM109 Source identification is other than “CMS”.	C
2100A	No	T4 - When 270 2100A NM103 or NM109 is missing.	C
2100B	No	41 - When the National Provider Identifier (NPI) located at 2100B NM109 is a valid FFS Medicare NPI and exists in HDT, 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 HDT.	C
2100B	No	43 - When the 2100B NM101 is not equal to “1P”, “FA” or “80” or when the NPI located at 2100B NM109 has an invalid Medicare Provider status. If you believe that the NPI is a valid FFS Medicare provider or supplier, contact your MAC for verification.	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
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 HDT. An overnight update may be required before the NPI can be used with HETS.	C
2100C	No	58 - When the 270 2100C DMG02 element and NM104 element are both missing.	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	71 - When the 270 2100C DMG02 element does not match the Medicare Beneficiary DOB on the database.	C
2100C	No	72 - When the 270 2100C NM109 element is either: • An invalid length or cannot be matched to any HICN or MBI[6] on the database, or • Missing. When the NM109 element is missing, the 271 AAA response will also return the value “MISSING” in the 271 2100C NM109, or • Inactive. When the NM109 is inactive, the 271 AAA response will also return the active HICN or MBI in the 271 2100C NM109 along with the requested HICN or MBI in the 2100C REF segment.	C

[6] Effective April 1, 2018

Loop	AAA01 Yes/ No Condition	AAA03 Reject Reason Code	AAA04 Follow-up Action Code
2100C	No	73 - When the 270 2100C NM103 element is missing, or the matching algorithm of the Medicare Beneficiary Last Name on the 270 request does not satisfy the matching algorithm of the Medicare Beneficiary Last Name in the database, or the last name is too long (41-60 characters in length).	C
2100C	No	73 - When the 270 2100C NM104 element does not satisfy the matching algorithm of the Medicare Beneficiary First Name in the database or the first name is too long (31-35 characters in length).	C

10 TRANSACTION SPECIFIC INFORMATION

Section 10 of this document is intended to replace Section 10 of the HETS 270/271 5010 Companion Guide.

This section defines specific requirements that CMS requires over and above the standard information in the ASC X12 270/271 version 005010X279A1 TR3 referenced in Section 1.1 of this document.

10.1 270 ELIGIBILITY REQUEST TRANSACTION

This section describes the values required by CMS in the 270 request. Any segments or elements not referenced in the following tables should be submitted on the 270 request as per the ASC X12 270/271 version 005010X279A1 TR3.

10.1.1 Information Source Level Structures

CMS will be the Information Source for all Medicare Eligibility Transactions. Table 6 defines specific requirements for the Header and Information Source data.

Table 6 - Header and Information Source

Loop ID	Reference	Name	X12 Codes	Notes/Comments
	BHT	Beginning of Hierarchical Transaction		
	BHT02	Transaction Set Purpose Code	13	HETS does not support cancellations.
2100A	NM1	Information Source Name		
2100A	NM102	Entity Type Qualifier	2	
2100A	NM103	Information Source Last or Organization Name		HETS always expects “CMS”.

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2100A	NM109	Information Source Primary Identifier		HETS always expects “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. Table 7 defines specific requirements for the Information Receiver data.

Table 7 - Information Receiver

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2100B	NM1	Information Receiver Name		
2100B	NM101	Entity Identifier Code	1P, 80, FA	HETS only sends responses for providers, hospitals and facilities.
2100B	NM109	Information Receiver Identification Number		The Medicare Enrolled Provider’s 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. Table 8 defines specific requirements for the Subscriber Level data.

Table 8 - Subscriber

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2100C	NM1	Subscriber Name		
2100C	NM103	Subscriber Last Name		Last Name is required for Medicare Beneficiary Identification using the Primary or Alternate Search options. Maximum length allowable is 40 characters.
2100C	NM104	Subscriber First Name		First name is required for Medicare Beneficiary Identification only when the Beneficiary’s date of birth is not submitted. Maximum length allowable is 30 characters.
2100C	NM107	Subscriber Name Suffix		When the suffix is part of the Medicare Beneficiary’s Last Name on the Medicare card, the suffix is required for Last Name matching. For convenience, the Subscriber Name Suffix can also be appended to the Subscriber Last Name field to meet matching constraints.

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2100C	NM109	Subscriber Primary Identifier		HICN or MBI[7] is required for all Medicare Beneficiary Search options. This element must exactly match the ID on the patient's Medicare card.
2100C	DMG	Subscriber Demographic Information		
2100C	DMG02	Subscriber Birth Date		Date of Birth is required for Medicare Beneficiary Identification only when the Beneficiary's first name is not submitted.
2100C	DTP	Subscriber Date		
2100C	DTP01	Date Time Qualifier	291	
2110C	EQ	Subscriber Eligibility or Benefit Inquiry		
2110C	EQ01	Service Type Code		HETS will accept all X12 STC codes.
2110C	EQ02	Composite Medical Procedure Identifier		HETS will accept all valid Procedure codes.

10.2 DSH 271 ELIGIBILITY RESPONSE TRANSACTION

This section describes the values returned by CMS in the DSH 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 ASC X12 270/271 version 005010X279A1 TR3.

Table 9 - Header and Information Source

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2100A	NM1	Information Source Name		
2100A	NM101	Entity Identifier Code	PR	
2100A	NM108	Identification Code Qualifier	PI	
2100A	NM109	Information Source Primary Identifier		HETS always returns "CMS".

Table 10 - Information Receiver

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2100B	NM1	Information Receiver Name		
2100B	NM101	Entity Identifier Code	1P, 80, FA	
2100B	NM109	Information Receiver Identification Number		The Provider's assigned NPI number as submitted on the 270 request.

[7] Effective April 1, 2018

Table 11 - Subscriber Demographic Data

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2000C	TRN	Subscriber Trace Number		
2000C	TRN01	Trace Type Code	2	
2100C	NM1	Subscriber Name		
2100C	NM103	Subscriber Last Name		If there are errors in the transaction, HETS will return the value from the 270. If a match is found, HETS will return the value from the CMS Eligibility Database.
2100C	NM104	Subscriber First Name		If there are errors in the transaction, HETS will return the value from the 270. If a match is found, HETS will return the value from the CMS Eligibility Database.
2100C	NM107	Subscriber Name Suffix		
2100C	NM109	Subscriber Primary Identifier		HETS returns the HICN or MBI[8] submitted on the 270 request or the active cross-referenced HICN or MBI when an inactive HICN or MBI is submitted. If a HICN or MBI was not submitted on the 270 request, a value of "MISSING" will be returned.
2100C	REF	Subscriber Additional Identification		A REF segment in the 2100C Loop is returned containing the HICN submitted on the 270 when an active/cross-referenced HICN or MBI is found and returned in the NM109.
2100C	REF01	Reference Identification Qualifier	Q4	This element is used to communicate the submitted HICN or MBI from the 270 request when a cross-referenced HICN or MBI is located.
2100C	REF02	Subscriber Supplemental Identifier		This element is used to communicate the submitted HICN or MBI from the 270 request when a cross-referenced HICN or MBI is located.
2100C	DTP	Subscriber Date		
2100C	DTP01	Date Time Qualifier	307 or 442	

Table 12 - Medicare Part A Plan Level Eligibility

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2110C	EB01	Eligibility or Benefit Information	1 or 6	

[8] Effective April 1, 2018

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2110C	EB04	Insurance Type Code	MA	EB04 will be omitted when requested dates are after a Medicare Beneficiary's Date of Death. When requested dates are during a period of Incarceration, Deportation or Alien Status, EB04 will be omitted only from the EB segment pertaining to the period of inactivity or ineligibility.
2110C	DTP	Subscriber Eligibility/Benefit Date		If multiple entitlement periods exist, HETS returns them in descending order - future, current, past. For inactive periods, the DTP segment will only be included for a specific date range.
2110C	DTP01	Date Time Qualifier	291	N/A

Table 13 - Medicare Advantage (MA) Enrollment Data

Loop ID	Reference	Name	X12 Codes	Notes/ Comments
2110C	EB	Subscriber Eligibility or Benefit Information	EB	MA Loop
2110C	EB01	Eligibility or Benefit Information	R	
2110C	EB04	Insurance Type Code	HM, HN, IN, PR, or PS	
2110C	REF	Subscriber Additional Identification		
2110C	REF01	Reference Identification Qualifier	18	
2110C	REF02	Subscriber Eligibility or Benefit Identifier		HETS returns the Contract Number and Plan Number, separated by a space. If a Plan Number is unavailable, HETS returns only the Contract Number.
2110C	DTP	Subscriber Eligibility/Benefit Date		
2110C	DTP01	Date Time Qualifier	290	
2110C	MSG	Message Text		
2110C	MSG01	Free Form Message Text		HETS returns "MCO Bill Option Code - [code value]". Code values returned are: A, B, C, 1 or 2.
2120C	NM1	Benefit Related Entity Name		
2120C	NM101	Entity Identifier Code	PR or PRP	
2120C	NM102	Entity Type Qualifier	2	
2120C	NM103	Benefit Related Entity Last or Organization Name		HETS returns the MA Insurer Name.

Loop ID	Reference	Name	X12 Codes	Notes/ Comments
2120C	N301	Benefit Related Entity Address Line		Medicare Insurer Address Line 1 if valid, otherwise not sent.
2120C	N302	Benefit Related Entity Address Line		Medicare Insurer Address Line 2 if valid, otherwise not sent.
2120C	N401	Benefit Related Entity City Name		Medicare Insurer City Name
2120C	N402	Benefit Related Entity State Code		Medicare Insurer State Code
2120C	N403	Benefit Related Entity Postal Zone or Zip Code		Medicare Insurer Postal ZIP Code
2120C	PER	Benefit Related Entity Contact Information		HETS returns the telephone number or website address in the PER03 and PER04 elements when the MA plan has only a telephone number or only a website address. If neither exists, then HETS does not return the PER segment.

Table 14 - MSP Enrollment Data

Loop ID	Reference	Name	X12 Codes	Notes/ Comments
2110C	EB	Subscriber Eligibility or Benefit Information	EB	MSP Loop
2110C	EB01	Eligibility or Benefit Information	R	
2110C	EB04	Insurance Type Code		HETS returns codes: 12, 13, 14, 15, 16, 41, 42, 43, 47, AP, LT or WC
2110C	REF	Subscriber Additional Identification		
2110C	REF01	Reference Identification Qualifier	IG	
2110C	REF02	Subscriber Eligibility or Benefit Identifier		HETS returns the MSP Policy Number, which is the group coverage plan in which the Medicare Beneficiary is enrolled..
2110C	DTP	Subscriber Eligibility/Benefit Date		
2110C	DTP01	Date Time Qualifier	290	
2120C	NM1	Benefit Related Entity Name		
2120C	NM101	Entity Identifier Code	PRP	
2120C	NM102	Entity Type Qualifier	2	
2120C	NM103	Benefit Related Entity Last or Organization Name		HETS returns the Primary Insurer Name.
2120C	N3	Benefit Related Entity Address	N3	Beginning of segment
2120C	N301	Benefit Related Entity Address Line		Primary Insurer Address Line 1 if valid, otherwise not sent.
2120C	N302	Benefit Related Entity Address Line		Primary Insurer Address Line 2 if valid, otherwise not sent.

Loop ID	Reference	Name	X12 Codes	Notes/ Comments
2120C	N4	Benefit Related Entity City State Zip		
2120C	N401	Benefit Related Entity City Name		Primary Insurer City
2120C	N402	Benefit Related Entity State Code		Primary Insurer State Code
2120C	N403	Benefit Related Entity Postal Zone or Zip Code		Primary Insurer ZIP Code

Table 15 - QMB Periods

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2110C	EB	Subscriber Eligibility or Benefit Information		QMB Loop Information in this table will be returned on the 271 response for entitled Beneficiaries when the there is no Date of Death on file or the requested start date(s) is before or equal to the Date of Death AND the Medicaid enrollment intersects at least one of the following: • One day within a calendar year contained in the request date(s) • The current date
2110C	EB01	Eligibility or Benefit Information	R	
2110C	EB04	Insurance Type Code	QM	Qualified Medicare Beneficiary
2100C	EB05	Plan Coverage Description		HETS returns the Medicaid enrollment State Code + “QMB Plan”
2110C	DTP	Subscriber Eligibility/Benefit Date		
2110C	DTP01	Date Time Qualifier	290	
2100C	DTP02	Date Time Format Qualifier		HETS returns ‘D8’ if the QMB period is still active and only has a start date. HETS returns ‘RD8’ if the QMB period has an end date.

APPENDIX A - SAMPLE DSH 270 ELIGIBILITY REQUEST TRANSACTION

```
□000000441□
ISA*00*     *00*     *ZZ*C123X456*ZZ*CMS
*171116*0734*^*00501*000005014*1*P*|~
GS*HS*D000000011*CMS*20171116*073411*5014*X*005010X279A1~
ST*270*000000001*005010X279A1~
BHT*0022*13*ALL*20171116*073411~
HL*1**20*1~
NM1*PR*2*CMS*****PI*CMS~
HL*2*1*21*1~
NM1*80*2*TEST*****XX*2223334444~
HL*3*2*22*0~
NM1*IL*1*SMITH*MARY****MI*123456789A~
DMG*D8*19240901~
DTP*291*RD8*20170101-20180330~
EQ*1~
SE*12*000000001~
GE*1*5014~
IEA*1*000005014~
□
```

APPENDIX B - SAMPLE DSH 271 ELIGIBILITY RESPONSE TRANSACTION

```
0000000951
ISA*00*     *00*     *ZZ*CMS      *ZZ*C123X456
*171116*0734*^*00501*000025349*0*T*|~
GS*HB*CMS*C123X456*20171116*07340000*1*X*005010X279A1~
ST*271*0001*005010X279A1~
BHT*0022*11*5010 MSP DATE SPECIFIC 002*20171116*07345830~
HL*1**20*1~
NM1*PR*2*CMS*****PI*CMS~
HL*2*1*21*1~
NM1*1P*2*MEIC*****XX*1234567893~
HL*3*2*22*0~
NM1*IL*1*SMITH*MARY****MI*123456789A~
DMG*D8*19240901*F~
DTP*307*RD8*20170101-20180330~
EB*1**30*MA~
DTP*291*D8*19931101~
EB*R**30*HN~
REF*18*H3952 008~
DTP*290*RD8*20070101-20171231~
MSG*MCO Bill Option Code - C~
LS*2120~
NM1*PRP*2*ABC HEALTH PLAN~
N3*123 MAIN ST~
N4*ANYTOWN*MD*999999999~
PER*IC**TE*9999999999*UR*www.abchealthplan.com~
LE*2120~
EB*R**30*12~
REF*IG*999999999~
DTP*290*D8*19931101~
LS*2120~
NM1*PRP*2*ABC INSURANCE COMPANY~
N3*123 MAIN ST~
N4*ANYTOWN*MD*999999999~
LE*2120~
SE*31*0001~
GE*1*1~
IEA*1*000025349~
```

APPENDIX C - REVISION HISTORY

Table 16 provides a summary of changes made to this document.

Table 16 - Document Revision History

Version	Date	Description of Changes
3-5	11/09/2017	Updates include: • Section 7.3 - Updated to include New Medicare Card transition period. Added Table 3 to explain HETS handling of HICN and MBI during the transition period. • Table 11 – Removed 2100C N3 and N4 loops from table. HETS no longer returns the Medicare Beneficiary's address in the DSH 271 response. • Tables 5, 8 & 11 – Updated to indicate that HETS will process either a HICN or MBI value effective April 1, 2018 • Appendix B - Removed 2100C N3 and N4 loops from the sample response. HETS no longer returns the Medicare Beneficiary's address in the DSH 271 response. Minor formatting and grammatical changes throughout the document.
3-4	10/24/2017	Updates include: • Section 1.3 - Updated the HETS Companion Guide URL. • Section 7.2 - Updated bullet to reflect that HETS will return a 999 response if a dependent loop is submitted in the 270 request. • Section 7.2 - 7.5 Updates to improve consistency between the Supplement and main HETS 270/271 Companion Guide. • Section 7.19 - Updated from Section 7.6 to match the main HETS 270/271 Companion Guide. • Section 7.20 - Updated from Section 7.7 to match the main HETS 270/271 Companion Guide. • Section 7.21 – Added to detail situations where HETS DSH response will return QMB Periods. • Table 12 – Removed reference to HETS returning a generic Baltimore, MD address if MA plan mailing address is not available. • Table 13 - Added new MSP code AP for No-Fault Medicare Set-Aside Arrangement (NFSMA) and new MSP code LT for Liability Medicare Set-Aside Arrangement (LMSA). • Table 14 - Added new table to detail 271 response for QMB Periods. • Appendix B - Removed 2100A PER loop from the sample response. HETS no longer returns a 2100A PER loop in each 271 response. Updated transaction dates. • Minor formatting and grammatical changes throughout the document.

Version	Date	Description of Changes
3-3	03/17/2016	• Section 7.1 - Updated section to include references to current X12 documentation and versioning. • Section 7.1 - 7.5 - Minor updates to language to ensure consistency with HETS 270/271 Companion Guide. • Section 7.3 - Added notes stressing that Trading Partners should not submit non-required data elements of the Medicare Beneficiary, including Middle Name/Initial and/or Gender Code. Sending non-required data elements may result in a 999 response. • Section 8.3 - Updated Table 4 with current list of 271 AAA responses. • Section 10 - Minor updates to language to ensure consistency with HETS 270/271 Companion Guide. All Tables updated to match style/format of HETS 270/271 Companion Guide. • Minor formatting and grammatical changes throughout the document.
3-2	03/22/2013	Table 10 - Updated address elements for missing data.
3-1	02/19/2013	Section 8.3 - Removed text reference to AAA code 74 since it was removed from the table in a previous release.