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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

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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 - 1.2 of this document are intended to replace Sections 1.1 - 1.2 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.

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 utilizes 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

- HETS 270/271 application data is updated once daily (early in the morning, Eastern Time). The HETS 271 response is not 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 DSH 271 response returns benefit data if the Medicare Beneficiary is entitled to Medicare Part A. The HETS 270/271 application does not return Medicare Part B eligibility data within a DSH 271 response.

- The HETS 270/271 application returns a 999 response if dependent level data is sent within a 270 request.
- The DSH 271 response always returns a basic set of eligibility information regardless of the Service Type Code (STC) submitted on the 270 request.
- The HETS 270/271 application accepts multiple STCs on a 270 request transaction.
- The DSH 271 response 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 constructs DSH 271 responses with the preferred delimiters as noted in Table 1 of this document.
- Trading Partners 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.

7.4 DATE REQUEST RULES

- The DSH 271 response responds with current eligibility information if no date is contained in the 270 request.
- CMS verifies 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 4 years in the past, based on the date the transaction was received. HETS does not accept future date(s) of service on DSH 270 requests. If requests are outside of this range, the HETS 270/271 application returns a AAA error in the 2100C Loop with a reject reason code of AAA03 = "62".
- Eligibility requests submitted for the maximum allowable date span take longer to process and return significantly more eligibility data on the 271 response. CMS urges HETS 270/271 Submitters to carefully consider which, if any, circumstances should 270 requests contain the maximum allowable date span. CMS discourages HETS Submitters from defaulting to the maximum allowable date span on all eligibility requests.

Table 2 illustrates the allowable request date ranges:

Table 2 - Request Date Calendar

If the Current Month Is:	Historical Requests Are Valid Through:	Future Requests:
January	January, 4 years ago	Not supported. DSH only allows historic or current date(s) of service.

If the Current Month Is:	Historical Requests Are Valid Through:	Future Requests:
February	February, 4 years ago	
March	March, 4 years ago	
April	April, 4 years ago	
May	May, 4 years ago	
June	June, 4 years ago	
July	July, 4 years ago	
August	August, 4 years ago	
September	September, 4 years ago	
October	October, 4 years ago	
November	November, 4 years ago	
December	December, 4 years ago	

Example: If an eligibility request is sent on December 1, 2019, requests from December 1, 2015 through December 1, 2019 will be accepted.

7.5 MEDICARE PART A & PART B ELIGIBILITY BUSINESS RULES

7.5.1 HETS 270/271 Business Rules

- The DSH 271 response will not return Medicare Part B eligibility data.
- Trading Partners should review the entire DSH 271 response to determine the appropriate eligibility status for the Medicare Beneficiary.
- To indicate periods of Medicare Part A entitlement, the HETS 270/271 application returns 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 returns 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.
- 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))
- For additional information, refer to Table 10.

7.5.2 HETS Date of Death Business Rules

The DSH 271 response utilizes entitlement data (including any listed Date of Death) from the Social Security Administration. The combination of the requested date(s) of service on the 270 request and the recorded Date of Death dictates the manner in which the DSH 271 response uses the Date of Death.

- If the requested dates(s) of service are **on or before** the recorded Date of Death the DSH 271 response will return Medicare Part A Entitlement date(s) and other applicable eligibility information for the date(s) up until the Date of Death. The DSH 271 response will also include a separate 2100C DTP segment that contains the Date of Death.
- If the requested date(s) of service are **after** the recorded Date of Death the DSH 271 response will note that the Beneficiary is ineligible by returning a 2110C Loop with element EB01= "6", EB03 = "30".

Figure 1 illustrates handling of Date of Death based on the date(s) of service submitted on the 270 request.

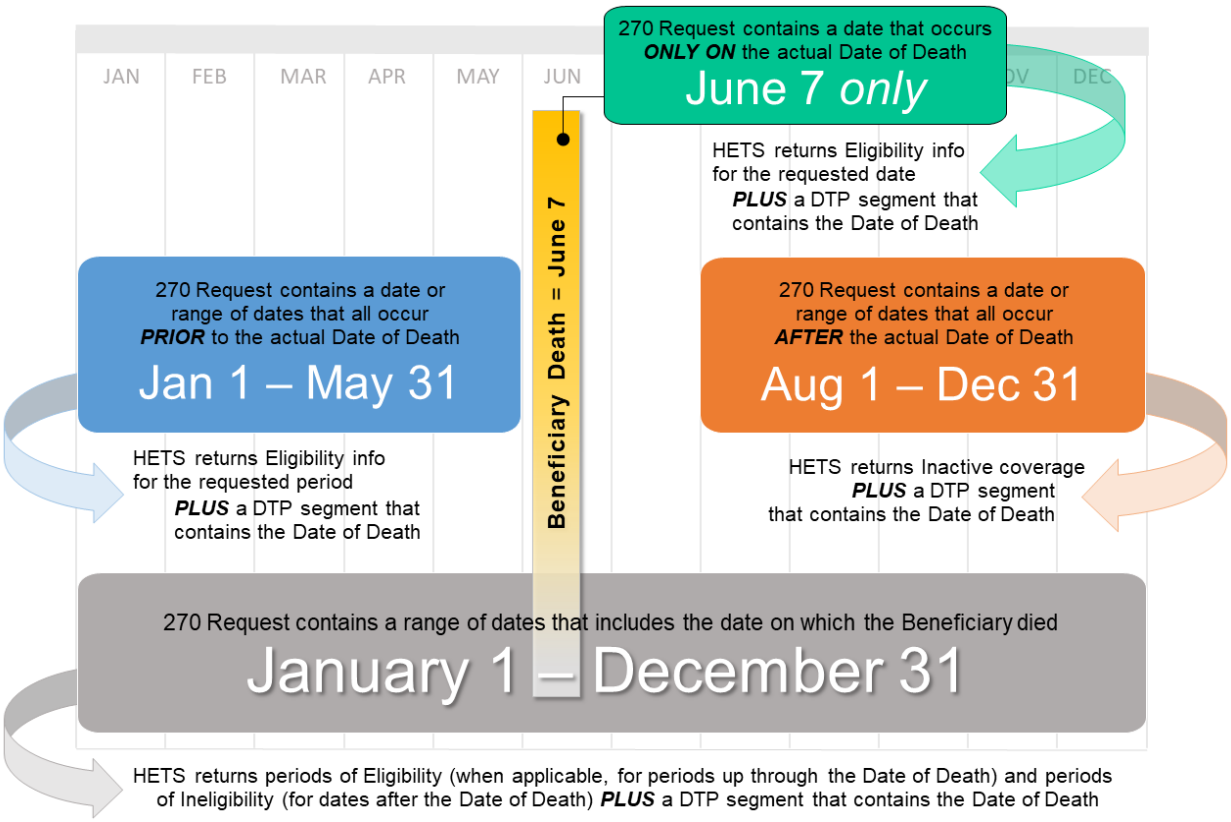

Figure 1. Date of Death Business Rules

- Example segments returned in a 271 response:

  Inactive Due to Date of Death

  DTP*442*D8*CCYYMMDD~ (DTP03 = Date of Death)
  EB*6**30~

- For additional information, refer to Table 10.

7.19 MA PLAN ENROLLMENT BUSINESS RULES

- All Medicare Beneficiary MA plans with enrollment periods that overlap the requested date(s) of service are returned within the DSH 271 response.
- The DSH 271 response returns 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 returns 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 is 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*U**30*HN~ (EB04 = Plan Type)
REF*18*H1234~ (REF02 = Contract Number)
REF*N6*001*PLANNAME~ (REF02 = Plan Number, REF03 = Plan Name)
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 11.

7.20 MEDICARE SECONDARY PAYER (MSP) ENROLLMENT BUSINESS RULES

- The DSH 271 response returns all Medicare Beneficiary insurance coverage policies that are primary to Medicare coverage, if the enrollment period overlaps the requested date(s) of service.
- If applicable, all MSP diagnosis codes related to each Medicare Beneficiary MSP enrollment period(s) return in the DSH 271 response. The DSH 271 response returns one MSG segment for each applicable MSP enrollment; that MSG segment includes all MSP diagnosis codes related to the specific MSP enrollment period. The DSH 271 response may return multiple MSG segments if the Medicare Beneficiary has multiple applicable MSP enrollment periods. The DSH 271 response only returns ICD-10 codes. The DSH 271 response will not return MSP diagnosis codes that are known to be invalid.
- Example segments returned in a DSH 271 response:
  - MSP

    EB*R**30*14~ (EB04 = MSP Insurance Type Code)
    REF*IG*123456789~ (REF02 = Insurance Policy Number)
    DTP*290*RD8*CCYYMMDD-CCYYMMDD~ (Completed MSP enrollment period)
    MSG*S8002XA,S40012A,S93609A,G5622~ (MSP related diagnosis codes)
    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~
    EB*R**30*14~
    REF*IG*54321~
    DTP*290*D8*CCYYMMDD~ (Ongoing MSP enrollment period)
    MSG*M545,M542,M25512,M25412,S40012A,G5622~ (MSP diagnosis codes)
    LS*2120~
    NM1*PRP*2*XYZ HEALTHPLAN~
    N3*987 BROADWAY~
    N4*ANYTOWN*HI*999999999~
    LE*2120~

- For additional information, refer to Table 12.

7.21 QUALIFIED MEDICARE BENEFICIARY (QMB) PERIOD BUINESS RULES

- HETS returns 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 only return in the DSH 271 response 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 returns 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 returns 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 3.

Table 3 - 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 4 years in the past, or a future date.	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 MBI 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.	C
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

Loop	AAA01 Yes/ No Condition	AAA03 Reject Reason Code	AAA04 Follow-up Action Code
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 is the Information Source for all Medicare Eligibility Transactions. Table 4 defines specific requirements for the Header and Information Source data.

Table 4 - 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”.
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 5 defines specific requirements for the Information Receiver data.

Table 5 - 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 6 defines specific requirements for the Subscriber Level data.

Table 6 - 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.
2100C	NM109	Subscriber Primary Identifier		MBI 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		

Loop ID	Reference	Name	X12 Codes	Notes/Comments
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. 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 7 - 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 8 - 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.

Table 9 - Subscriber Demographic Data

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2000C	TRN	Subscriber Trace Number		
2000C	TRN01	Trace Type Code	2	

Loop ID	Reference	Name	X12 Codes	Notes/Comments
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 MBI submitted on the 270 request. If a MBI was not submitted on the 270 request, a value of “MISSING” will be returned.
2100C	DTP	Subscriber Date		
2100C	DTP01	Date Time Qualifier	152, 307 or 442	A value of 152 is returned when the submitted MBI has an end date on file, the 271 response includes benefit information and the request Date(s) of Service overlap the terminated MBI’s effective period.

Table 10 - Medicare Part A Plan Level Eligibility

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2110C	EB01	Eligibility or Benefit Information	1 or 6	
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 - current then 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 11 - Medicare Advantage (MA) Enrollment Data

Loop ID	Reference	Name	X12 Codes	Notes/ Comments
2110C	EB	Subscriber Eligibility or Benefit Information	EB	MA Loop

Loop ID	Reference	Name	X12 Codes	Notes/ Comments
2110C	EB01	Eligibility or Benefit Information	U	
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		MA Contract Number
2110C	REF	Subscriber Additional Identification		
2110C	REF01	Reference Identification Qualifier	N6	
2110C	REF02	Subscriber Eligibility or Benefit Identifier		MA Plan Number (if available)t Number
2110C	REF03	Description		MA Plan Name (if available)
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.
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

Loop ID	Reference	Name	X12 Codes	Notes/ Comments
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 12 - 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	
2110C	MSG	Message Text		
2110C	MSG01	Free Form Message Text		HETS returns any applicable diagnosis codes related to the MSP enrollment period detailed in the prior EB/REF/DTP loops. HETS returns diagnosis codes in this field, with multiple values (if applicable) separated by commas.
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.
2120C	N4	Benefit Related Entity City State Zip		
2120C	N401	Benefit Related Entity City Name		Primary Insurer City

Loop ID	Reference	Name	X12 Codes	Notes/ Comments
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 13 - 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

```
□0000000441□
ISA*00*     *00*     *ZZ*D123X456*ZZ*CMS
*191216*0734*^*00501*000005014*1*P*|~
GS*HS*D123X456*CMS*20191216*073411*5014*X*005010X279A1~
ST*270*000000001*005010X279A1~
BHT*0022*13*ALL*20191216*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*20160101-20190830~
EQ*1~
SE*12*000000001~
GE*1*5014~
IEA*1*000005014~
□
```

APPENDIX B - SAMPLE DSH 271 ELIGIBILITY RESPONSE TRANSACTION

```
□0000001108□
ISA*00*     *00*     *ZZ*CMS      *ZZ*D123X456
*191216*0734*^*00501*000025349*0*T*|~
GS*HB*CMS*D123X456*20191216*07340000*1*X*005010X279A1~
ST*271*0001*005010X279A1~
BHT*0022*11*5010 MSP DATE SPECIFIC 002*20191216*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*20160101-20190830~
EB*R***QM*TX QMB Plan~
DTP*290*D8*20180101~
EB*R***QM*TX QMB Plan~
DTP*290*RD8*20160901-20171231~
EB*1**30*MA~
DTP*291*D8*19931101~
EB*U**30*HN~
REF*18*H1234~
REF*N6*001*PLANNAME~
DTP*290*RD8*20070101-20171231~
MSG*MCO Bill Option Code - C~
LS*2120~
NM1*PRP*2*ORGNAME~
N3*ADDRESSLINE1*ADDRESSLINE2~
N4*CITY*ST*ZIPCODE~
PER*IC**TE*AAABBBCCCC*UR*www.website.com~
LE*2120~
EB*R**30*12~
REF*IG*GROUPCOVERAGEPLANPOLICYNUMBER ~
DTP*290*RD8*20110601-20160201~
MSG*S8002XA,S40012A,S93609A,G5622~
LS*2120~
NM1*PRP*2*ORGNAME~
N3*ADDRESSLINE1*ADDRESSLINE2~
N4*CITY*ST*ZIPCODE~
LE*2120~
SE*37*0001~
GE*1*1~
IEA*1*000025349~
□
```

APPENDIX C - REVISION HISTORY

Table 14 provides a summary of changes made to this document.

Table 14 - Document Revision History

Version	Date	Description of Changes
3-9	12/09/2019	Updates include: • Section 7.5 – Separated into two sub-sections (7.5.1 – HETS 270/271 Business Rules and 7.5.2 – HETS Date of Death Business Rules) to improve readability • Added Figure 1 (Date of Death Business Rules) to Section 7.5.2 • Removed all references to HICN as HETS solely supports MBI effective 01/01/2020
3-8	10/17/2018	Updates include: • Section 7.19 – Updated to reflect revised handling of MA Contract/PBP Information • Section 7.20 – Added bullet to explain that HETS will return any applicable diagnosis codes for the MSP enrollment period as a MSG segment. Multiple enrollment periods may result in multiple MSG segments (one per MSP enrollment • Table 11 -- Updated to reflect revised handling of MA Contract/PBP Information • Table 12 -- Updated to reflect that HETS can return MSG segments which list any applicable diagnosis codes for the MSP enrollment period. Multiple enrollment periods may result in multiple MSG segments (one per MSP enrollment)
3-7	07/12/2018	Updates include: Removed all references to the 4/1/2018 beginning of the New Medicare Card transition period • Section 7.3 – Removed from this document. Please refer to the HETS Companion Guide Section 7.3 for information about Medicare Beneficiary Matching Rules • Section 7.4 – Updated to reflect that HETS now accepts historical Date(s) of Service of up to 4 years. Bullet added to note that CMS recommends against defaulting to the maximum allowable date span. Table 4 updated to reflect the historical Date(s) of Service change • Table 11 -- Modified to reflect that HETS will, if applicable, return a 271 2100C DTP01 value of “”152” when indicating that a MBI has an end date Minor formatting and grammatical changes throughout the document.

Version	Date	Description of Changes
3-6	03/20/2018	Updates include: • Section 7.4 – Updated to reflect that DSH no longer supports future Dates of Service • Section 7.19 – Updated to reflect that HETS returns a 271 2110C EB01 of 'U' for Medicare Advantage Plans. CMS strongly recommends that Medicare Providers/Suppliers contact the Medicare Advantage plan directly to confirm the Beneficiary's Medicare Advantage plan eligibility information • Table 4 – Updated to reflect that DSH no longer supports future Dates of Service • Table 5 – Updated the note for 271 2100C AAA03 = 62 to reflect that DSH no longer supports future Dates of Service • Table 13 – Updated to reflect that HETS returns a 271 2110C EB01 of 'U' for Medicare Advantage Plans. CMS strongly recommends that Medicare Providers/Suppliers contact the Medicare Advantage plan directly to confirm the Beneficiary's Medicare Advantage plan eligibility information • Appendix B – Updated sample transaction to include 2018 Dates of Service. Updated sample transaction to reflect that HETS now returns a 271 2110C EB01 of 'U' for Medicare Advantage Plans Minor formatting and grammatical changes throughout the document.
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.

Version	Date	Description of Changes
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.
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.