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HIPAA Eligibility Transaction System (HETS)
Health Care Eligibility Benefit Inquiry and Response (270/271)
5010 Companion Guide

FINAL

Version: 10-14

Date of Last Revision: July 2019

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.

The 271 response returned by the HETS 270/271 application should not be interpreted as a guarantee of payment. Payment of benefits remains subject to all health benefit plan terms, limits, conditions, exclusions and the member's eligibility at the time services are rendered.

Preface

This *Companion Guide* to the ASC X12N/005010X279A1 Health Care Eligibility Benefit Inquiry and Response and the ASC X12C/005010X231A1 Implementation Acknowledgement for Health Care Insurance (999) Technical Report Type 3 (TR3), adopted under HIPAA, clarifies and specifies the data content when exchanging Medicare Beneficiary eligibility data electronically with CMS utilizing the HIPAA Eligibility Transaction System (HETS) 270/271 application. Transmissions based on this *Companion Guide*, used in tandem with the previously referenced TR3s, are compliant with both X12 syntax and the TR3.

This *Companion Guide* is intended to convey information that is within the framework of the TR3s adopted for use under HIPAA. This *Companion Guide* is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the TR3.

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1 Introduction

1.1 Scope

This document defines the Medicare eligibility request sent from Medicare-authorized Trading Partners 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 supports the ASC X12 270/271 version 005010X279A1 and the ASC X12 999 version 005010X231A1 TR3s that can be found at the following web site: http://store.x12.org/store/. 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. To transmit data with CMS, Trading Partners may connect to the HETS 270/271 application via the CMS Extranet, which is a secure closed private network, or via the internet using a digital certificate. 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 either an Eligibility Response (271), an Implementation Acknowledgement (999), 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. Additionally,

the 271 response returned by the HETS 270/271 application should not be interpreted as a guarantee of payment.

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. Eligibility/benefit questions about Qualified Medicare Beneficiary (QMB) eligibility should be directed to the 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.

1.3 References

The ASC X12 TR3s that detail the full requirements for these transactions can be purchased from the publisher, Washington Publishing Company (WPC) at their website http://store.x12.org/store/.

The HETS Trading Partner Agreement Form (TPA) 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 and to access the TPA: http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp/HowtoGetConnectedHETS270271.html.

For more information on the Web Services Communication Protocol Specifications for connecting to the HETS 270/271 application, refer to the HETS Trading Partner SOAP/MIME Connectivity Instructions available online here: http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp/Downloads/HETS270271SOAPMIMEConnectivity.pdf.

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. The HETS 270/271 application is not a Medicare claims processing or appeals system. Providers’ authorized staff members 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, an excessive number of resubmissions of the same eligibility request in a single day, requesting psychiatric data when the NPI is not a Psychiatric provider) 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/copayment
- 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) or Medicare Beneficiary Identifier (MBI)

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 or MBI 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 1-800-833-4455 to request a replacement Medicare Health Insurance card from RRB.

It is assumed that the reader of this document is familiar with the ASC X12 270/271 version 005010X279A1 and ASC X12 999 version 005010X231 TR3s and the transaction format and content rules contained within them. This *Companion Guide* is intended to be a complement to the ASC X12 270/271 and 999 TR3 versions noted above 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. A potential Trading Partner 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

Entities must apply for and be granted access as an authorized Trading Partner before they will be able to utilize the HETS 270/271 application. Entities must complete an application via the HETS Trading Partner Agreement located at the following link: http://cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp/Downloads/HETS_Trading_Partner_Agreement_Form.pdf

Instructions to complete the sign-up process can be found at the following link: http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp/HowtoGetConnectedHETS270271.html

2.3 Certification and Testing Overview

Trading Partners are required to submit test transactions to ensure that their systems are 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

4.1.1 Trading Partner Registration

To access the HETS 270/271 application, 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. Trading Partners are also required to recertify their HETS 270/271 application access annually by completing the Trading Partner Agreement (TPA) recertification process as instructed by CMS.

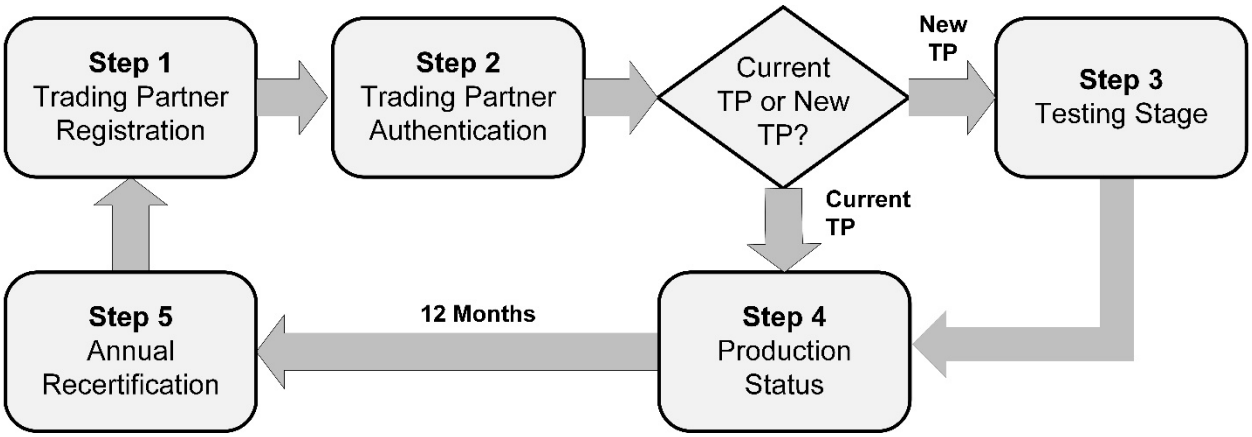

Figure 1. Process for Submitting 270 Transactions

Step 1: Trading Partner Registration
Complete and submit the HETS Trading Partner Agreement Form. 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 Form and approve or deny any Submitter ID requests.

Step 3: Testing Stage
MCARE will have a Trading Partner send up to 50 test transactions and verify that all systems involved can properly submit and receive X12 compliant transactions. The Usage Indicator (ISA15) must be “T.”

Step 4: Production Status
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.”

Step 5: Annual Recertification
Trading Partners that are in Production Status are required to recertify their access annually at a date predetermined by CMS. Trading Partners must complete an updated HETS Trading Partner Agreement and submit it per CMS’ instructions. The updated Trading Partner Agreement is validated to ensure it remains compliant with CMS policy.

4.1.2 Transaction Process

A Trading Partner may submit a 270 request to the HETS 270/271 application using Transmission Control Protocol/Internet Protocol (TCP/IP), Simple Object Access Protocol (SOAP) + Web Services Description Language (WSDL) or Hypertext Transfer Protocol (HTTP)/Multipurpose Internet Mail Extensions (MIME) Multipart communication protocols. The HETS 270/271 application authenticates the Trading Partner and ensures that the Trading Partner is associated with valid National Provider IDs (NPI) in the HETS database. If the Trading Partner is not authorized, or is not associated with valid NPIs, then an appropriate error response is returned. If the Trading Partner is authorized, then the appropriate response is returned. Figure 2 illustrates the high-level process for communicating with the HETS 270/271 application. The lock icons represent system checkpoints that must be passed before eligibility information is returned on the 271 response.

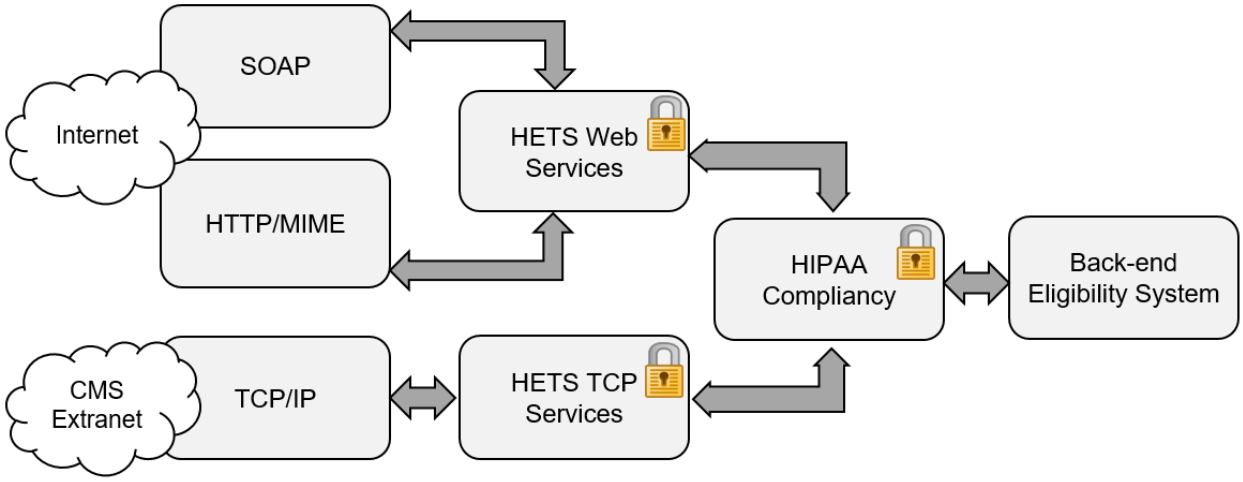

Figure 2. Transaction Process

4.2 Transmission Administrative Procedures

4.2.1 Schedule, Availability, and Downtime Notification

The HETS 270/271 application is typically available 24 hours a day, 7 days a week. At this time, there are no standing HETS 270/271 maintenance windows. MCARE will

notify HETS Trading Partners of any planned downtime. All current and archived downtime notifications are available via the following page within the CMS HETS Help website: https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp/MCARE-Notification-Archive.html.

Any unplanned downtime with the HETS 270/271 application during Help Desk operational hours will also be communicated to the Trading Partners via email and posted to the HETS Help website, http://go.cms.gov/hetshelp 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 transaction and resubmit, following the same processes and procedures of the original file.

4.3 Communication Protocol Specifications

Trading Partners may connect to the HETS 270/271 application via one of the following methods:

- TCP/IP over the CMS Extranet
  Additional information about TCP/IP connectivity over the CMS Extranet is available in Section 4.3.1.
- SOAP + WSDL (“SOAP”)
- HTTP MIME Multipart (“MIME”)
  Additional information about SOAP + WSDL or HTTP MIME Multipart connectivity is available in Section 4.3.2 through Section 4.3.4.

4.3.1 CMS Extranet

The HETS 270/271 application supports transactions through the CMS Extranet 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 request 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 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 to the HETS 270/271 application.

When the last requested 271 response has been received, Trading Partners should close the socket connection immediately. 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 Trading Partner is returned in the same session in which the 270 request was submitted.

The standard format of the TCP/IP Communication Transport Protocol Wrapper, SOHLLLLLLLLLLSTX<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.
LLLLLLLLLL	# of bytes, including spaces, of the 270 request	10		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		This is a required element.

Element	Description	Length	Hexadecimal Value	Note(s)
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 3.

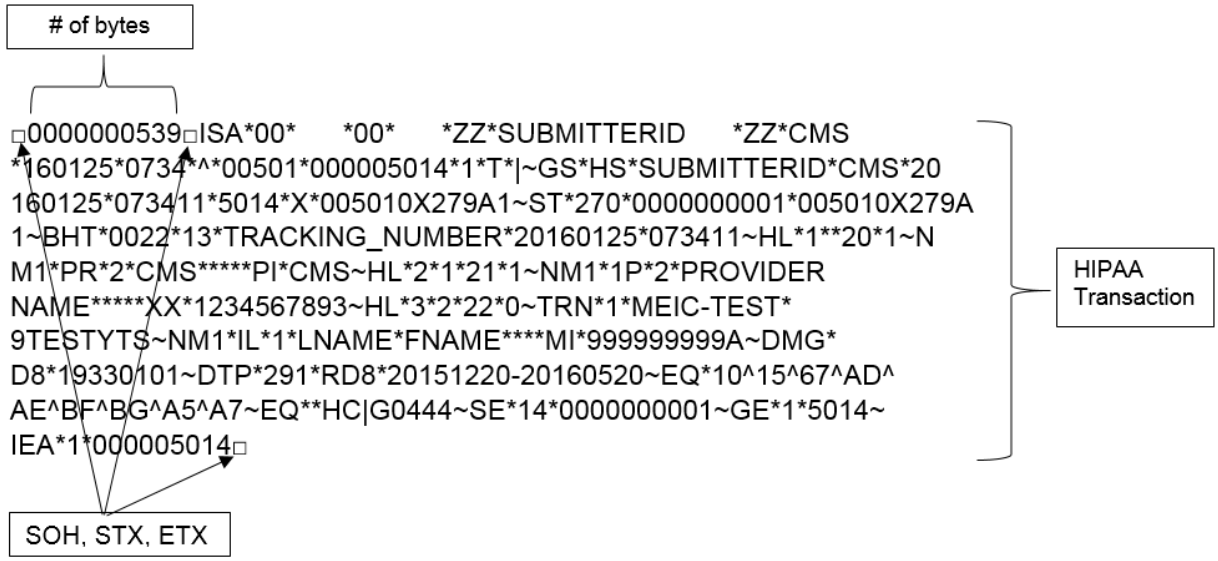

Figure 3. Example of TCP/IP Communication Transport Protocol Wrapper

Refer to the Extended Control Set matrix in the Appendix of the ASC X12 270/271 version 005010X279A1 TR3 for additional information about SOH, STX, and ETX.

4.3.2 Web Services Connectivity via SOAP + WSDL (“SOAP”) or HTTP MIME Multipart (“MIME”)

To connect to the HETS 270/271 application via SOAP or MIME, Trading Partners will need to authenticate with an X.509 Digital Certificate using the Transport Layer Security (TLS) 1.2 open standard for client certificate-based authentication. TLS 1.2 is required for compliance with the federally mandated NIST Special Publication 800-52r1.

The Trading Partner’s IP address is verified by CMS prior to allowing the 270 inquiry through to the HETS 270/271 application. Note that the Trading Partner’s IP address must be an address from the organization’s Production (not Testing) environment. Also, note that the supplied Trading Partner IP address must be a public address.

The information provided in the following steps should allow the Trading Partners to locate proper digital certificates for HETS connectivity. Trading Partners will need to generate a Certificate Signing Request (CSR) for obtaining the digital certificate for their organization. The CSR generation process is platform-specific. Please review the CSR generation process for your Certificate Authority (CA) carefully, as shown in the links

found in the following three subsections, and contact the CAs directly in order to obtain the digital certificate. CMS requires that all Trading Partners using SOAP or MIME use a SHA2-256 digital certificate.

Note: The certificates listed for each CA are the minimum level required to connect to the HETS 270/271 application. Trading Partners may choose to procure a higher level of certificate.

Before accessing the HETS 270/271 application via SOAP or MIME, new and existing Trading Partners must provide the Digital Certificate to CMS by contacting MCARE. MCARE will verify the certificate and initiate the process to configure Trading Partner access to the HETS 270/271 application. If the Trading Partner's Digital Certificate has not been approved or properly configured, the SOAP or MIME connection to the HETS 270/271 application will be rejected. Trading Partners that acquire a new Digital Certificate for use with HETS 270/271 must provide a copy of Digital Certificate to CMS by contacting MCARE. The Trading Partner will also be instructed to complete a new copy of the HETS Trading Partner Agreement as outlined in Section 9.

For more information on the Web Services Communication Protocol Specifications for connecting to the HETS 270/271 application, refer to the *HETS Trading Partner SOAP/MIME Connectivity Instructions* available online here: http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp/Downloads/HETS270271SOAPMIMEConnectivity.pdf.

The Trading Partners will need to procure a digital certificate from one of the following CAs detailed in the subsections below in order to allow their infrastructure to connect to the HETS servers. Information on certificate procurement and platform-specific CSR generation processes can be found on each CA's webpage. The links to their home pages has been provided below in Section 4.3.2.1 through Section 4.3.2.3.

Trading Partners must use one of the following CAs in the subsections below to procure a Digital Certificate.

4.3.2.1 DigiCert

Information on digital certificates provided by DigiCert can be found using the following link: http://www.digicert.com

Digital certificates issued by the following DigiCert Intermediate certificates are accepted:

- DigiCert SHA2 Assured ID CA
- DigiCert SHA2 Secure Server CA
- DigiCert SHA2 Extended Validation Server CA
- DigiCert SHA2 High Assurance Server CA
- DigiCert Assured ID CA G2

- DigiCert Global CA G2

4.3.2.2 Entrust

Information on digital certificates provided by Entrust can be found using the following link: http://www.entrust.net

Digital certificates issued by the following Entrust Intermediate certificates are accepted:

- Entrust Certification Authority – L1K
- Entrust Certification Authority – L1M

4.3.2.3 Symantec

Information on digital certificates provided by Symantec can be found using the following link: http://www.symantec.com

Digital certificates issued by the following Symantec Intermediate certificates are accepted:

- Symantec Class 3 EV SSL CA – G3
- Symantec Class 3 Secure Server CA – G4
- Symantec Class 3 Extended Validation SHA256 SSL CA

4.3.3 SOAP + WSDL ("SOAP")

The HETS 270/271 application also supports Internet transactions formatted according to SOAP standards set forth by the WSDL for Extensible Markup Language (XML) envelope formatting, submission, and retrieval.

4.3.3.1 SOAP XML Schema

The XML schema definition used by the HETS 270/271 application is located at:

http://www.caqh.org/sites/default/files/core/wsdl/CORERule2.2.0.xsd

4.3.3.2 WSDL Information

The WSDL definition used by the HETS 270/271 application is located at:

http://www.caqh.org/sites/default/files/core/wsdl/CORERule2.2.0.wsdl

4.3.3.3 SOAP Version Requirements

The HETS 270/271 application requires that all SOAP transactions conform to SOAP Version 1.2.

4.3.3.4 Submission/Retrieval

SOAP transactions are submitted to HETS 270/271 via a specific URL. Refer to the *HETS Trading Partner SOAP/MIME Connectivity Instructions* for additional information.

The X12 payload must be embedded using the Inline method (CDATA element) for real-time SOAP transactions. For more information, refer to the W3C recommendation on SOAP messaging framework located at: http://www.w3.org/TR/soap12-part1

4.3.3.5 SOAP Header Requirements

The SOAP Header must include the timestamp element which must be digitally signed. The Web Services Security Binary Security Token must be added to the SOAP Header which is used for verification of the signature. The following link should be used as a reference when constructing the SOAP Header:
http://www.caqh.org/sites/default/files/core/phase-ii/policy-rules/270-v5010.pdf

4.3.3.6 SOAP Body Requirements

Only those characters referenced in the Basic and the Extended Character Sets noted in the Appendix of the ASCX12 270/271 version 005010X279A1 TR3 including the 005010X279E1 Errata are acceptable within a HETS 270 inquiry. The following link should be used as a reference when constructing the SOAP Body:
http://www.w3.org/TR/soap12-part1

Required HETS-specific body elements for 270 requests using SOAP are defined in Table 2.

Table 2. Required Body Elements for 270 Requests Using SOAP

Element Name	Description
PayloadType	X12_270_Request_005010X279A1
ProcessingMode	RealTime
PayloadID	Refer to Section 4.4.2 of the Phase II CORE 270: Connectivity Rule for structural guidelines for CORE envelope metadata.
TimeStamp	Format is CCYY-MM-DDTHH:MM:SSZ. Refer to http://www.w3.org/TR/xmlschema11-2/ for more information.
SenderID	This is a user defined alphanumeric field. The value must be 10 characters in length. Recommended value is the HETS 270/271 SOAP Submitter ID plus trailing zeros for a total of 10 characters.
ReceiverID	CMS
CORERuleVersion	2.2.0
Payload	X12 request. This element must be digitally signed and the entire payload should be enclosed within a CDATA tag.

Table 3 defines HETS-specific body elements for X12 responses using SOAP.

Table 3. Required Body Elements for X12 Responses Using SOAP

Element Name	Description
PayloadType	X12_271_Response_005010X279A1, X12_TA1_Response_00501X231A1, X12_999_Response_005010X231A1
ProcessingMode	RealTime
PayloadID	Refer to Section 4.4.2 of the Phase II CORE 270: Connectivity Rule for structural guidelines for CORE envelope metadata.
TimeStamp	Format is CCYY-MM-DDTHH:MM:SSZ. Refer to http://www.w3.org/TR/xmlschema11-2/ for more information.
SenderID	CMS
ReceiverID	The value of this field will exactly match the SenderID submitted in the 270 request. Refer to Table 2 for additional information on 270 request SenderID.
CORERuleVersion	2.2.0
Payload	X12 response

4.3.3.7 SOAP Digital Signature

The SOAP communication protocol requires Trading Partners embed their certificate within the eligibility request and digitally sign the SOAP Body Payload and SOAP Header Timestamp using their private key. CMS will embed their certificate in the 271 response enabling the Trading Partner to verify it came from CMS. Trading Partners can obtain a copy of CMS' Certificate in advance by contacting the MCARE Help Desk. Refer to the following link for details related to digital signatures as they relate to SOAP: http://www.w3.org/TR/SOAP-dsig/

4.3.3.8 SOAP Examples

Examples of a SOAP request and response can be found in Sections 4.2.2.3 and 4.2.2.4 of the CORE Phase II Connectivity Rule at this link: http://www.caqh.org/sites/default/files/core/phase-ii/policy-rules/270-v5010.pdf

4.3.4 HTTP MIME Multipart ("MIME")

HETS will support standard MIME messages. The MIME format used must be multipart/form-data.

CORE does not specify the naming conventions as a mandate. HETS will implement the MIME body parts with the same field names as the SOAP element nodes. The response will be returned as MIME multipart/form-data, with the Payload body part containing the X12 response.

Trading Partners must specify appropriate MIME headers. The MIME specification is very precise, and requires that the headers and the body be constructed perfectly. The HETS implementation of MIME allows for the use of the Basic and Extended Character Sets as noted in the Appendix of the ASCX12 270/271 version 005010X279A1 TR3 including the 005010X279E1 Errata only. Please refer to the RFC 2388 – returning values from Forms: multipart/form-data to review header and body specifications. The

RFC 2388 can be found at the following link:
http://www.faqs.org/rfcs/rfc2388.html

4.3.4.1 Submission/Retrieval

MIME transactions are submitted to HETS 270/271 via a specific URL. Refer to the HETS Trading Partner SOAP/MIME Connectivity Instructions for additional information.

A MIME transaction must be constructed exactly to the multipart/form-data specifications. Refer to http://www.faqs.org/rfcs/rfc2388.html for more information on multipart/form header and body specifications.

4.3.4.2 HTTP MIME Multipart Header Requirements

MIME messages will have standard HTTP header data elements, such as POST, HOST, Content-Length, and Content-Type. The supported Content-Type is MIME multipart/form-data.

4.3.4.3 HTTP MIME Multipart Body Requirements

Since CORE does not specify naming conventions, HETS will implement MIME with the same field names as SOAP. Required body elements for MIME transactions are defined in Table 4.

Table 4. Required Body Elements for 270 Requests Using MIME

Element Name	Description
PayloadType	X12_270_Request_005010X279A1
ProcessingMode	RealTime
PayloadID	Refer to Section 4.4.2 of the Phase II CORE 270: Connectivity Rule for structural guidelines for CORE envelope metadata.
TimeStamp	Format is CCYY-MM-DDTHH:MM:SSZ. Refer to http://www.w3.org/TR/xmlschema11-2/ for more information.
SenderID	This is a user defined alphanumeric field. The value must be 10 characters in length. Recommended value is the HETS 270/271 MIME Submitter ID plus trailing zeros for a total of 10 characters.
ReceiverID	CMS
CORERuleVersion	2.2.0
Payload	X12 request. The X12 request must be submitted as part of the MIME request and not as an attachment. If an attachment is received, the transaction will be rejected. The request does not need to be enclosed within a CDATA tag. See Appendix A for an example of the 270 request that would appear here.

Table 5 defines HETS-specific body elements for X12 responses using MIME.

Table 5. Required Body Elements for X12 Responses Using MIME

Element Name	Description
PayloadType	X12_271_Response_005010X279A1, X12_999_Response_005010X231A1 or X12_TA1_Response_00501X231A1
ProcessingMode	RealTime
PayloadID	Refer to Section 4.4.2 of the Phase II CORE 270: Connectivity Rule for structural guidelines for CORE envelope metadata.
TimeStamp	Format is CCYY-MM-DDTHH:MM:SSZ. Refer to http://www.w3.org/TR/xmlschema11-2/ for more information.
SenderID	CMS
ReceiverID	This value of this field will exactly match the SenderID submitted in the 270 request. Refer to Table 4 for additional information on 270 request SenderID.
CORERuleVersion	2.2.0
Payload	X12 response

4.3.4.4 HTTP MIME Multipart Examples

Examples of a MIME request and response can be found in Sections 4.2.1.1 and 4.2.1.2 of the CORE Phase II Connectivity Rule at this link:
http://www.caqh.org/sites/default/files/core/phase-ii/policy-rules/270-v5010.pdf

4.4 Security

The HETS 270/271 application is located at a secure CMS data center. The CMS Extranet 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. Trading Partners transmitting with SOAP or MIME must obtain a digital certificate and send the transaction to the HETS 270/271 application via secure internet connection. Additionally, the HETS 270/271 application authorizes Trading Partners based on either their originating Internet Protocol (IP) address or digital certificate 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 Trading Partners 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 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 ASC X12 270/271 version 005010X279A1 TR3. 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 version 005010X279A1 TR3 assume the version referenced in Section 1.1 of this *Companion Guide*.

6.1 Interchange Control Structure (ISA/IEA)

Table 6 describes the values specifically required by the HETS 270/271 application within the ISA Header of the 270 request. The HETS 270/271 application does not expect any custom values for the IEA segment within the 270 request. Please follow the rules as specified by the ASC X12 270/271 version 005010X279A1 TR3.

Table 6. 270 ISA Segment Rules

Reference	Name	X12 Codes	Notes/Comments
ISA	Interchange Control Header		
ISA01	Authorization Information Qualifier	00	HETS always expects “00.”
ISA03	Security Information Qualifier	00	HETS always expects “00.”
ISA05	Interchange ID Qualifier	ZZ	HETS always expects “ZZ.”
ISA06	Interchange Sender ID		HETS always expects the Trading Partner Submitter ID assigned by CMS.

Reference	Name	X12 Codes	Notes/Comments
ISA07	Interchange ID Qualifier	ZZ	HETS always expects “ZZ.”
ISA08	Interchange Receiver ID		HETS always expects “CMS.”
ISA09	Interchange Date		HETS always expects a current date.
ISA14	Acknowledgment Requested	0,1	HETS will not return the TA1 acknowledgement receipt of a real time transaction even if acknowledgment is requested.

6.2 Functional Group Structure (GS/GE)

Table 7 describes the values specifically required by the HETS 270/271 application within the GS Header of the 270 request. The HETS 270/271 application does not expect any custom values for the GE segment within the 270 request.

Please follow the rules as specified by the ASC X12 270/271 version 005010X279A1 TR3 for all elements not included in Table 7.

Table 7. 270 GS Segment Rules

Reference	Name	X12 Codes	Notes/Comments
GS	Functional Group Header		
GS02	Application Sender’s Code		HETS always expects the Trading Partner Submitter ID assigned by CMS.
GS03	Application Receiver’s Code		HETS always expects “CMS.”

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 ASC X12 270/271 version 005010X279A1 TR3.

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 ASC X12 270/271 version 005010X279A1TR3 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 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 delimiters in Table 8. HETS will utilize these delimiters for all 271 responses (regardless of the delimiters the Trading Partner sent in the 270 request).

Table 8. Preferred 270 Request 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 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 271 response returns the following basic set of eligibility information if the Medicare Beneficiary is entitled to Part A and/or Part B for all valid 270 requests.
    - Medicare Beneficiary Demographics
    - Part A and B Entitlement including any Periods of Inactivity
    - Coverage Status of Requested and Supported STCs
    - MSP, MA, and Part D Plan Enrollment Information (where applicable)
    - Plan Level Financial Information
- The HETS 270/271 application will accept multiple Service Type Codes (STCs) and/or Healthcare Common Procedure Coding System (HCPCS) codes on a 270 request.
- Additional eligibility information will be returned when the following supported STCs are sent within a 270 request: AD, AE, AF, AG, A5, A7, BF, BG, CQ, RN, 10, 42, 45, 47, 48, 49, and 67.

- Additional eligibility information returns when the following supported HCPCS Codes are sent within a 270 request: 76706, 76977, 77067, 77078, 77080, 77081, 80061, 81528, 82270, 82465, 82947, 82950, 82951, 83718, 84478, 90670, 90732, G0101, G0102, G0103, G0104, G0105, G0106, G0117, G0118, G0120, G0121, G0123, G0130, G0143, G0144, G0145, G0147, G0148, G0297, G0328, G0402, G0403, G0404, G0405, G0438, G0439, G0442, G0443, G0444, G0445, G0446, G0447, G0472, G0473, G0475, G0499, P3000, and Q0091.
- The HETS 270/271 application returns the Medicare coverage status for the following supported STCs when sent within a 270 request: 1, 2, 3, 4, 5, 6, 7, 8, 10, 12, 13, 14, 15, 18, 20, 23, 24, 25, 26, 27, 28, 30, 33, 35, 36, 37, 38, 39, 40, 41, 42, 45, 47, 48, 49, 50, 51, 52, 53, 54, 62, 65, 67, 68, 69, 73, 76, 78, 80, 81, 82, 83, 86, 88, 93, 98, 99, A0, A3, A4, A5, A6, A7, A8, AD, AE, AF, AG, AI, AJ, AK, AL, BF, BG, BH, BT, BU, BV, CQ, DM, MH, RN, and UC.
- The 271 response only returns the coverage status of the “child” components of STCs 1, 30, 35, 47 and/or MH if they are sent within a 270 request. If the requested date(s) of service start date is after the Date of Death, then the “child” components are not returned. The “child” components are not returned when the Medicare Beneficiary is ineligible. The “child” component STCs are defined in the Front Matter of the ASC X12 270/271 version 005010X279A1 TR3.
- The 271 response returns STCs 1, 47, and MH when requested on the 270 and the Medicare Beneficiary is ineligible for Medicare Part A. The 271 response returns STCs 1, 35, 47, and MH when requested on the 270 and the Medicare Beneficiary is ineligible for Medicare Part B.
- The 271 response returns the following supported STCs as covered under Medicare Part A: 10, 15, 42, 45, 48, 49, 65, 69, 76, 78, 83, A5, A7, AG, BT, BU, BV, and RN. The coverage status of the Part A covered STCs is returned in the EB01 data element of the Part A Entitlement 2110C Loop.
- The 271 response returns the following supported STCs as covered under Medicare Part B: 2, 3, 4, 5, 6, 7, 8, 10, 12, 13, 14, 18, 20, 23, 24, 25, 26, 27, 28, 33, 36, 37, 38, 39, 40, 42, 50, 51, 52, 53, 62, 65, 67, 69, 73, 76, 78, 80, 81, 83, 86, 93, 98, 99, A0, A3, A4, A6, A8, AD, AE, AF, AI, AJ, AK, AL, BF, BG, BH, BT, BU, BV, DM, RN and UC. The coverage status of the Part B covered STCs is returned in the EB01 data element of the Part B Entitlement 2110C Loop.
- The 271 response returns the following supported STCs as not covered (EB01= “I”) under Medicare: 41, 54, 68, and 82.
- When STC = “30” is submitted on a 270 request, the 271 response returns the coverage status of the following STCs: 2, 3, 23, 24, 25, 26, 27, 28, 33, 36, 37, 38, 39, 40, 41, 42, 45, 48, 49, 50, 51, 52, 53, 54, 67, 69, 73, 76, 83, 86, 88, 98, A4, A5, A6, A7, A8, AG, AI, AJ, AK, AL, BT, BU, BV, DM, UC.
- The following scenarios will also produce a response as though STC= “30” was requested.
    - No STC is requested

  - A requested STC is not supported by HETS
  - A requested HCPCS code is not supported by HETS
- The 271 response returns the Medicare Beneficiary's Part D coverage status with STC = "88" in a separate 2110C Loop when STC = "88" or "30" is specifically requested or if the HETS 270/271 application is responding as if STC = "30" was requested.
- The following STCs are free services and are covered at 100% by Medicare Part A and/or Part B; therefore, deductibles, copayment, and coinsurance liabilities do not apply: 5, 42, 45, 67, and AJ. The 271 response returns all Part A free service information in a single 2110C EB loop with the potential for multiple DTP segments, regardless of what calendar year they fall within. HETS will handle Part B free service information in the same manner as a single 271 2110C EB loop with the potential for multiple DTP segments.
- The 271 response returns an additional 2110C Loop for any STC where the deductible and/or coinsurance amounts differ from the Plan Level amounts.
- The 271 response returns the coverage status for STCs 48 and 49 when STCs AG, 47, 48, and/or 49 are sent within a 270 request except when the requested date(s) of service start date is after the Date of Death or the Medicare Beneficiary is ineligible.
- The 271 response may return multiple EB loops to reflect the Medicare Beneficiary's plan level financials, benefit, and enrollment history and/or the EQ values sent within a 270 request.
- The 271 response does not include 2110C loops for future year deductibles, coinsurance, and copayment per day when these values have not yet been published by CMS. 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 271 response will include the DOEBA and DOLBA dates of all hospital spells intersecting the current date and/or the calendar (years) of the date/date range of the 270 request. This data returns in the HETS 271 response for any specific Service Type Code (STC) or HCPCS code in the 270 request. Example segments returned in a 271 response:

  EB*D**30*MA~
  DTP*292*RD8*CCYYMMDD-CCYYMMDD~ (DTP03 = DOEBA and DOLBA Dates)
- Trading Partners receive a 271 response 2100A AAA error 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.
- The HETS 270/271 application returns a 999 error response if dependent-level data is sent within a 270 request.

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), 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 9 describes the necessary data elements for the required primary and alternate search options supported by the HETS 270/271 application.

Table 9. HETS 270/271 Search Options

Search Option	HICN or MBI	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 accepts either the HICN or MBI on 270 requests. HETS Submitters can submit either the MBI or HICN in the 270 2100C NM109 element (using the identical 270 2100C NM108 qualifier). HETS will accept either the HICN or the MBI until December 31, 2019. Effective January 1, 2020, HETS will only accept the MBI. Table 10 outlines HETS 270/271 HICN and MBI processing during the New Medicare Card transition period.

Table 10. HETS HICN & MBI Processing During the New Medicare Card Transition Period

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 returns a HICN in the 271 response. Additionally, if certain criteria are met, HETS returns 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 is 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 returns an MBI in the 271 response. Additionally, if the individual qualifies for Medicare under RRB, HETS returns 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 the HETS 270/271 application will 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.
- If the Medicare Beneficiary's submitted HICN is found but is not the Medicare Beneficiary's active HICN, the HETS 270/271 application cross-references the submitted (but now inactive) HICN to the active HICN. HETS only performs the

cross-reference function if all other submitted data elements match the Medicare Beneficiary record. In cross-reference HICN scenarios, the 271 response will return the updated, active HICN in 271 2100C NM109, the submitted (now inactive) HICN in a 271 2100C REF segment and a 271 2100C AAA03 = “72” error code. The Trading Partner may then send a new 270 request with the active HICN. HETS does not cross-reference MBIs.

- If applicable, the HETS 270/271 application returns a MBI’s end date on 271 responses that a) contain benefit information and b) include a Date(s) of Service which overlaps the terminated MBI’s effective period. Medicare Providers/Suppliers should contact the Medicare Beneficiary to obtain an updated MBI number.
- 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 the HETS 270/271 application returns a 999 response. Additionally, HETS rejects 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 9.
- If the search criteria do not produce a match to a Medicare Beneficiary, the 271 response includes the appropriate AAA03 error code in the 271 response. Refer to Section 8.3 of this *Companion Guide* for additional information.

7.4 Date Request Rules

- The 271 response returns current eligibility information if no date is contained in the 270 request.
- CMS will verify that the date(s) requested on the 270 request are within the HETS 270/271 application’s allowable date span. The allowable date span is up to four years 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 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 11 illustrates the allowable request date ranges.

Table 11. Request Date Calendar

If the Current Month Is:	Historical Requests Are Valid Through:	Future Requests Are Valid Through:
January	January, 4 years ago	May of the current year
February	February, 4 years ago	June of the current year

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

Example: If an eligibility request is sent on September 1, 2019, requests from September 1, 2015 through January 1, 2020 will be accepted.

7.5 Medicare Part A & Part B Eligibility Business Rules

- Trading Partners should review the entire 271 response to determine the appropriate eligibility status for the Medicare Beneficiary.
- To indicate periods of Medicare entitlement, the 271 response returns a 2110C Loop with element EB01 = “1” along with applicable EB03 covered STCs and the Subscriber Eligibility/Benefit Date (DTP03) where DTP01 = “291” with beginning and end dates, where appropriate, for each applicable entitlement period.
- The 271 response returns a 2110C Loop with element EB01= “6” for Part A and/or Part B along with applicable EB03 covered STCs 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 271 response returns a 2110C Loop with element EB01 = “6” 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.

- 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.
- The 271 response will return a 2110C Loop with element EB01= "6", EB03 = "30" plus any covered STCs from the 270 request that are supported by HETS, and no eligibility data when the Medicare Beneficiary is deceased and the Date of Death is prior to the requested date(s) of service. STCs that are supported by HETS but are not covered for the Medicare Beneficiary will be returned in the 271 response as non-covered.
    - If requested in the 270 request (and all other data create a match), eligibility information for STC "CQ" is returned separately from all other supported STCs. This separate eligibility loop reflects the coverage for the requested Date(s) of Service submitted on the 270 request.
- 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 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. Date of Death is returned on the 2100C DTP segment.
- Example segments returned in a 271 response:

  Part A Entitlement

  EB*1**30^42^45^48^49^69^76^83^A5^A7^AG^BT^BU^BV^RN*MA~
  DTP*291*RD8*CCYYMMDD-CCYYMMDD~ (DTP03 = Entitlement and Termination Dates (where applicable))

  Part B Entitlement

  EB*1**30^2^3^23^24^25^26^27^28^33^36^37^38^39^40^42^50^51^52^53^67^69^73^76^83^86^98^A4^A6^A8^AI^AJ^AK^AL^BT^BU^BV^DM^RN^UC*MB~
  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**30^10~
  EB*I**30^41~

  Entitled but Inactive Due to Incarceration, Deportation or Alien Status

  Inactive Period

  EB*6**30~
  DTP*307*RD8*CCYYMMDD-CCYYMMDD~ (DTP03 = Inactive Date(s))
  Entitlement Period

  EB*1**30^42^45^48^49^69^76^83^A5^A7^AG^BT^BU^BV^RN*MA~
  DTP*291*D8*CCYYMMDD~ (DTP03 = Part A Entitlement Date(s))

EB*1**30^2^3^23^24^25^26^27^28^33^36^37^38^39^40^42^50^51^52^53^67^69^73^76^83^86^98^A4^A6^A8^AI^AJ^AK^AL^BT^BU^BV^DM^RN^UC*MB~
DTP*291*D8*CCYYMMDD~ (DTP03 = Part B Entitlement Date(s))

For additional information, refer to Table 24.

7.6 Medicare Plan Level Part A Deductible Business Rules

- The 271 response returns the following Part A Plan Level financial information in the 2110C Loop on every 271 response when the Medicare Beneficiary is Part A entitled:
    - The base Part A deductible amount for every calendar year of the date/date range on the 270 request plus the start year of the earliest intersecting spell.
    - The remaining Part A deductible amount for every calendar year within the date/date range on the 270 request plus the start year of the earliest intersecting spell.
    - The remaining Part A deductible amount and applicable DOEBA/DOLBA dates for every spell that intersects within 60 days of the date/date range on the 270 request.
- The 271 response returns the Part A deductible as zero in an additional 2110C Loop for STCs 42 or 45 when applicable and the Medicare Beneficiary is Part A entitled.
- Example segments returned in a 271 response:

  Part A Deductible Financial Data

  EB*C**30*MA**26*1364~ (EB07 = Part A Base Deductible 2019)
  DTP*291*RD8*20190101-20191231~ (Dates within calendar year when no QMB enrollment is present)
  EB*C**30*MA**26*1340~ (EB07 = Part A Base Deductible 2018)
  DTP*291*RD8*20180101-20181231~ (Dates within calendar year when no QMB enrollment is present)
  EB*C**30*MA**29*1364~ (EB07 = Part A Base Deductible as Remaining 2019)
  DTP*291*RD8*20190101-20191231~ (Dates within calendar year when no QMB enrollment is present)
  EB*C**30*MA**29*1340~ (EB07 = Part A Base Deductible as Remaining 2018)
  DTP*291*RD8*20180101-20181231~ (Dates within calendar year when no QMB enrollment is present)
  EB*C**30*MA**29*0~ (EB07 = Part A Spell Remaining)
  DTP*291*RD8*20180101-20180106~ (Dates within DOEBA-DOLBA when no QMB enrollment is present)

  Covered at 100% -- Part A

EB*C**42^45*MA**26*0~ (EB07 = 0 to display the Part A Base Deductible is not applicable)
DTP*292*RD8*20190101-20191231~ (Dates within calendar year when no QMB enrollment is present)
DTP*292*RD8*20180101-20181231~ (Dates within calendar year when no QMB enrollment is present)

For additional information, refer to Table 25.

7.7 Medicare Plan Level Part B Deductible and Coinsurance Business Rules

The purpose of this section is to explain the HETS 270/271 application business rules for Part B deductible and coinsurance amounts. Section 7.7.1 illustrates the business rules for STCs. Section 7.7.2 illustrates the business rules for supported HCPCS codes.

7.7.1 STC Financial Business Rules

- The 271 response returns the following Part B Plan Level financial information in the 2110C Loop on every 271 response when a supported STC, non-supported STC or no STC is submitted and the Medicare Beneficiary is Part B entitled:
    - The Part B base deductible amount for every calendar year within the date/date range on the 270 request.
    - The Part B remaining deductible amount for every calendar year within the date/date range on the 270 request.
    - The Part B coinsurance amount for every calendar year within the date/date range sent within a 270 request.
- The 271 response returns the Part B deductible and coinsurance percentage as zero for STC 5, 42, 67 and/or AJ in an additional 2110C loop when the Medicare Beneficiary is Part B entitled and any of the following conditions exist on the 270 request.
    - STCs 5, 42, 67 or AJ are explicitly requested
    - STCs 1, 30 or MH are requested
    - HETS responds as if STC 30 was requested - refer to Section 7.2
- Example segments returned in a 271 response:

  Part B Deductible Financial Data

  EB*C**30*MB**23*185~ (EB07 = Part B Base Deductible 2019)
  DTP*291*RD8*20190101-20191231~ (Dates within calendar year when no QMB enrollment is present)
  EB*C**30*MB**23*183~ (EB07 = Part B Base Deductible 2018)
  DTP*291*RD8*20180101-20181231~ (Dates within calendar year when no QMB enrollment is present)
  EB*C**30*MB**29*0~ (EB07 = Part B Remaining Deductible 2019)

DTP*291*RD8*20190101-20191231~ (Dates within calendar year when no QMB enrollment is present)
EB*C**30*MB**29*0~ (EB07 = Part B Remaining Deductible 2018)
DTP*291*RD8*20180101-20181231~ (Dates within calendar year when no QMB enrollment is present)
EB*A**30*MB**27**.2~ (EB08 = Plan Level Coinsurance Percentage 2019)
DTP*291*RD8*20190101-20191231~ (Dates within calendar year when no QMB enrollment is present)
EB*A**30*MB**27**.2~ (EB08 = Plan Level Coinsurance Percentage 2018)
DTP*291*RD8*20180101-20181231~ (Dates within calendar year when no QMB enrollment is present)

Covered at 100% -- Part B

EB*C**5^42^67^AJ*MB**23*0~ (EB07 = 0 to display the Part B Base Deductible is not applicable)
DTP*292*RD8*20190101-20191231~ (Dates within calendar year when no QMB enrollment is present)
DTP*292*RD8*20180101-20181231~ (Dates within calendar year when no QMB enrollment is present)
EB*A**5^42^67^AJ*MB**27*0~ (EB07 = 0 to display the Part B Coinsurance is not applicable)
DTP*292*RD8*20190101-20191231~ (Dates within calendar year when no QMB enrollment is present)
DTP*292*RD8*20180101-20181231~ (Dates within calendar year when no QMB enrollment is present)

For additional information, refer to Table 26.

7.7.2 Medicare HCPCS Code Financial Business Rules

The 271 response returns Part B HCPCS financial data in the 2110C Loop with the current system transaction processing date for the supported HCPCS code submitted when:

- The next eligible date year is prior to or equal to the current year. The current year is determined by the year of the system date on which the 270 request is received by the HETS 270/271 application.
- The Beneficiary is not dual-eligible for both Medicare and Medicaid (QMB) as of the current system transaction processing date. Refer to Section 7.21 for additional information.
- The HCPCS code deductible and/or coinsurance details do not match the Part B Plan Level deductible and/or coinsurance amount.

When the HCPCS code deductible and/or coinsurance details for a specific code match the Part B Plan Level deductible and/or coinsurance amount, only the Next Eligible Date is returned if applicable and no financial data will be returned.

- Example segments returned in a 271 response:

  Part B Deductible Amount:

  EB*C***MB**23*0******HC|80061~ (EB07 = Deductible Amount of “0”, EB13-2 = HCPCS Code)
  DTP*292*D8*CCYYMMDD~ (DTP03 = the current system transaction processing date)

  Part B Coinsurance Amount:

  EB*A***MB**27*0******HC|80061~ (EB07 = Coinsurance Amount of “0”, EB13-2 = HCPCS Code)
  DTP*292*D8*CCYYMMDD~ (DTP03 = the current system transaction processing date)

For additional information, refer to Table 27 and Table 28.

7.8 Medicare Part A Hospital and Skilled Nursing Facility (SNF) Spells Business Rules

- STC 47, 48, 49, AG, A5 or A7 must be sent within a 270 request to receive Hospital Spell data in the 271 response.
    - Hospital Base days and Hospital remaining days and copayment amounts return with Hospital Spell data.
    - Lifetime reserve base days, Lifetime remaining days and copayment amount return with Hospital Spell data.
- STC AG must be sent within a 270 request to receive SNF data in the 271 response.
- Hospital Base days and Hospital remaining days and copayment amounts return with SNF Spell data.
- A SNF spell will always be accompanied by a prior Hospital stay.
- The dates of a Hospital/SNF spell (2110C Loop, Element DTP01 = “435”) return 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 are not specified.
- The 271 response returns all Hospital/SNF spells that fall within 60 days of the date or date range specified in the 270 request.
- If a single Hospital/SNF spell spans more than one calendar year, the 271 response returns 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 271 response returns default values for Part A Spell data.
- Overlapping Hospital spells may indicate a change in Medicare Beneficiary primary entitlement from Medicare Part A to a Medicare Advantage plan. Please review the response to determine if the Medicare Beneficiary is covered by Medicare Part A or a Medicare Advantage plan.

- STC A7 must be sent within a 270 request to receive Lifetime Psychiatric Limitation Data for Psychiatric Base Days and Psychiatric Remaining Days in the 271 response.
- Example segments returned in a 271 response:

  Hospital Days Base

  EB*B**30*MA**26*0~ (EB07 = $0 for Medicare Part A Copayment per Part A Spell)
  HSD***DA**30*0~ (From Day 1)
  HSD***DA**31*60~ (Thru Day 60)
  HSD*****26*1~ (Per Part A Spell)
  DTP*435*RD8*CCYYMMDD-CCYYMMDD~ (Dates within calendar year when no QMB enrollment is present)
  EB*B**30*MA**7*341~ (EB07 = $ for 2019 Medicare Part A Copayment Days)
  HSD***DA**30*60~ (From Day 61)
  HSD***DA**31*90~ (Thru Day 90)
  HSD*****26*1~ (Per Part A Spell)
  DTP*435*RD8*CCYYMMDD-CCYYMMDD~ (Dates within calendar year when no QMB enrollment is present)

  Hospital Days Base as Remaining

  EB*B**30*MA**26*0~ (EB07 = $0 for Medicare Part A Copayment per Part A Spell)
  HSD***DA**29*60~ (60 Days Remaining at $0 per Day)
  HSD*****26*1~ (Per Part A Spell)
  DTP*435*RD8*CCYYMMDD-CCYYMMDD~ (Dates within calendar year when no QMB enrollment is present)
  EB*B**30*MA**7*341~ ($ Amt for 2019 Medicare Part A Copayment Days)
  HSD***DA**29*30~ (30 Days Remaining at $ Amt per Day)
  HSD*****26*1~ (Per Part A Spell)
  DTP*435*RD8*CCYYMMDD-CCYYMMDD~ (Dates within calendar year when no QMB enrollment is present)

  Hospital Spell Days Remaining

  EB*B**30*MA**26*0~ (EB07 = $0 for Medicare Part A Copayment per Part A Spell)
  HSD***DA**29*56~ (56 Days Remaining at $0 per Day)
  HSD*****26*1~ (Per Part A Spell)
  DTP*435*RD8*CCYYMMDD-CCYYMMDD~ (DOEBA-DOLBA) (Dates within DOEBA-DOLBA when no QMB enrollment is present)
  EB*B**30*MA**7*341~ (EB07 = $ for 2019 Medicare Part A Copayment Days)
  HSD***DA**29*30~ (30 Days Remaining at $ Amt per Day)
  HSD*****26*1~ (Per Part A Spell)

DTP*435*RD8*CCYYMMDD-CCYYMMDD~ (DOEBA-DOLBA) (Dates within DOEBA-DOLBA when no QMB enrollment is present)

SNF Days Base

EB*B**AG*MA**26*0~ (EB07 = $0 for Medicare Part A Copayment per Part A SNF Spell)
HSD***DA**30*0~ (From Day 1)
HSD***DA**31*20~ (Thru Day 20)
HSD*****26*1~ (Per SNF Spell)
DTP*435*RD8*CCYYMMDD-CCYYMMDD~ (Dates within calendar year when no QMB enrollment is present)
EB*B**AG*MA**7*170.50~ (EB07 = $ Amt for 2019 Medicare Part A Copayment Days)
HSD***DA**30*20~ (From Day 21)
HSD***DA**31*100~ (Thru Day 100)
HSD*****26*1~ (Per SNF Spell)
DTP*435*RD8*CCYYMMDD-CCYYMMDD~ (Dates within calendar year when no QMB enrollment is present)

SNF Days Base as Remaining

EB*B**AG*MA**26*0~ (EB07 = $0 for Medicare Part A Copayment per Part A SNF Spell)
HSD***DA**29*20~ (20 Days Remaining at $0 per Day)
HSD*****26*1~ (Per SNF Spell)
DTP*435*RD8*CCYYMMDD-CCYYMMDD~ (Dates within calendar year when no QMB enrollment is present)
EB*B**AG*MA**7*170.50~ (EB07 = $ Amt for 2019 Medicare Part A Copayment Days)
HSD***DA**29*80~ (80 Days Remaining at $ Amt per Day)
HSD*****26*1~ (Per SNF Spell)
DTP*435*RD8*CCYYMMDD-CCYYMMDD~ (Dates within calendar year when no QMB enrollment is present)

SNF Spell Days Remaining

EB*B**AG*MA**26*0~ (EB07 = $0 for Medicare Part A Copayment per Part A SNF Spell)
HSD***DA**29*18~ (18 Days Remaining at $0 per Day)
HSD*****26*1~ (Per SNF Spell)
DTP*435*RD8*CCYYMMDD-CCYYMMDD~ (DOEBA-DOLBA) (Dates within DOEBA-DOLBA when no QMB enrollment is present)
EB*B**AG*MA**7*170.50~ (EB07 = $ Amt for 2019 Medicare Part A Copayment Days)
HSD***DA**29*80~ (80 Days Remaining at $ Amt per Day)
HSD*****26*1~ (Per SNF Spell)
DTP*435*RD8*CCYYMMDD-CCYYMMDD~ (DOEBA-DOLBA) (Dates within DOEBA-DOLBA when no QMB enrollment is present)

Lifetime Reserve Days

EB*K**30*MA**32***DY*60~ (EB10 = Lifetime Base Days)

EB*K**30*MA**33***DY*58~ (EB10 = Lifetime Remaining Days)
EB*K**30*MA**7*682~ (2019 Copayment Amt per Day)
DTP*435*RD8*CCYYMMDD-CCYYMMDD~ (Dates within calendar year when no QMB enrollment is present)

Lifetime Psychiatric Limitation Days

EB*K**A7*MA**32***DY*190~ (EB10=Lifetime Psychiatric Base Days)
EB*K**A7*MA**33***DY*180~ (EB10=Lifetime Psychiatric Remaining Days)

For additional information, refer to Table 30.

7.9 Home Health Periods Business Rules

- Home Health information for all periods that overlap the requested date(s) will only be returned on the 271 response when STC “42” is sent within a 270 request.
- The DTP03 dates associated with DTP01 = “472” are the Home Health period Start and End Date(s).
- The DTP03 dates associated with DTP01 = “193” and “194” are the Home Health period DOEBA and DOLBA.
- When EB13 = “HC|G0180”, the DTP03 date associated with DTP01 = “193” is the Home Health period Certification Date.
- When EB13 = “HC|G0179”, the DTP03 date associated with DTP01 = “193” is the Home Health period Recertification Date.
- Home Health NPI return in the 2120C Loop NM109 element. The HETS 270/271 application will use multiple loops to return both the Contractor ID and the Provider ID.
- If a Contractor name is unavailable, HETS returns the Contract Number alone without the Contractor name.
- Example segments returned in a 271 response:

Home Health Benefit Data if Beneficiary is Medicare entitled

EB*X**42***26~ (EB03 = Home Health Care)
DTP*472*RD8*CCYYMMDD-CCYYMMDD~ (DTP03 = Home Health Start and End Dates)
DTP*193*D8*CCYYMMDD~ (DTP03 = DOEBA)
DTP*194*D8*CCYYMMDD~ (DTP03 = DOLBA)
LS*2120~
NM1*PR*2*MAC*****PI*12345~ (NM103=Contractor Name*; NM109 = Contractor Number)
NM1*1P*1******XX*1234567893~ (NM109 = Provider NPI)
LE*2120~
EB*X**********HC|G0180~
DTP*193*D8*CCYYMMDD~ (Home Health Certification Start Date)

EB*X**********HC|G0179~
DTP*193*D8*CCYYMMDD~ (Home Health Recertification Start Date)
*If Contractor Name is unavailable, NM103 is not returned.

For additional information, refer to Table 31.

7.10 Preventive Care Business Rules

- Preventive services are described by the Healthcare Common Procedure Coding System (HCPCS). Although there are many HCPCS codes for which Medicare provides payment, the following is a listing of the preventive categories and the associated HCPCS code(s) supported by the HETS 270/271 application:
    - Annual Alcohol Misuse Screening includes code G0442 and G0443.
    - Annual Depression Screening includes code G0444.
    - Annual Wellness Visit (AWV) includes codes G0438 and G0439.
    - Cardiovascular Disease Screening (CARD) includes codes 80061, 82465, 83718, and 84478.
    - Colorectal Cancer Screening (COLO) includes codes 81528, G0104, G0105, G0106, G0120 and G0121.
    - Computed Tomography Bone Mineral Density Study includes code 77078.
    - Diabetes Screening Tests (DIAB) includes codes 82947, 82950, and 82951.
    - Dual Energy X-ray Absorptiometry (DXA) Bone Density Study; axial skeleton includes code 77080.
    - DXA Bone Density Study; appendicular skeleton includes code 77081.
    - Fecal Occult Blood Test (FOBT) includes codes G0328 and 82270.
    - Glaucoma Screening (GLAU) includes codes G0117 and G0118.
    - Hepatitis B Virus (HBV) in Adults Screening includes code G0499.
    - Hepatitis C Virus (HCV) in Adults Screening includes code G0472.
    - Human Immunodeficiency Virus (HIV) Infection Screening includes code G0475.
    - Intensive Behavioral Counseling for Obesity includes code G0447 and G0473.
    - Intensive Behavioral Therapy (IBT) for Cardiovascular Disease (CVD) includes code G0446.

- Initial Preventive Physical Examination[1] (IPPE) includes codes G0402, G0403, G0404, and G0405.
- Low dose CT scan (LDCT) for Lung Cancer Screening includes codes G0297.
- Pneumococcal Vaccine[2] (PPV) includes codes 90670 and 90732.
- Prostate Cancer Screening (PROS) includes codes G0102 and G0103.
- Screening and High Intensive Behavioral Counseling (HIBC) to prevent STIs includes code G0445.
- Screening Mammography (MAMM) includes codes 77067.
- Screening Pap Test (PAPT) includes codes Q0091, P3000, G0123, G0143, G0144, G0145, G0147, and G0148.
- Screening Pelvic Exam (PCBE) includes code G0101.
- Single Energy X-ray Study includes code G0130.
- Ultrasound Bone Density Measurement and Interpretation includes code 76977.
- Ultrasound Screening for Abdominal Aortic Aneurysm (AAA) includes code 76706.

- Preventive care information displays current date 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 eligible to receive services specified by the HCPCS.
- The HETS 270/271 application ignores any procedure modifier value in EQ02-3 of the 2110C Loop when received on a 270 request.
- Eligibility for preventive services returns in individual 2110C Loops within a 271 response when supported HCPCS codes are submitted 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.
- If the technical and professional components of a HCPCS code have different next eligible dates, then the 271 response returns a separate 2110C Loop for each date.
- Example segments returned in a 271 response:

  Preventive Care with the same Professional and Technical date

  EB*D***MB*********HC|G0121~ (EB13-2 = HCPCS Code)
  DTP*348*D8*CCYYMMDD~ (DTP03 = Next Eligible Date)

[1] 271 responses for IPPE HCPCS codes may, in certain circumstances, return a 271 2110C EB loop indicating that the Medicare Beneficiary is ineligible for this service.
[2] Pneumococcal vaccines are one-time services. If the 271 response does not include these preventive service code(s), then the Medicare Beneficiary already received the vaccination for this code.

Preventive Care with different Professional and Technical dates for the HCPCS codes and Modifiers

EB*D***MB*********HC|G0103|26~ (EB13-2 = HCPCS Code, EB13-3 = HCPCS Modifier)
DTP*348*D8*20150701~ (DTP03 = Next Eligible Professional Date)
EB*D***MB*********HC|G0103|TC~ (EB13-2 = HCPCS Code, EB13-3 = HCPCS Modifier)
DTP*348*D8*20150601~ (DTP03 = Next Eligible Technical Date)

For additional information, refer to Table 32.

7.11 Smoking/Tobacco Cessation Counseling Business Rules

- Eligibility for smoking/tobacco cessation counseling benefits return within a 271 response when STC “67” is submitted 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.
- The 271 response returns both the base number and the number of remaining smoking/tobacco cessation counseling sessions. If any counseling sessions have been used in the last 12 months (based on the HETS 270/271 system date), the initial cessation session date of the period will also be returned. Any previous smoking/tobacco cessation periods will not be returned. No next eligible date will be returned, but Medicare Providers can interpret the presence of a smoking/tobacco cessation initial session date within the last 12 months to determine Medicare Beneficiary eligibility.
- Example segments returned in a 271 response:

  No Prior Smoking/Tobacco Cessation Counseling Usage within 12 Months

  EB*F**67*MB**22***VS*8~ (EB10 = Smoking Cessation Base Sessions)
  HSD*VS*8***29~ (HSD02 = Smoking Cessation Remaining Sessions)

  OR

  Prior Smoking/Tobacco Cessation Counseling Usage within 12 Months

  EB*F**67*MB**22***VS*8~ (EB10 = Smoking Cessation Base Sessions)
  HSD*VS*3***29~ (HSD02 = Smoking Cessation Remaining Sessions)
  DTP*292*D8*20180501~ (DTP03 = Smoking Cessation Initial Session Date)

For additional information, refer to Table 33.

7.12 Therapy Services Business Rules

- The dollar amount used by the Medicare Beneficiary for therapy services returns 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) and when STC “AD”, “AE” and/or “AF” is sent within a 270 request.

- The 271 response will not return Therapy service information 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 271 response returns the coverage status for AE and AF if either AE or AF is sent within a 270 request except when the requested Date(s) of Service start date is after the Date of Death or if the Medicare Beneficiary is ineligible.
- The 271 response returns EB03 = “AE” to represent a combined usage for Physical and Speech Therapy.
- Example segments returned in a 271 response:

    Therapy Services

    EB*D**AD*MB***200~ (EB03 = AD for Occupational Therapy, EB07 = $200 Therapy Amount Used)
    DTP*292*RD8*CCYY0101-CCYY1231~ (Calendar Year)
    MSG*Used Amount~

    EB*D**AE*MB***500~ (EB03 = AE for Physical/Speech Therapy, EB07 = $500 Therapy Amount Used)
    DTP*292*RD8*CCYY0101-CCYY1231~ (Calendar Year)
    MSG*Used Amount~

For additional information, refer to Table 34.

7.13 Pulmonary Rehabilitation Services Business Rules

- The 271 response returns eligibility for Pulmonary Rehabilitation (PR) services when the data is available and STC “BF” is submitted for a Medicare Beneficiary that has active Part B Entitlement at the time of the 270 request. Professional and/or Technical Sessions Remaining may be returned.
- Example segments returned in a 271 response:

    Pulmonary Rehabilitation Services

    EB*F**BF*MB**29***CA*72~ (EB10 = PR Sessions Remaining)
    MSG*Professional~
    EB*F**BF*MB**29***CA*72~
    MSG*Technical~

For additional information, refer to Table 35.

7.14 Cardiac Rehabilitation and Intensive Cardiac Rehabilitation Services Business Rules

- The 271 response returns eligibility for Cardiac Rehabilitation (CR) and Intensive Cardiac Rehabilitation (ICR) services when the data is available and STC “BG” is

submitted for a Medicare Beneficiary that has active Part B Entitlement at the time of the 270 request. Professional and/or Technical Sessions Used may be returned.

- Example segments returned in a 271 response:

  Cardiac Rehabilitation Services

  EB*F**BG*MB*****99*72~ (EB10 = CR Sessions Used)
  MSG*Professional~
  EB*F**BG*MB*****99*72~
  MSG*Technical~

  Intensive Cardiac Rehabilitation Services

  EB*F**BG*MB*****99*72~ (EB10 = ICR Sessions Used)
  MSG*Intensive Cardiac Rehabilitation - Professional~
  EB*F**BG*MB*****99*72~
  MSG*Intensive Cardiac Rehabilitation - Technical~

For additional information, refer to Table 36 and Table 37.

7.15 End Stage Renal Disease (ESRD) Periods Business Rules

- STC “CQ” or “RN” must be sent within a 270 request to receive ESRD dialysis coverage status and benefit information in a 271 response.
- The HETS 271 response will only return ESRD Coverage Period(s) that overlap with the Date(s) of Service submitted on the 270 request. If the returned ESRD Coverage Period(s) include ESRD Dialysis and/or ESRD Transplant Effective Date(s), then the HETS 271 response will also return that information. ESRD Dialysis and Transplant data may be historically limited (i.e., only going back six years or similar).
- The HETS 271 response for ESRD Coverage Period(s) includes the ESRD Coverage Period(s) effective date and, when applicable, also includes the following:
  - ESRD Coverage Period End Date
  - ESRD Dialysis Start Date
  - ESRD Dialysis End Date
  - ESRD Transplant Effective Date
- The HETS 271 response for ESRD coverage does not include dialysis method code or method start date.
- Example segments returned in a 271 response:

  ESRD coverage with no ESRD End Date

  EB*D**RN~ (ESRD Benefit Information)
  DTP*292*D8*CCYYMMDD~ (DTP01 ‘292’ = ESRD Coverage Period
  DTP03 = ESRD Coverage Start date only)

  ESRD coverage with an ESRD End Date

  EB*D**RN~ (ESRD Benefit Information)

DTP*292*RD8*CCYYMMDD-CCYYMMDD)~ (DTP01 ‘292’ = ESRD Coverage Period DTP03 = ESRD Coverage Start and End dates)

ESRD coverage with ESRD Dialysis Start and End dates

EB*D**RN~ (ESRD Benefit Information)
DTP*292*RD8*CCYYMMDD-CCYYMMDD~ (DTP01 ‘292’ = ESRD Coverage Period DTP03 = ESRD Coverage Start and End dates)
DTP*472*RD8*CCYYMMDD-CCYYMMDD~ (DTP01 ‘472’ = ESRD Dialysis DTP03 = ESRD Dialysis dates – this example includes both ESRD Dialysis Start and End dates)

ESRD coverage with ESRD Dialysis Start and End dates plus ESRD Transplant Effective date

EB*D**RN~ (ESRD Benefit Information)
DTP*292*RD8*CCYYMMDD-CCYYMMDD)~ (DTP01 ‘292’ = ESRD Coverage Period DTP03 = ESRD Coverage Start and End dates)
DTP*472*RD8*CCYYMMDD-CCYYMMDD~ (DTP01 ‘472’ = ESRD Dialysis DTP03 = ESRD Dialysis dates – this example includes both ESRD Dialysis Start and End dates
DTP*096*D8*CCYYMMDD~ (DTP01 ‘096’ = ESRD Transplant DTP03 = Transplant Effective date

For additional information, refer to Table 38.

7.16 Hospice Care Periods Business Rules

- The Hospice section provides eligibility information when the Hospice benefit is effective and, when applicable, when the Hospice period terminates. When Hospice coverage is elected, the Medicare 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.
- The 271 response returns Hospice information when:
    - STC 45 is sent within the 270 request and
    - The Medicare Beneficiary is Part A entitled for at least one day within the date(s) requested on the 270.
- The 271 Hospice response includes all Hospice episodes and/or Notices of Election (NOE) that appear on the Medicare Beneficiary’s file, regardless of the Date(s) of Service submitted on the 270 request. The 271 response no longer includes a

Hospice Occurrence Count. Hospice providers should utilize the returned Hospice episodes and/or NOE to determine Hospice status.

- The 271 response returns Revocation Codes in an MSG segment for the corresponding Hospice period. Revocation Code values returned by the HETS 270/271 application are:

  Medicare Beneficiary in Hospice Care

  "0" – Not revoked, open spell
  Medicare Beneficiary with Hospice Care Revoked

  "1" – Revoked by notice of revocation
  "2" – Revoked by notice of revocation with a non-payment code of "N" and an occurrence code of "42"
  "3" – Revoked by a Hospice claim with an occurrence code of "23"

- Example segments returned in a 271 response:

  Hospice Care with one NOE and one Hospice episode

  EB*X**45*MA**26~
  DTP*292*D8*20190701~ ('D8' DTP02 value indicates a NOE)
  MSG*Revocation Code – 0~
  LS*2120~
  NM1*1P*2******XX*1234567893~
  LE*2120~
  EB*X**45*MA**26~
  DTP*292*RD8*20120106-20120401~ ('RD8' DTP02 value indicates a Hospice episode)
  MSG*Revocation Code – 1~
  LS*2120~
  NM1*1P*2******XX*1234567893~
  LE*2120~

For additional information, refer to Table 39.

7.17 Blood Deductible Business Rules

- The base number of units for which the Medicare Beneficiary is liable per year and the number of units remaining for the annual blood deductible return 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) and when STC "10" is sent within a 270 request.
- Annual blood deductible does not return 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.
- Example segments returned in a 271 response:

Blood Deductible

EB*E**10***23***DB*3~ (EB10 = Units Excluded)
HSD*FL*2***29~ (HSD02 = Units Remaining)
DTP*292*RD8*CCYYMMDD-CCYYMMDD~ (DTP03 = Calendar Year)

For additional information, refer to Table 40.

7.18 Part D Plan Enrollment Business Rules

- All Medicare Part D plans with enrollment periods that overlap the requested date(s) of service return 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/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/index.html and choose “PDP Plan Directory.”
- MA plans that offer Prescription Drug Coverage as a part of an HMO, PPO, POS, or Indemnity plan return 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 return once, with the “OT” designation.
- Example segments returned in a 271 response:

  Part D Coverage Status

  EB*1**88~

  Part D Enrollment

  EB*R**88*OT~ (EB04 = OT – Prescription Drug Coverage)
  REF*18*S12345~ (REF02 = Contract Number)
  REF*N6*001*PLANNAME~ (REF02 = Plan Number, REF03 = Plan Name)
  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*UR*www.plan.com~ (PER04 = Plan Telephone Number, PER06 = Contract Website Address)
  LE*2120~

For additional information, refer to Table 23 and Table 41.

7.19 MA Plan Enrollment Business Rules

Eligibility/Benefit for Medicare Advantage (MA)

Questions regarding eligibility/benefit for Medicare Advantage (MA) should be directed to the appropriate plan(s) identified in the eligibility response.

- All Medicare Beneficiary MA plans with enrollment periods that overlap the requested date(s) of service return within the 271 response.
- The 271 response returns one of the following qualifiers within element EB04 in the 2110C Loop 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 271 response returns only the most recent plan designation (HMO, Indemnity, PPO, POS) 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 returns for Insurance Type Code values “HM”, “HN”, “IN”, “PR” and “PS.” The MCO Bill Option Codes returned in the 271 response are:

  Medicare 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
  Medicare 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
- The 271 response returns a 271 2110C EB01 value of “U” when the Beneficiary is enrolled in a Medicare Advantage plan. While HETS does return basic Medicare Advantage plan information, CMS strongly recommends that Medicare Providers/Suppliers contact the Medicare Advantage plan directly to confirm the Beneficiary’s Medicare Advantage plan eligibility information. In addition, indication of coverage does not imply or guarantee payment by the plan.
- The 271 response returns a 271 2110C EB03 value of “30^CQ” when the Beneficiary is enrolled in a MA plan and STC ''CQ” was included on the 270 request.

- 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.”
- MA plans that offer Prescription Drug Coverage as a part of an HMO, PPO, POS or Indemnity plan return 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*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 42.

7.20 Medicare Secondary Payer (MSP) Enrollment Business Rules

- The 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 271 response. The 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 271 response may return multiple MSG segments if the Medicare Beneficiary has multiple applicable MSP enrollment periods. The 271 response only returns ICD-10 codes. The 271 response will not return MSP diagnosis codes that are known to be invalid.
- Example segments returned in a 271 response:

MSP
EB*R**30*14~
REF*IG*12345~
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~
N3*123 MAIN ST~
N4*ANYTOWN*MD*21204~
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 43.

7.21 Qualified Medicare Beneficiary (QMB) Period Business Rules

- The 271 response returns a 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 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 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) or unique DOEBA year of any spell being returned
    - The DOEBA-DOLBA of any spell being returned
    - The current date
- The 271 response returns QMB period financials in separate 2110C loop EB segments with EB04 = 'QM' and with unique DTP segment(s) reflecting dates when the Beneficiary is enrolled in a QMB period and financial details.
- The 271 response does not return Medicare Part A and Part B Free Services financial 2110C loop EB segments for dates within the calendar year(s) requested when the Beneficiary is enrolled in a QMB period.

- The 271 response does not return financial information for preventive HCPCS codes when the Beneficiary is dual-eligible for both Medicare and Medicaid (QMB) as of the current system transactions processing date.
- Example QMB segments returned in a 271 response:
    - 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)
    - Example of a QMB Part A Base Deductible Period returned in a 271 2110C loop:

      EB*C**30*QM*Medicare Part A*26*0~
      DTP*291*RD8*CCYYMMDD-CCYYMMDD~ (Dates within calendar year when Beneficiary is dual eligible for Medicare and Medicaid)
    - Example of a QMB Part A Hospital Days Base returned in a 271 2110C loop:

      EB*B**30*QM*Medicare Part A*26*0~
      HSD***DA**30*0~
      HSD***DA**31*60~
      HSD*****26*1~
      DTP*435*RD8*CCYYMMDD-CCYYMMDD~ (Dates within calendar year when Beneficiary is dual eligible for Medicare and Medicaid)
      EB*B**30*QM*Medicare Part A*7*0~
      HSD***DA**30*60~
      HSD***DA**31*90~
      HSD*****26*1~
      DTP*435*RD8*CCYYMMDD-CCYYMMDD~ (Dates within calendar year when Beneficiary is dual eligible for Medicare and Medicaid)
    - Example of a QMB Part A Hospital Days Base as Remaining returned in a 271 2110C loop:

      EB*B**30*QM*Medicare Part A*26*0~
      HSD***DA**29*60~
      HSD*****26*1~
      DTP*435*RD8*CCYYMMDD-CCYYMMDD~ (Dates within calendar year when Beneficiary is dual eligible for Medicare and Medicaid)
      EB*B**30*QM*Medicare Part A*7*0~
      HSD***DA**29*30~
      HSD*****26*1~
      DTP*435*RD8*CCYYMMDD-CCYYMMDD~ (Dates within calendar year when Beneficiary is dual eligible for Medicare and Medicaid)
    - Example of a QMB Part A Hospital Days Remaining returned in a 271 2110C loop:

EB*B**30*QM*Medicare Part A*26*0~
HSD***DA**29*50~
HSD*****26*1~
DTP*435*RD8*CCYYMMDD-CCYYMMDD~ (Dates within spell DOEBA/DOLBA when Beneficiary is dual eligible for Medicare and Medicaid)
EB*B**30*QM*Medicare Part A*7*0~
HSD***DA**29*30~
HSD*****26*1~
DTP*435*RD8*CCYYMMDD-CCYYMMDD~ (Dates within spell DOEBA/DOLBA when Beneficiary is dual eligible for Medicare and Medicaid)

- Example of a QMB SNF Days Base returned in a 271 2110C loop:

  EB*B**AG*QM*Medicare Part A*26*0~
  HSD***DA**30*0~
  HSD***DA**31*20~
  HSD*****26*1~
  DTP*435*RD8*CCYYMMDD-CCYYMMDD~ (Dates within calendar year when Beneficiary is dual eligible for Medicare and Medicaid)
  EB*B**AG*QM*Medicare Part A*7*0~
  HSD***DA**30*20~
  HSD***DA**31*100~
  HSD*****26*1~
  DTP*435*RD8*CCYYMMDD-CCYYMMDD~ (Dates within calendar year when Beneficiary is dual eligible for Medicare and Medicaid)

- Example of a QMB SNF Days Base as Remaining returned in a 271 2110C loop:

  EB*B**AG*QM*Medicare Part A*26*0~
  HSD***DA**29*20~
  HSD*****26*1~
  DTP*435*RD8*CCYYMMDD-CCYYMMDD~ (Dates within calendar year when Beneficiary is dual eligible for Medicare and Medicaid)
  EB*B**AG*QM*Medicare Part A*7*0~
  HSD***DA**29*80~
  HSD*****26*1~
  DTP*435*RD8*CCYYMMDD-CCYYMMDD~ (Dates within calendar year when Beneficiary is dual eligible for Medicare and Medicaid)

- Example of a QMB SNF Days Remaining returned in a 271 2110C loop:

  EB*B**AG*QM*Medicare Part A*26*0~
  HSD***DA**29*20~
  HSD*****26*1~

DTP*435*RD8*CCYYMMDD-CCYYMMDD~ (Dates within spell DOEBA/DOLBA when Beneficiary is dual eligible for Medicare and Medicaid)
EB*B**AG*QM*Medicare Part A*7*0~
HSD***DA**29*80~
HSD*****26*1~
DTP*435*RD8*CCYYMMDD-CCYYMMDD~ (Dates within spell DOEBA/DOLBA when Beneficiary is dual eligible for Medicare and Medicaid)

- Example of a QMB Part A Lifetime Reserve returned in a 271 2110C loop:

  EB*K**30*QM*Medicare Part A*7*0~
  DTP*435*RD8*CCYYMMDD-CCYYMMDD~ (Dates within calendar year when Beneficiary is dual eligible for Medicare and Medicaid)

- Example of a QMB Part B Base Deductible returned in a 271 2110C loop:

  EB*C**30*QM*Medicare Part B*23*0~
  DTP*291*RD8*CCYYMMDD-CCYYMMDD~ (Dates within calendar year when Beneficiary is dual eligible for Medicare and Medicaid)

- Example of a QMB Part B Coinsurance returned in a 271 2110C loop:

  EB*A**30*QM*Medicare Part B*27*0~
  DTP*291*RD8*CCYYMMDD-CCYYMMDD~ (Dates within calendar year when Beneficiary is dual eligible for Medicare and Medicaid)

For additional information, refer to Table 44.

7.22 Medicare Diabetes Prevention Program (MDPP) Business Rules

- HETS 270/271 supports Service Type Code ‘CQ’ (‘Case Management’) in the HETS 270 request. HETS Submitters can utilize the ‘CQ’ STC to request eligibility details for the Medicare Diabetes Prevention Program (MDPP). When this STC is present on the HETS 270 request and all other provided information creates a match, the 271 response includes Medicare Beneficiary eligibility, previous MDPP benefit usage (if any) and zero patient financial liability for MDPP services. If applicable to the Medicare Beneficiary, the 271 response also returns End Stage Renal Disease (ESRD) information when STC ‘CQ’ is present. The 271 response returns MDPP Eligibility separately from other Part B Covered Services, reflecting only requested dates.
- Active Medicare Part B coverage is required for MDPP eligibility. Medicare Beneficiaries that have opted for Medicare Advantage coverage should contact their Medicare Advantage plan for MDPP Coverage Information. Medicare Beneficiaries in an active ESRD occurrence are not MDPP eligible.

- HETS 270/271 incorporates the MDPP end date of Period 2 into MDPP service eligibility. If the Medicare Beneficiary is ineligible for MDPP services because of their MDPP Period 2 end date, the 271 MDPP response will include an additional DTP segment providing that Period 2 end date.
- If eligible, the 271 response returns HCPCS codes for MDPP services previously rendered for the Medicare Beneficiary. Medicare Providers can utilize this historical MDPP usage information to determine the next available MDPP service for a Medicare Beneficiary.

  Based on prior MDPP usage, HETS 270/271 can potentially return the following MDPP HCPCS codes on a 271 response:

  - The 271 response returns a single MDPP HCPCS code of G9873 (representing 'Initiating Payment') when the Medicare Beneficiary has no prior MDPP usage.
  - The 271 response returns the MDPP HCPCS code, the Billing Provider NPI and the Date of Service for each utilized MDPP HCPCS code. Potential MDPP HCPCS codes that can be returned as actual usage are G9873, G9874, G9875, G9876, G9877, G9878, G9879, G9880, G9881, G9882, G9883, G9884, G9885, G9890, and G9891.

  Based on prior usage, MDPP HCPCS codes G9890 and G9891 can be returned multiple times. All other MDPP HCPCS codes are once-in-a-lifetime services and only return once in a 271 response.

  While the 271 response may include the MDPP HCPCS listed above, HETS 270/271 does not support use of these MDPP HCPCS codes on a 270 request. HETS 270/271 will disregard these HCPCS codes if submitted on a 270 request. Submitters requesting prior MDPP usage information on the 271 response should submit STC "CQ."
- The HETS 270/271 application returns a limited eligibility response for MDPP-only suppliers. An NPI's status as a MDPP supplier is determined via the 'D1' specialty code on the NPI record. MDPP suppliers can contact MCARE for additional information regarding this limited eligibility response. The limited eligibility response for MDPP suppliers disregards any non-MDPP related STCs and/or HCPCS codes submitted in the request.
- Example MDPP segments returned in a normal 271 response:

  - MDPP Information for Medicare Beneficiary with No Prior MDPP Usage

  EB*1**CQ*MB~
  DTP*292*RD8*CCYYMMDD-CCYYMMDD~ (DTP03 = MDPP Entitlement Period)
  EB*C**CQ*MB**23*0~ (EB07 = Deductible Amount of "0")
  DTP*292*RD8*CCYYMMDD-CCYYMMDD~ (DTP03 = MDPP Entitlement Period)

EB*A**CQ*MB**27*0~ (EB07 = Coinsurance Amount of “0”)
DTP*292*RD8*20180115-20180201~ (DTP03 = MDPP Entitlement Period)
EB*1***MB*********HC|G9873~ (HCPCS G9873 represents ‘Initiating Payment’)

- MDPP Information for Medicare Beneficiary with Prior MDPP Usage

EB*1**CQ*MB~
DTP*292*RD8*CCYYMMDD-CCYYMMDD~ (DTP03 = MDPP Entitlement Period)
EB*C**CQ*MB**23*0~ (EB07 = Deductible Amount of “0”)
DTP*292*RD8*CCYYMMDD-CCYYMMDD~ (DTP03 = MDPP Entitlement Period)
EB*A**CQ*MB**27*0~ (EB07 = Coinsurance Amount of “0”)
DTP*292*RD8*20180115-20180201~ (DTP03 = MDPP Entitlement Period)
EB*D***MB*********HC|G9873~ (HCPCS G9873 represents ‘Initiating Payment’)
DTP*472*D8*20180605~ (Date of Service)
LS*2120~
NM1*1P*2******XX*1234567893~ (NPI rendering MDPP service)
LE*2120~
EB*D***MB*********HC|G9891~ (different MDPP HCPCS code)
DTP*472*D8*20180720~ (Date of Service)
LS*2120~
NM1*1P*2******XX*1222222223~ (NPI rendering MDPP service)
LE*2120~
EB*D***MB*********HC|G9891~ (HCPCS code G9891 returned multiple times)
DTP*472*D8*20180827~ (Date of Service)
LS*2120~
NM1*1P*2******XX*1111111113~ (Different NPI rendering MDPP service)
LE*2120~
EB*D***MB*********HC|G9874~ (different MDPP HCPCS code)
DTP*472*D8*20180973~ (Date of Service)
LS*2120~
NM1*1P*2******XX*1234567893~ (NPI rendering MDPP service)
LE*2120~

- MDPP Information for Medicare Beneficiary with Exhausted MDPP Eligibility

EB*6**CQ*MB~
DTP*292*RD8*20190901-20190930~ (DTP03 = Requested Dates of Service)

DTP*194*D8*20190501~ (DTP03 = MDPP End Date of Period 2)

For additional information, refer to Table 45.

8 Acknowledgements and Error Codes

Only one response is sent for each 270 request that is submitted – a TA1, a 999, a 271, or a proprietary error message. There are no CMS reports regarding the 270/271 transactions available to Trading Partners.

8.1 TA1

The TA1 Interchange Acknowledgement is used by the HETS 270/271 application to communicate the rejection of a 270 request based on errors encountered with X12 compliance, formatting, or CMS specific requirements of the ISA/IEA Interchange segments. Following are examples of when a TA1 may return if one of the conditions listed below exists:

- A 270 request is received and the version of the transmission cannot be determined.
- A 270 request is received and the version of the transmission is unsupported by the HETS 270/271 application. This includes previously accepted versions that are no longer supported.
- The Trading Partner is not authorized for the submitted X12 version.
- The sender is not authorized as an active HETS 270/271 Trading Partner.

8.2 999

The 999 Implementation Acknowledgement is used by the HETS 270/271 application to communicate the rejection of a 270 request based on errors encountered with X12 compliance, formatting, or CMS specific requirements within the data segments between the Functional Group Header (GS) and Functional Group Trailer (GE). Refer to the ASC X12 999 version 005010X231A1 TR3 for additional information.

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 returns to the Trading Partner. If no error exists, the Medicare Beneficiary eligibility data returns 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 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 are specified in Table 12.

Table 12. 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.	R
2100A	No	79 – When 270 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 HETS Desktop (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 HETS Desktop (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 HETS Desktop (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 more than 4 months in the future from current day.	C
2100C	No	71 – When the 270 2100C DMG02 element does not match the Medicare Beneficiary DOB on the database.	C

Loop	AAA01 Yes/ No Condition	AAA03 Reject Reason Code	AAA04 Follow-up Action Code
2100C	No	72 – When the 270 2100C NM109 element is either: • An invalid length or cannot be matched to any HICN or 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, or • Inactive. In HICN cross-reference scenarios, the 271 AAA response will return the submitted HICN in a 271 2100C REF segment, and the updated, active HICN in the 2100C NM109 element.	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
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

8.4 Proprietary Error Message

Proprietary error messages are sent only when it is impossible to formulate an X12 compliant 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 messages is described in Table 13.

Table 13. Proprietary Error Message Format

Data Element	Description	Size	Comments
Transaction ID	Transaction ID	4	Data content will be “HETS”
Transaction Reference Number	Trace Identification Number or (ISA13)	30	Spaces
Date/Time Stamp	System Date & Time	17	CCYYMMDDHHMMSSddd
Response Code Indicator	ISA Formatting Error	1	Space
Message Code	Error Code	8	Error code, refer to Table 14 of this *Companion Guide*
Message Text Description	Error Descriptions	500	“Message Text Description”, refer to Table 14 of this *Companion Guide*

Table 14 describes the proprietary error message codes.

Table 14. 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	ETX is not in the expected location.
HTS00104	Unexpected System Exception occurred while processing transaction. Please resubmit.
HTS00105	Transmission Wrapper Length invalid, missing or not numeric.
HTS00111	Transmission inbound message was empty.
HTS00158	Submitter ID/Transaction Source Mismatch.
HTS00160	The Transaction Envelope could not be read, please correct and resubmit.
HTS00201	ISA13 not 9 characters in length.
HTS00203	ISA13 and IEA02 do not match.
HTS00204	ISA13 must be numeric.
HTS00206	ISA13 is missing.
HTS00207	IEA02 is missing.
HTS00208	IEA02 not 9 characters in length.
HTS00210	IEA02 must be numeric.
HTS00250	Certificate not valid for Submitter ID.

8.5 Common Error Processing for SOAP+WSDL and HTTP MIME/Multipart

The HETS 270/271 application processes SOAP and MIME transactions and returns errors as described in this section.

8.5.1 HTTP Status and Error Codes

The processing and error codes for the HTTP layer are defined as part of the HTTP specifications: http://www.w3.org/Protocols/rfc2616/rfc2616-sec10.html. The intended use of these status and error codes in processing transactions is specified in Table 4.3.3.1 of the Phase II CORE 270: Connectivity Rule. This document is located at: http://www.caqh.org/pdf/CLEAN5010/270-v5010.pdf.

8.5.2 Envelope Processing Status and Error Codes

Table 15 describes envelope processing status and error codes specific to the HETS 270/271 application for SOAP and MIME transactions.

Table 15. Envelope Processing Status and Errors

Error Code	Error Message
<FieldName>Illegal	Illegal value provided for <FieldName>.

Error Code	Error Message
<FieldName>Required	The field <FieldName> is required but was not provided.
VersionMismatch	The CORERuleVersion sent is not acceptable to the Receiver.
Success	Envelope was processed successfully.

8.5.3 SOAP-Specific Processing Errors

Table 16 describes examples of SOAP processing errors.

Table 16. SOAP-Specific Processing Errors

Error Code	Error Message
UnAuthorized	The signature could not be verified.

8.5.4 MIME-Specific Processing Errors

HETS does not return any MIME specific processing errors.

8.5.5 SOAP and MIME Transaction Error Processing

Transaction processing errors, described in Sections 8.1 through 8.4 of this *Companion Guide*, are returned as a SOAP message or MIME Multipart/form-data containing the related response. Refer to those sections for additional information.

9 Trading Partner Agreements

In order to submit requests to the HETS 270/271 application, a prospective applicant must complete the trading partner registration process via submission of a HETS 270/271 Trading Partner Agreement (TPA). Refer to Section 2.2 of this *Companion Guide* for information regarding registering as a Trading Partner.

HETS Trading Partners will promptly contact the MCARE Help Desk at 1-866-324-7315 if the name of the Authorized Representative noted on the TPA changes. HETS Trading Partners agree to recertify their HETS access annually by re-submitting a new TPA upon CMS request. Failure to complete the recertification process will result in the HETS Trading Partner's loss of access to the HETS 270/271 Application.

The HETS 270/271 application validates 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 returns a TA1 Interchange Acknowledgement as outlined in Section 8.1 of this *Companion Guide*.

Trading Partners may not send transactions to be executed with Usage Indicator (ISA15) = “P” until testing has been completed and approval to submit production

transactions has been finalized. The HETS 270/271 application returns 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

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 *Companion Guide*.

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 17 defines specific requirements for the header and information source data.

Table 17. 270 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	HETS does not support individuals as information sources.
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

Trading Partners that submit transactions on behalf of a 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 18 defines specific requirements for the Information Receiver data.

Table 18. 270 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 270 request. Table 19 defines specific requirements for the Subscriber Level data.

Table 19. 270 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	NM108	Subscriber Identification Code Qualifier	MI	
2100C	NM109	Subscriber Primary Identifier		HICN or 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; however, only those codes specified by this *Companion Guide* will return explicit benefit information. All other X12 codes will return only the basic set of eligibility data as defined in Section 7.2 of this guide.
2110C	EQ02	Composite Medical Procedure Identifier		HETS will accept all valid Procedure codes; however, only those codes specified by this *Companion Guide* will return explicit benefit information. All other valid Procedure 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 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 20. 271 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 21. 271 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 22. 271 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 submitted on the 270 request, or in HICN cross-reference scenarios, the updated, active HICN. If a HICN or MBI was not submitted on the 270 request, a value of "MISSING" will be returned.
2100C	REF	Subscriber Additional Identification		In HICN cross-reference scenarios, a REF segment is returned in the 2100C Loop to provide the expired HICN value that was submitted on the 270 request.
2100C	REF01	Reference Identification Qualifier	Q4	This element is used when a corrected, cross-referenced HICN has been returned in NM109. The HICN that was submitted on the 270 request will be returned in the following REF02 element.
2100C	REF02	Subscriber Supplemental Identifier		This element is used to communicate the submitted HICN from the 270 request when a cross-referenced HICN is located.

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2100C	N3	Subscriber Address		
2100C	N301	Subscriber Address Line		Medicare Beneficiary Address Line 1 or “Unknown” if any address lines are missing or invalid on the database.
2100C	N4	Subscriber City State Zip		
2100C	N401	Subscriber City Name		Medicare Beneficiary City Name or “Baltimore” if any address lines are missing or invalid on the database.
2100C	N402	Subscriber State Code		Medicare Beneficiary State Code or “MD” if any address lines are missing or invalid on the database.
2100C	N403	Subscriber Postal Zone or Zip Code		Medicare Beneficiary Postal ZIP Code or “21244” if any address lines are missing or invalid on the database.
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 23. 271 Part D Plan Coverage

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2110C	EB	Subscriber Eligibility or Benefit Inquiry		
2110C	EB01	Eligibility or Benefit Information	1 or 6	This information will be returned if STC 30 or 88 is requested, an STC is not present or a Non-Supported STC is requested.
2110C	EB03	Service Type Code	88	This information will be returned if STC 30 or 88 is requested, an STC is not present or a Non-Supported STC is requested.

Table 24. 271 Part A and Part B Plan Level Eligibility

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2110C	EB	Subscriber Eligibility or Benefit Information		Refer to Section 7.2 for a list of Medicare Part A and Part B STCs supported by the HETS 270/271 application.
2110C	EB01	Eligibility or Benefit Information	1 or 6	
2110C	EB04	Insurance Type Code	MA or MB	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 not be returned.
2110C	DTP01	Date Time Qualifier	291	

Table 25. 271 Part A and Part B Plan Level Deductible

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2110C	EB	Subscriber Eligibility or Benefit Information		
2110C	EB01	Eligibility or Benefit Information	C	
2110C	EB04	Insurance Type Code	MA, MB or QM	
2110C	EB05	Plan Coverage Description		HETS returns "Medicare Part A" or "Medicare Part B" when EB04 = "QM."
2110C	EB06	Time Period Qualifier	23, 26, or 29	
2110C	DTP	Subscriber Eligibility/Benefit Date		
2110C	DTP01	Date Time Qualifier	291 or 292	HETS returns "291" only when EB03 = "30"; otherwise, HETS returns "292."

Table 26. 271 Part B Plan Level Coinsurance

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2110C	EB	Subscriber Eligibility or Benefit Information		Refer to Section 7.2 for a list of Medicare Part B STCs supported by the HETS 270/271 application.
2110C	EB01	Eligibility or Benefit Information	A	
2110C	EB04	Insurance Type Code	MB or QM	
2110C	EB05	Plan Coverage Description		HETS returns “Medicare Part B” when EB04 = “QM.”
2110C	EB06	Time Period Qualifier	27	
2110C	DTP	Subscriber Eligibility/Benefit Date		
2110C	DTP01	Date Time Qualifier	291 or 292	HETS returns “291” when EB03 = “30” only; otherwise, HETS returns “292.”

Table 27. 271 Part B Plan Level Deductible - Supported HCPCS Codes

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2110C	EB	Subscriber Eligibility or Benefit Information		Refer to Section 7.10 for a list of Medicare Preventive HCPCS supported by the HETS 270/271 application.
2110C	EB01	Eligibility or Benefit Information	C	Preventive Services EB Loop(s)
2110C	EB04	Insurance Type Code	MB	
2110C	EB06	Time Period Qualifier	23 or 29	
2110C	EB13-1	Product or Service ID Qualifier	HC	
2110C	EB13-2	Procedure Code		HCPCS Code
2110C	DTP	Subscriber Eligibility/Benefit Date		
2110C	DTP01	Date Time Qualifier	292	
2110C	DTP03	Eligibility or Benefit Date Time Period		HETS returns the current system transaction processing date.

Table 28. 271 Part B Plan Level Coinsurance - Supported HCPCS Codes

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2110C	EB	Subscriber Eligibility or Benefit Information		Refer to Section 7.10 for a list of Medicare Preventive HCPCS supported by the HETS 270/271 application.
2110C	EB01	Eligibility or Benefit Information	A	Preventive Services EB Loop(s)
2110C	EB04	Insurance Type Code	MB	
2110C	EB06	Time Period Qualifier	27	
2110C	EB13-1	Product or Service ID Qualifier	HC	
2110C	EB13-2	Procedure Code		HCPCS Code
2110C	DTP	Subscriber Eligibility/Benefit Date		
2110C	DTP01	Date Time Qualifier	292	
2110C	DTP03	Eligibility or Benefit Date Time Period		HETS returns the current system transaction processing date.

Table 29. 271 Part A Hospital Spell Data

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2110C	EB	Subscriber Eligibility or Benefit Information		
2110C	EB01	Eligibility or Benefit Information	D	
2110C	EB04	Insurance Type Code	MA	
2110C	EB06	Time Period Qualifier	27	
2110C	DTP	Subscriber Eligibility/Benefit Date		
2110C	DTP01	Date Time Qualifier	292	
2110C	DTP03	Eligibility or Benefit Date Time Period		DOEBA and DOLBA dates of all hospital spells intersecting the current date and/or the calendar (years) of the date/date range of the 270 request.

Table 30. 271 Part A Hospital and SNF Data

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2110C	EB	Subscriber Eligibility or Benefit Information		Part A Days Allowed Per Spell Loop This loop will repeat for every Part A Spell returned and for each calendar year included in the Plan dates from the 270. Information in this table is for STCs “48”, “49”, “AG”, “A5”, and “A7.” If STC “47” is requested, the HETS 270/271 application will return information for STCs “48” and “49.” Refer to Section 7.2 for more information.
2110C	EB01	Eligibility or Benefit Information	B	
2110C	EB03	Service Type Code	30	
2110C	EB04	Insurance Type Code	MA or QM	
2110C	EB05	Plan Coverage Description		HETS returns “Medicare Part A” when EB04 = “QM.”
2110C	EB06	Time Period Qualifier	7	
2110C	HSD	Health Care Services Delivery		Hospital Days Base or Base as Remaining Days
2110C	HSD03	Unit or Basis for Measurement Code	DA	
2110C	HSD05	Time Period Qualifier	29, 30 or 31	
2110C	HSD	Healthcare Services Delivery		Hospital Episodes
2110C	HSD05	Time Period Qualifier	26	
2110C	DTP	Subscriber Eligibility/Benefit Date		
2110C	DTP01	Date Time Qualifier	435	
2110C	EB	Subscriber Eligibility or Benefit Information		Part A Days Remaining Per Spell Loop This loop will repeat for every Part A Spell returned and for each calendar year included in the Plan dates from the 270.
2110C	EB01	Eligibility or Benefit Information	B	
2110C	EB03	Service Type Code	30	
2110C	EB04	Insurance Type Code	MA or QM	

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2110C	EB05	Plan Coverage Description		HETS returns “Medicare Part A” when EB04 = “QM.”
2110C	EB06	Time Period Qualifier	7	
2110C	HSD	Health Care Services Delivery		Hospital Days Remaining
2110C	HSD03	Unit or Basis for Measurement Code	DA	
2110C	HSD05	Time Period Qualifier	29	
2110C	HSD	Health Care Services Delivery		Hospital Episodes
2110C	HSD05	Time Period Qualifier	26	
2110C	DTP	Subscriber Eligibility/Benefit Date		DOEBA and DOLBA are related to a single Inpatient Spell and NOT to the individual general benefit.
2110C	DTP01	Date Time Qualifier	435	
2110C	EB	Subscriber Eligibility or Benefit Information		SNF Days Allowed Per Spell Loop This loop will repeat for every Part A Spell returned and for each calendar year included in the Plan dates from the 270.
2110C	EB01	Eligibility or Benefit Information	B	
2110C	EB03	Service Type Code	AG	
2110C	EB04	Insurance Type Code	MA or QM	
2110C	EB05	Plan Coverage Description		HETS returns “Medicare Part A” when EB04 = “QM.”
2110C	EB06	Time Period Qualifier	7	
2110C	HSD	Health Care Services Delivery		SNF Days Base or Base as Remaining Days
2110C	HSD03	Unit or Basis for Measurement Code	DA	
2110C	HSD05	Time Period Qualifier	29, 30 or 31	
2110C	HSD	Health Care Services Delivery		SNF Episodes
2110C	HSD05	Time Period Qualifier	26	
2110C	DTP	Subscriber Eligibility/Benefit Date		
2110C	DTP01	Date Time Qualifier	435	N/A

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2110C	EB	Subscriber Eligibility or Benefit Information		SNF Days Remaining Per Spell Loop This loop will repeat for every Part A Spell returned and for each calendar year included in the Plan dates from the 270.
2110C	EB01	Eligibility or Benefit Information	B	
2110C	EB03	Service Type Code	AG	
2110C	EB04	Insurance Type Code	MA or QM	
2110C	EB05	Plan Coverage Description		HETS returns “Medicare Part A” when EB04 = “QM.”
2110C	EB06	Time Period Qualifier	7	
2110C	HSD	Health Care Services Delivery		SNF Days Remaining segment
2110C	HSD03	Unit or Basis for Measurement Code	DA	
2110C	HSD05	Time Period Qualifier	29	
2110C	HSD	Health Care Services Delivery		SNF Episodes
2110C	HSD05	Time Period Qualifier	26	
2110C	DTP	Subscriber Eligibility/Benefit Date		DOEBA and DOLBA are related to a single Inpatient Spell and NOT to the individual general benefit.
2110C	DTP01	Date Time Qualifier	435	
2110C	EB	Subscriber Eligibility or Benefit Information		Lifetime Reserve Base or Remaining Days Loop This loop will repeat for each calendar year included in the Plan dates from the 270.
2110C	EB01	Eligibility or Benefit Information	K	
2110C	EB03	Service Type Code	30	
2110C	EB04	Insurance Type Code	MA	
2110C	EB06	Time Period Qualifier	32 or 33	
2110C	EB09	Quantity Qualifier	DY	
2110C	EB	Subscriber Eligibility or Benefit Information		Lifetime Reserve Copayment per Day Amount Loop This loop will repeat for each calendar year included in the Plan dates from the 270.

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2110C	EB01	Eligibility or Benefit Information	K	
2110C	EB03	Service Type Code	30	
2110C	EB04	Insurance Type Code	MA or QM	
2110C	EB05	Plan Coverage Description		HETS returns “Medicare Part A” when EB04 = “QM.”
2110C	EB06	Time Period Qualifier	7	
2110C	DTP	Subscriber Eligibility/Benefit Date		
2110C	DTP01	Date Time Qualifier	435	
2110C	EB	Subscriber Eligibility or Benefit Information	EB	Psychiatric Limitation Days Loop This loop will repeat for each calendar year included in the Plan dates from the 270.
2110C	EB01	Eligibility or Benefit Information	K	
2110C	EB03	Service Type Code	A7	
2110C	EB04	Insurance Type Code	MA	
2110C	EB06	Time Period Qualifier	32 or 33	
2110C	EB09	Quantity Qualifier	DY	

Table 31. 271 Home Health Data

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2110C	EB	Subscriber Eligibility or Benefit Information		Home Health Loop Information in this table will be returned on the 271 response when STC “42” is submitted on a 270 request. Home Health Data will be returned only for episodes with end dates.
2110C	EB01	Eligibility or Benefit Information	X	
2110C	EB06	Time Period Qualifier	26	
2110C	DTP	Subscriber Eligibility/Benefit Date		

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2110C	DTP01	Date Time Qualifier	472, 193 or 194	HETS returns “472” for Home Health Start and End Dates; HETS returns “193” for DOEBA and “194” for DOLBA.
2120C	NM1	Subscriber Benefit Related Entity Name		
2120C	NM101	Entity Identifier Code	PR	
2120C	NM102	Entity Type Qualifier	2	
2120C	NM103	Benefit Related Entity Last or Organization Name		HETS returns “National Government Services, Inc.”, “National Heritage Insurance Company”, “Palmetto GBA”, or “United Government Services, CA.”
2120C	NM108	Identification Code Qualifier	PI	
2120C	NM109	Benefit Related Entity Identifier		HETS returns 00180, 00380, 00450, 00454, 00456,06001, 06004,06014,11004, 14004 or 14014
2120C	NM1	Subscriber Benefit Related Entity Name		
2120C	NM101	Entity Identifier Code	1P	
2120C	NM103	Name Last or Organization Name		
2120C	NM108	Identification Code Qualifier	XX	
2110C	EB	Subscriber Eligibility or Benefit Information		Home Health Certification Loop
2110C	EB01	Eligibility or Benefit Information	X	
2110C	EB13	Composite Medical Procedure Identifier	HC| G0180	HETS returns “HC|G0180” to indicate Home Health Certification.
2110C	DTP	Subscriber Eligibility/Benefit Date		
2110C	DTP01	Date Time Qualifier	193	HH Certification date
2110C	EB	Subscriber Eligibility or Benefit Information		Home Health Recertification Loop
2110C	EB01	Eligibility or Benefit Information	X	

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2110C	EB13	Composite Medical Procedure Identifier	HC| G0179	HETS returns “HC|G0179” to indicate Home Health Recertification.
2110C	DTP	Subscriber Eligibility/Benefit Date		
2110C	DTP01	Date Time Qualifier	193	HH Recertification date

Table 32. 271 Preventive Data

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2110C	EB	Subscriber Eligibility or Benefit Information		Preventive Services Loop(s) Refer to Section 7.10 for a list of Medicare Preventive HCPCS supported by the HETS 270/271 application.
2110C	EB01	Eligibility or Benefit Information	D or 6	HETS may return “6” to indicate ineligibility for particular IPPE HCPCS codes.
2110C	EB04	Insurance Type Code	MB	
2110C	EB13-1	Product or Service ID Qualifier	HC	
2110C	EB13-3	Procedure Modifier	26 or TC	HETS returns “26” or “TC.” HETS will omit EB13-3 if the dates of the HCPCS professional and technical components are the same.
2110C	DTP	DTP		
2110C	DTP01	Date Time Qualifier	348	

Table 33. 271 Smoking/Tobacco Cessation Data

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2110C	EB	Subscriber Eligibility or Benefit Information		Smoking/Tobacco Cessation Sessions Remaining Loop Information in this table will be returned on the 271 response when STC “67” is submitted on a 270 request.
2110C	EB01	Eligibility or Benefit Information	F	
2110C	EB03	Service Type Code	67	
2110C	EB04	Insurance Type Code	MB	

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2110C	EB06	Time Period Qualifier	22	
2110C	EB09	Quantity Qualifier	VS	N/A
2100C	EB10	Quantity	N/A	Smoking/Tobacco Cessation Base Sessions
2110C	HSD	Health Care Services Delivery		
2110C	HSD01	Quantity Qualifier	VS	
2100C	HSD02	Quantity	N/A	Smoking/Tobacco Cessation Remaining Sessions
2110C	DTP	Subscriber Eligibility/Benefit Date		
2110C	DTP01	Date Time Qualifier	292	
2110C	DTP03	Date Time Period	N/A	If applicable, HETS returns the Smoking/Tobacco Cessation Initial Session Date (within the last 12 months based on HETS system date)

Table 34. 271 Therapy Services Data

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2110C	EB	Subscriber Eligibility or Benefit Information		Occupational Therapy Service Loop Refer to Section 7.12 for a list of Medicare Therapy Services supported by the HETS 270/271 application. Information in this section will be returned on the 271 response when STC “AD” is submitted on a 270 request.
2110C	EB01	Eligibility or Benefit Information	D	
2110C	EB04	Insurance Type Code	MB	
2110C	EB07	Benefit Amount		HETS returns the Occupational Therapy Used Amount.
2110C	DTP	Subscriber Eligibility/Benefit Date		
2110C	DTP01	Date Time Qualifier	292	
2110C	MSG	Message Text		

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2110C	MSG01	Free-form Message Text		HETS returns “Used Amount.”
2110C	EB	Subscriber Eligibility or Benefit Information		Physical/Speech Therapy Used Loop Information in this section will be returned on the 271 response when STC “AE” and/or “AF” are submitted on a 270 request.
2110C	EB01	Eligibility or Benefit Information	D	
2110C	EB03	Service Type Code	AE	HETS always returns “AE” regardless of whether “AE”, “AF”, or “AE/AF” is requested.
2110C	EB04	Insurance Type Code	MB	
2110C	EB07	Benefit Amount		HETS returns the combined Physical/Speech Therapy Used Amount.
2110C	DTP	Subscriber Eligibility/Benefit Date		
2110C	DTP01	Date Time Qualifier	292	
2110C	MSG	Message Text		
2110C	MSG01	Free-form Message Text		HETS returns “Used Amount.”

Table 35. 271 Pulmonary Rehabilitation Services

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2110C	EB	Subscriber Eligibility or Benefit Information		Pulmonary Rehabilitation Loop Refer to Section 7.13 for a list of Medicare Pulmonary Rehabilitation Services supported by the HETS 270/271 application. Information in this table will be returned on the 271 response when STC “BF” is submitted on a 270 request.
2110C	EB01	Eligibility or Benefit Information	F	
2110C	EB04	Insurance Type Code	MB	
2110C	EB06	Time Period Qualifier	29	
2110C	EB09	Quantity Qualifier	CA	

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2110C	EB10	Quantity		HETS returns the number of Pulmonary Rehabilitation sessions remaining.
2110C	MSG	Message Text		
2110C	MSG01	Free-form Message Text		HETS returns “Professional” or “Technical.”

Table 36. 271 Cardiac Rehabilitation Services

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2110C	EB	Subscriber Eligibility or Benefit Information		Cardiac Rehabilitation Loop Refer to Section 7.14 for a list of Medicare Cardiac Rehabilitation Services supported by the HETS 270/271 application. Information in this table will be returned on the 271 response when STC “BG” is submitted on a 270 request.
2110C	EB01	Eligibility or Benefit Information	F	
2110C	EB04	Insurance Type Code	MB	
2110C	EB09	Quantity Qualifier	99	
2110C	EB10	Quantity		HETS returns the number of Cardiac Rehabilitation sessions used.
2110C	MSG	Message Text		
2110C	MSG01	Free-form Message Text		HETS returns “Professional” or “Technical.”

Table 37. 271 Intensive Cardiac Rehabilitation Services

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2110C	EB	Subscriber Eligibility or Benefit Information		Intensive Cardiac Rehabilitation Loop Refer to Section 7.14 for a list of Medicare Intensive Cardiac Rehabilitation Services supported by the HETS 270/271 application. Information in this table will be returned on the 271 response when STC “BG” is submitted on a 270 request.
2110C	EB01	Eligibility or Benefit Information	F	

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2110C	EB04	Insurance Type Code	MB	
2110C	EB09	Quantity Qualifier	99	
2110C	EB10	Quantity		HETS returns the number of Intensive Cardiac Rehabilitation sessions used.
2110C	MSG	Message Text		
2110C	MSG01	Free-form Message Text		HETS returns “Intensive Cardiac Rehabilitation- Professional” or “Intensive Cardiac Rehabilitation-Technical.”

Table 38. 271 ESRD Data

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2110C	EB	Subscriber Eligibility or Benefit Information		ESRD Loops Information in this table will be returned on the 271 response when STC “CQ” or “RN” is submitted on a 270 request. Refer to Section 7.15
2110C	EB01	Eligibility or Benefit Information	D	
2110C	EB03	Service Type Code	RN	
2110C	DTP	Subscriber Eligibility/Benefit Date		
2110C	DTP01	Date Time Qualifier	292	HETS returns any ESRD Coverage Period that overlaps the requested Date(s) of Service. If the ESRD Coverage Period is ongoing, then only the coverage start date will be returned.
2110C	DTP02	Date Time Format Qualifier		HETS returns ‘D8’ if the ESRD period only has a start date. HETS returns ‘RD8’ if the ESRD period has a start and end date.
2110C	DTP	Subscriber Eligibility/Benefit Date	DTP	Beginning of segment
2110C	DTP01	Date Time Qualifier	472	If the associated ESRD Coverage Period includes a Dialysis Period, HETS returns ESRD Dialysis information with a ‘472’ qualifier in DTP01. If the ESRD Dialysis period is ongoing, then only a coverage start date will be returned.

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2110C	DTP02	Date Time Format Qualifier		HETS returns ‘D8’ if the ESRD Dialysis period only has a start date. HETS returns ‘RD8’ if the ESRD Dialysis period has a start and end date.
2110C	DTP	Subscriber Eligibility/Benefit Date	DTP	Beginning of segment
2110C	DTP01	Date Time Qualifier	096	If the associated ESRD Coverage Period includes an ESRD Transplant Effective Date, HETS returns that ESRD Transplant Effective date.
2110C	DTP02	Date Time Format Qualifier	D8	If applicable, HETS returns ‘D8’ and then the ESRD Transplant Effective Date in DTP03.

Table 39. 271 Hospice Data

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2110C	EB	Subscriber Eligibility or Benefit Information		Hospice Periods Occurrence Loop Information in this table will be returned on the 271 response when STC “45” is submitted on a 270 request. Refer to Section 7.16.
2110C	EB01	Eligibility or Benefit Information	X	
2110C	EB04	Insurance Type Code	MA	
2110C	EB06	Time Period Qualifier	26	
2110C	DTP	Subscriber Eligibility/Benefit Date		
2110C	DTP01	Date Time Qualifier	292	
2110C	DTP02	Date Time Format Qualifier	D8, RD8	If applicable, HETS returns ‘D8’ for Notice of Election (NOE) periods and ‘RD8’ for Hospice periods.
2110C	MSG	Message Text		
2110C	MSG01	Free-form Message Text	N/A	HETS returns “Revocation code – [Revocation code value].” Revocation code values returned are: 0, 1, 2, or 3.
2120C	NM1	Subscriber Benefit Related Entity Name		
2120C	NM101	Entity Identifier Code	1P	

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2120C	NM102	Entity Type Qualifier	2	
2120C	NM108	Identification Code Qualifier	XX	

Table 40. 271 Blood Deductible Data

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2110C	EB	Subscriber Eligibility or Benefit Information		Blood Deductible Loop Information in this table will be returned on the 271 response when STC “10” is submitted on a 270 request. Refer to Section 7.17.
2110C	EB01	Eligibility or Benefit Information	E	
2110C	EB03	Service Type Code	10	
2110C	EB06	Time Period Qualifier	23	
2110C	EB09	Quantity Qualifier	DB	
2110C	EB10	Benefit Quantity	N/A	HETS returns the base number of Blood Deductible units.
2110C	HSD	Health Care Services Delivery		
2110C	HSD01	Quantity Qualifier	FL	
2110C	HSD02	Quantity	N/A	HETS returns the number of Blood Deductible Units Remaining.
2110C	HSD05	Time Period Qualifier	29	
2110C	DTP	Subscriber Eligibility/Benefit Date		
2110C	DTP01	Date Time Qualifier	292	

Table 41. 271 Part D Enrollment Data

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2110C	EB	Subscriber Eligibility or Benefit Information		Part D Enrollment Loop Refer to Section 7.18.
2110C	EB01	Eligibility or Benefit Information	R	

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2110C	REF	Subscriber Additional Identification		
2110C	REF01	Reference Identification Qualifier	18	
2110C	REF02	Subscriber Eligibility or Benefit Identifier		Part D Contract Number
2110C	REF	Subscriber Additional Identification		
2110C	REF01	Reference Identification Qualifier	N6	
2110C	REF02	Subscriber Eligibility or Benefit Identifier		Part D Plan Number (if available)
2110C	REF03	Description		Part D Plan Name (if available)
2110C	DTP	Subscriber Eligibility/Benefit Date		
2110C	DTP01	Date Time Qualifier	292	
2120C	NM1	Subscriber Benefit Related Entity Name		
2120C	NM101	Entity Identifier Code	PR	
2120C	NM102	Entity Type Qualifier	2	
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	Subscriber Benefit Related Entity Contact Information		HETS returns the telephone number or website address in the PER03 and PER04 elements when the Part D plan has only a telephone number or only a website address. If neither exists, then HETS does not return the PER segment.

Table 42. 271 Medicare Advantage (MA) Enrollment Data

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2110C	EB	Subscriber Eligibility or Benefit Information		MA Loop Refer to Section 7.19.
2110C	EB01	Eligibility or Benefit Information	U	
2110C	EB03	Service Type Code	30 or 30^CQ	HETS 270/271 returns a 271 2110C EB03 value of “30^CQ” when the Beneficiary is enrolled in a Medicare Advantage plan and STC 'CQ' was included on the 270 request.
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)
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	

Loop ID	Reference	Name	X12 Codes	Notes/Comments
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
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 43. 271 Medicare Secondary Payer (MSP) Enrollment Data

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2110C	EB	Subscriber Eligibility or Benefit Information		MSP Loop Refer to Section 7.20
2110C	EB01	Eligibility or Benefit Information	R	N/A
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.

Loop ID	Reference	Name	X12 Codes	Notes/Comments
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	N4	
2120C	N401	Benefit Related Entity City Name		Primary Insurer City if valid, otherwise not sent.
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 44. 271 Qualified Medicare Beneficiary (QMB) Periods

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2110C	EB	Subscriber Eligibility or Benefit Information		QMB Loop Refer to Section 7.21.

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2110C	EB01	Eligibility or Benefit Information	R	N/A
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	
2110C	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.

Table 45. 271 Medicare Diabetes Prevention Program (MDPP) Services

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2110C	EB	Subscriber Eligibility or Benefit Information		MDPP Entitlement Loop. Information in this section will be returned on the 271 response when STC “CQ” is submitted on a 270 request. Refer to Section 7.22.
2110C	EB01	Eligibility or Benefit Information	1 or 6	
2110C	EB03	Service Type Code	CQ	
2110C	EB04	Insurance Type Code	MB	
2110C	DTP	Subscriber Eligibility/Benefit Date		
2110C	DTP01	Date Time Qualifier	194 or 292	DTP01 qualifier 194 is only used for loops that include a Medicare Beneficiary’s end date for MDPP Period 2; this end date is factored into the MDPP ineligible coverage response in the prior EB segment.

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2110C	DTP02	Date Time Format Qualifier		HETS typically returns the same DTP02 qualifier and dates submitted on the 270 request. If the requested dates intersect date(s) without active Part B entitlement, then multiple DTP segments will be returned to illustrate periods of eligibility or ineligibility.
2110C	EB	Subscriber Eligibility or Benefit Information		MDPP Deductible (reflecting zero due)
2110C	EB01	Eligibility or Benefit Information	C	
2110C	EB03	Service Type Code	CQ	
2110C	EB04	Insurance Type Code	MB	
2110C	EB06	Time Period Qualifier	23	
2110C	EB07	Monetary Amount	0	MDPP services require zero deductible
2110C	DTP	Subscriber Eligibility/Benefit Date		Beginning of segment.
2110C	DTP01	Date Time Qualifier	292	
2110C	DTP02	Date Time Format Qualifier		If the requested dates intersect date(s) without active Part B entitlement, DTP segments will be returned to illustrate only eligible MDPP periods.
2110C	EB	Subscriber Eligibility or Benefit Information		MDPP Coinsurance (reflecting zero due)
2110C	EB01	Eligibility or Benefit Information	A	
2110C	EB03	Service Type Code	CQ	
2110C	EB04	Insurance Type Code	MB	
2110C	EB06	Time Period Qualifier	27	
2110C	EB08	Monetary Amount	0	MDPP services require zero coinsurance
2110C	DTP	Subscriber Eligibility/Benefit Date		Beginning of segment.
2110C	DTP01	Date Time Qualifier	292	

Loop ID	Reference	Name	X12 Codes	Notes/Comments
2110C	DTP02	Date Time Format Qualifier		
2110C	DTP03	Date Time Period		If the requested dates intersect date(s) without active Part B entitlement, DTP segments will be returned to illustrate only eligible MDPP periods.
2110C	EB	Subscriber Eligibility or Benefit Information		MDPP Usage Detail
2110C	EB01	Eligibility or Benefit Information	1 or D	
2110C	EB04	Insurance Type Code	MB	
2110C	EB13-1	Product or Service ID Qualifier		HC
2110C	EB13-2	Procedure Code		MDPP HCPCS Code
2110C	DTP	Subscriber Eligibility/Benefit Date		
2110C	DTP01	Date Time Qualifier	472	
2110C	DTP02	Date Time Format Qualifier	D8	
2110C	DTP03	Date Time Period		Date the MDPP service was rendered
2120C	NM1	Subscriber Benefit Related Entity Name		MDPP Rendering Provider Information
2120C	NM101	Entity ID Code	1P	
2120C	NM102	Entity Type Qualifier	2	
2120C	NM108	Identification Code Qualifier	XX	
2120C	NM109	Identification Code		NPI of the MDPP Supplier that rendered service

Appendix A – Sample 270 Eligibility Request Transaction

This example includes the minimum required data elements for a HETS 270 request. Additional data may be submitted but may also negatively affect the HETS response.

Sample 270 Eligibility Request

□0000000560□

ISA*00* *00* *ZZ*SUBMITTERID *ZZ*CMS *190908*0734*^*00501*000005014*1*P*|~

GS*HS*SUBMITTERID*CMS*20190908*073411*5014*X*005010X279A1~
ST*270*000000001*005010X279A1~
BHT*0022*13*TRANSA*20190908*073411~
HL*1**20*1~
NM1*PR*2*CMS*****PI*CMS~
HL*2*1*21*1~
NM1*1P*2*IRNAME*****XX*1234567893~
HL*3*2*22*0~
TRN*1*TRACKNUM*ABCDEFGHIJ~
NM1*IL*1*LNAME*FNAME****MI*1EG4TE5MK73~
DMG*D8*19400401~
DTP*291*RD8*20180101-20190908~
EQ*10^14^30^42^45^48^67^A7^AD^AE^AG^BF^BG^RN~
EQ**HC|80061~
EQ**HC|G0117~
EQ**HC|G0402~
SE*16*000000001~
GE*1*5014~
IEA*1*000005014~

Appendix B – Sample 271 Eligibility Response

Not all of the information presented in this example will be present on every HETS 271 response. This example is for illustrative purposes only and shows the various eligibility information that a 271 response may contain, including Part A, Part B, SNF, Hospital, Preventive, Smoking Cessation, Blood Deductible, Hospice, MSP (including MSP enrollment diagnosis codes), Home Health, Medicare Advantage, Part D, Inactive Periods, Preventive HCPCS, Rehabilitation, and Occupational, Physical, & Speech Therapies. This example does not include QMB Periods or MDPP benefits.

Sample 271 Eligibility Response

```
□0000004759□
ISA*00* *00* *ZZ*CMS *ZZ*SUBMITTERID *190908*0734*^*00501*111111111*0*P*|~
GS*HB*CMS*SUBMITTERID*20190908*07340000*1*X*005010X279A1~
ST*271*0001*005010X279A1~
BHT*0022*11*TRANSA*20190908*07342355~
HL*1**20*1~
NM1*PR*2*CMS*****PI*CMS~
HL*2*1*21*1~
NM1*1P*2*IRNAME*****XX*1234567893~
HL*3*2*22*0~
TRN*2*TRACKNUM*ABCDEFGHIJ~
NM1*IL*1*LNAME*FNAME*M***MI*1EG4TE5MK73~
N3*ADDRESSLINE1*ADDRESSLINE2~
N4*CITY*ST*ZIPCODE~
DMG*D8*19400401*F~
DTP*307*RD8*20180101-20190908~
EB*6**30~
DTP*307*RD8*20180101-20180108~
EB*I**41^54~
EB*1**88~
EB*1**30^10^42^45^48^49^69^76^83^A5^A7^AG^BT^BU^BV^RN*MA~
DTP*291*D8*20050401~
EB*D**30*MA~
DTP*292*RD8*20180116-20180120~
EB*C**30*MA**26*1364~
DTP*291*RD8*20190101-20191231~
EB*C**30*MA**26*1340~
DTP*291*RD8*20180101-20181231~
EB*C**30*MA**29*1364~
DTP*291*RD8*20190101-20191231~
EB*C**30*MA**29*1340~
DTP*291*RD8*20180101-20181231~
EB*C**30*MA**29*0~
DTP*291*RD8*20180116-20180120~
EB*C**42^45*MA**26*0~
DTP*292*RD8*20190101-20191231~
DTP*292*RD8*20180101-20181231~
EB*B**30*MA**26*0~
HSD***DA**30*0~
HSD***DA**31*60~
HSD*****26*1~
```

DTP*435*RD8*20190101-20191231~
EB*B**30*MA**7*341~
HSD***DA**30*60~
HSD***DA**31*90~
HSD*****26*1~
DTP*435*RD8*20190101-20191231~
EB*B**30*MA**26*0~
HSD***DA**30*0~
HSD***DA**31*60~
HSD*****26*1~
DTP*435*RD8*20180101-20181231~
EB*B**30*MA**7*335~
HSD***DA**30*60~
HSD***DA**31*90~
HSD*****26*1~
DTP*435*RD8*20180101-2011231~
EB*B**30*MA**26*0~
HSD***DA**29*60~
HSD*****26*1~
DTP*435*RD8*20190101-20191231~
EB*B**30*MA**7*341~
HSD***DA**29*30~
HSD*****26*1~
DTP*435*RD8*20190101-20191231~
EB*B**30*MA**26*0~
HSD***DA**29*60~
HSD*****26*1~
DTP*435*RD8*20180101-20181231~
EB*B**30*MA**7*335~
HSD***DA**29*30~
HSD*****26*1~
DTP*435*RD8*20180101-20181231~
EB*B**30*MA**26*0~
HSD***DA**29*56~
HSD*****26*1~
DTP*435*RD8*20180116-20180120~
EB*B**30*MA**7*335~
HSD***DA**29*30~
HSD*****26*1~
DTP*435*RD8*20180116-20180120~
EB*B**AG*MA**26*0~
HSD***DA**30*0~
HSD***DA**31*20~
HSD*****26*1~
DTP*435*RD8*20190101-20191231~
EB*B**AG*MA**7*170.50~
HSD***DA**30*20~
HSD***DA**31*100~
HSD*****26*1~
DTP*435*RD8*20190101-20191231~
EB*B**AG*MA**26*0~
HSD***DA**30*0~
HSD***DA**31*20~

HSD*****26*1~
DTP*435*RD8*20180101-20181231~
EB*B**AG*MA**7*167.50~
HSD***DA**30*20~
HSD***DA**31*100~
HSD*****26*1~
DTP*435*RD8*20180101-20181231~
EB*B**AG*MA**26*0~
HSD***DA**29*20~
HSD*****26*1~
DTP*435*RD8*20190101-20191231~
EB*B**AG*MA**7*170.50~
HSD***DA**29*80~
HSD*****26*1~
DTP*435*RD8*20190101-20191231~
EB*B**AG*MA**26*0~
HSD***DA**29*20~
HSD*****26*1~
DTP*435*RD8*20180101-20181231~
EB*B**AG*MA**7*167.50~
HSD***DA**29*80~
HSD*****26*1~
DTP*435*RD8*20180101-20181231~
EB*B**AG*MA**26*0~
HSD***DA**29*16~
HSD*****26*1~
DTP*435*RD8*20180116-20180120~
EB*B**AG*MA**7*167.50~
HSD***DA**29*80~
HSD*****26*1~
DTP*435*RD8*20180116-20180120~
EB*K**30*MA**32***DY*60~
EB*K**30*MA**33***DY*58~
EB*K**30*MA**7*682~
DTP*435*RD8*20190101-20191231~
EB*K**30*MA**7*670~
DTP*435*RD8*20180101-20181231~
EB*K**A7*MA**32***DY*190~
EB*K**A7*MA**33***DY*180~
EB*1**30^2^3^5^10^14^23^24^25^26^27^28^33^36^37^38^39^40^42^50^51^52^53^67^69^73^76^83^86^98
^A4^A6^A8^AD^AE^AF^AI^AJ^AK^AL^BF^BG^BT^BU^BV^DM^RN^UC*MB~
DTP*291*D8*20050401~
EB*C**30*MB**23*185~
DTP*291*RD8*20190101-20191231~
EB*C**30*MB**23*183~
DTP*291*RD8*20180101-20181231~
EB*C**30*MB**29*0~
DTP*291*RD8*20190101-20191231~
EB*C**30*MB**29*0~
DTP*291*RD8*20180101-20181231~
EB*A**30*MB**27**.2~
DTP*291*RD8*20190101-20191231~
EB*A**30*MB**27**.2~

DTP*291*RD8*20180101-20181231~
EB*C**42^67^AJ*MB**23*0~
DTP*292*RD8*20190101-20191231~
DTP*292*RD8*20180101-20181231~
EB*A**42^67^AJ*MB**27**0~
DTP*292*RD8*20190101-20191231~
DTP*292*RD8*20180101-20181231~
EB*C***MB**23*0******HC|80061~
DTP*292*D8*20180304~
EB*A***MB**27**0*****HC|80061~
DTP*292*D8*20180304~
EB*D***MB*********HC|80061~
DTP*348*D8*20130105~
EB*D***MB*********HC|G0117~
DTP*348*D8*20120107~
EB*6***MB*********HC|G0402~
EB*F**67*MB**22***VS*8~
HSD*VS*6***29~
DTP*292*D8*20180501~
EB*D**AD*MB***200~
DTP*292*RD8*20190101-20191231~
MSG*USED AMOUNT~
EB*D**AD*MB***1345~
DTP*292*RD8*20180101-20181231~
MSG*USED AMOUNT~
EB*D**AE*MB***0~
DTP*292*RD8*20190101-20191231~
MSG*USED AMOUNT~
EB*D**AE*MB***0~
DTP*292*RD8*20180101-20181231~
MSG*USED AMOUNT~
EB*F**BF*MB**29***CA*72~
MSG*Professional~
EB*F**BF*MB**29***CA*72~
MSG*Technical~
EB*F**BG*MB*****99*0~
MSG*Professional~
EB*F**BG*MB*****99*0~
MSG*Technical~
EB*F**BG*MB*****99*15~
MSG*Intensive Cardiac Rehabilitation – Professional~
EB*F**BG*MB*****99*15~
MSG*Intensive Cardiac Rehabilitation – Technical~
EB*X**42***26~
DTP*472*RD8*20171222-20180116~
LS*2120~
NM1*PR*2*ORGNAME*****PI*CONTR~
NM1*1P*2******XX*1234567890~
LE*2120~
EB*X***********HC|G0180~
DTP*193*D8*20170101~
EB*X***********HC|G0179~
DTP*193*D8*20170501~

DTP*193*D8*20170301~
EB*X**45*MA**26~
DTP*292*RD8*20180201-20180301~
MSG*Revocation Code – 1~
LS*2120~
NM1*1P*2******XX*1234567890~
LE*2120~
EB*D**RN~
DTP*292*D8*20190201~
EB*E**10***23***DB*3~
HSD*FL*1***29~
DTP*292*RD8*20190101-20191231~
EB*E**10***23***DB*3~
HSD*FL*2***29~
DTP*292*RD8*20180101-20181231~
EB*R**88*OT~
REF*18*S1234~
REF*N6*001*PLANNAME~
DTP*292*D8*20130101~
LS*2120~
NM1*PRP*2*ORGNAME~
N3*ADDRESSLINE1*ADDRESSLINE2~
N4*CITY*ST*ZIPCODE~
PER*IC**TE*AAABBBCCCC*UR*www.website.com~
LE*2120~
EB*U**30*IN~
REF*18*H1234~
REF*N6*001*PLANNAME~
DTP*290*D8*20090101~
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*13~
REF*IG*GROUPCOVERAGEPLANPOLICYNUMBER~
DTP*290*RD8*20110601-20180131~
MSG*S8002XA,S40012A,S93609A,G5622~
LS*2120~
NM1*PRP*2*ORGNAME~
N3*ADDRESSLINE1*ADDRESSLINE2~
N4*CITY*ST*ZIPCODE~
LE*2120~
SE*248*0001~
GE*1*1~
IEA*1*111111111~
□

Appendix C – Acronyms

Table 46 presents a list of acronyms used in this document.

Table 46. 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
HDT	HETS Desktop
HETS	HIPAA Eligibility Transaction System
HICN	Health Insurance Claim Number
HIPAA	Health Insurance Portability and Accountability Act of 1996
HMO	Health Maintenance Organization
HTTP	Hypertext Transfer Protocol
ICD	International Classification of Diseases
IP	Internet Protocol
IPPE	Initial Preventive Physical Exam
MA	Medicare Advantage
MAC	Medicare Administrative Contractor
MBI	Medicare Beneficiary Identifier
MCARE	Medicare Customer Assistance Regarding Eligibility
MDPP	Medicare Diabetes Prevention Program
MIME	Multipurpose Internet Mail Extensions
MSP	Medicare Secondary Payer
NOE	Notice of Election
NPI	National Provider Identifier
POS	Point of Service
PPO	Preferred Provider Organization
QMB	Qualified Medicare Beneficiary
RRB	Railroad Retirement Board
SNF	Skilled Nursing Facility
SOAP	Simple Object Access Protocol
STC	Service Type Code

Acronym	Definition
TCP	Transmission Control Protocol
TPMS	Trading Partner Management System
TR3	ASC X12 270/271 Implementation Guide. Formerly known as the IG.
WSDL	Web Services Description Language
XML	Extensible Markup Language

Appendix D – Revision History

Table 47 provides a summary of changes made to this document.

Table 47. Document Revision History

Version	Date	Description of Changes
10-14	07/31/2019	Changes include: Section 7.16 – Updated to reflect that 271 Hospice information returns all Hospice episodes or NOE regardless of the Date(s) of Service requested on the 270. Also noted that HETS no longer returns a Hospice Occurrence Count in the 271 response. Section 7.22 – Updated to reflect possible return of a MDPP Period 2 end date for Medicare Beneficiaries that have exhausted their MDPP eligibility Table 32 – Previous Table 32 (271 Part A Hospice Occurrence Count) removed from previous version. HETS no longer returns a Hospice Occurrence Count in the 271 response. Subsequent tables re-numbered. Table 45. Updated to reflect possible return of a MDPP Period 2 end date for Medicare Beneficiaries that have exhausted their MDPP eligibility. Appendix B. Updated eligibility response example to include revised Hospice handling.
10-13	02/19/2019	Changes include: Section 4.2.1 – Updated to reflect that HETS does not currently have a standing maintenance window. HETS is typically available 24 hours a day, 7 days a week. Table 6 – Added ISA09 and a clarifying note that HETS always expects a current date Section 7.2 – Added Service Type Code “RN” to the list of supported codes. Added code “G0499” to the list of supported HCPCS codes Section 7.10 – Added code “G0499” to list of supported preventive service HCPCS codes Section 7.11 – Updated to reflect revised handling of Smoking/Tobacco Cessation benefits on the 271 Section 7.15 – Updated to reflect revised handling of ESRD benefits on the 271 Table 32 – Updated note for 271 2110C EB10 element Table 34 – Updated to reflect revised handling of Smoking/Tobacco Cessation benefits on the 271 Table 39 – Updated to reflect revised handling of ESRD benefits on the 271
10-12	10/10/2018	Changes include: Section 7.16 – Added bullet to explain that HETS returns the date of the current Notice of Election (NOE) as the hospice period start date Section 7.18 – Updated to reflect revised handling of Part D Contract/PBP Information 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) Section 7.22 – Updated to reflect that if eligible, HETS will return HCPCS codes detailing previous MDPP usage Table 42 – Updated to reflect revised handling of Part D Contract/PBP Information Table 43 – Updated to reflect revised handling of MA Contract/PBP Information Table 44 – 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) Table 46 – Updated to reflect that if eligible, HETS will return HCPCS codes detailing previous MDPP usage Appendix C – Table 47. Added ICD and NOE

Version	Date	Description of Changes
10-11	07/27/2018	Changes include: Section 7.2 – Reinstate HCPCS codes 90670 and 90732 to list of supported codes Section 7.10 – Reinstate PPV HCPCS codes to list of supported preventive service HCPCS codes
10-10	07/12/2018	Changes include: Section 7.2 – Removed HCPCS codes 90670 and 90732 from list of supported codes 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 11 updated to reflect the historical Date(s) of Service change Section 7.10 – Removed PPV HCPCS codes from list of supported preventive service HCPCS codes
10-9	06/27/2018	Changes include: Table 12 – Updated the cause of 271 2100C AAA03 = '72' responses Table 46 -- Modified the DTP02 element note to reflect that the date information returned in this loop is based on the 270 request Date(s) of Service. Updated MDPP Coinsurance loop to reflect that HETS returns a coinsurance Percentage (EB08) instead of coinsurance Monetary Amount (EB07). In any case, authorized MDPP services require zero deductible or coinsurance
10-8	04/26/2018	Changes include: Removed all references to the 4/1/2018 beginning of the New Medicare Card transition period Section 7.2 – Added Service Type Code "CQ" to the list of supported codes Section 7.3 – Added bullet to explain that, if applicable, HETS returns an MBI's end date on the 271 response if the Date(s) of Service overlaps the terminated MBI's effective period. Updated this section to reflect that HETS will not return cross-referenced MBI values Section 7.5 – Updated to reflect the MDPP benefit information is returned in a separate eligibility loop than other STCs Section 7.10 – Updated to reflect that if HETS does not return preventive HCPCS codes 90670 or 90732, then the Medicare Beneficiary has already received these one-time services Section 7.15 – Updated to reflect that Service Type Code "CQ" will return ESRD information (if applicable) Section 7.19 – Updated to reflect that HETS returns a different 271 2110C EB03 value of "30^CQ" if STC "CQ" is included in the 270 request (and all other data creates a match) Section 7.22 – Added to document to explain MDPP support Table 22 – Modified to reflect that HETS will, if applicable, return a 271 2100C DTP01 value of '"52" when indicating that a MBI has an end date. Updated to reflect that HETS will not returned cross-referenced MBI values Table 39 – Updated to reflect that Service Type Code "CQ" will return ESRD information (if applicable) Table 43 – Added 271 2110C EB03 details Table 46 – Added to detail eligibility information for MDPP services Appendix C – Table 47. Added MDPP Minor grammatical and formatting updates throughout the document

Version	Date	Description of Changes
10-7	02/07/2018	Changes include: 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 12 – Updated the cause of 271 2100A AAA03 = '42' responses Table 43 -- 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 A – Updated sample transaction to include 2018 Dates of Service Appendix B – Added a loop to the 271 response to illustrate HETS returning a Medicare beneficiary ineligible for a specific IPPE HCPCS code. 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 grammatical and formatting updates throughout the document
10-6	11/13/2017	Changes include: Sections 1.4.2 - 1.4.3 – Updated to indicate that HETS will process either a HICN or MBI value effective April 1, 2018 Section 7.2 – Removed HCPCS code G0202 from list of supported codes. Removed note which stated that HCPCS code 77067 should not be sent prior to 01/01/2018. Section 7.3 – Updated to include New Medicare Card transition period. Added Table 10 to explain HETS handling of HICN and MBI during the transition period. Section 7.10 – Removed HCPCS code G0202 from list of supported codes. Removed note which stated HCPCS code 77067 should not be sent prior to 01/01/2018. Tables 12, 19 & 22 – Updated to indicate that HETS will process either a HICN or MBI value effective April 1, 2018 Appendices A & B – Updated 270 & 271 examples to include a MBI being sent in the 270 request and a MBI being returned in the 271 response. Appendix C – Table 45. Added 'MBI' Minor grammatical and formatting updates throughout the document
10-5	11/07/2017	Changes include: Section 7.8 – Updated sample Hospital/SNF loops to reflect that HETS will return the 2110C EB06 value of '26' for Full Days Co-Payment amount. HETS previously returned '7' as the 2110C EB06 for both Full Days Co-Payment amount. HETS will still return the 2110C EB06 as '7' for Hospital/SNF Coinsurance Co-Payment amount Section 7.21 – Updated sample QMB Hospital/SNF loops to reflect that HETS has uncoupled the Hospital/SNF Full Days and Coinsurance Days from a single EB loop into separate EB loops. The EB06 of the Hospital/SNF Full Days Co-Payment amount also changed from '7' to '26' Table 29 – Updated to reflect change of 2110C EB06 value from "7' to '26' for Hospital/SNF Full Days Co-Payment amount Appendix B – Updated sample 271 response to reflect change of 2110C EB06 value from '7' to '26' for Hospital/SNF Full Days Co-Payment amount Minor grammatical and formatting updates throughout the document

Version	Date	Description of Changes
10-4	10/12/2017	Changes include: Section 1.2 – Added note to indicate that questions about QMB eligibility should be directed to State online Medicaid eligibility systems or other documentation Section 7.2 – Added HCPCS codes 77067, 81528, G0297, G0442, G0443, G0472, G0473 and G0475 to the list of HETS supported HCPCS codes. Added notes to reflect that code G0202 will no longer be effective 01/01/2018 and that code 77067 would only become effective 01/01/2018. Added bullet to indicate that HETS will return hospital spell DOEBA-DOLBA for all spells that intersect the calendar year(s) of the date request regardless of STC or HCPCS code present on the 270 Section 7.6 – Updated to reflect that HETS will return all Part A Free Services date(s) within a single 271 2110C loop EB segment with the potential for multiple DTP segments. Also updated 271 2110C DTP segment example to reflect that for 100% covered Part A services, HETS will return dates within a calendar year where no QMB enrollment is present Section 7.7.1 – Updated to reflect that HETS will return all Part B Free Services date(s) within a single 271 2110C loop EB segment with the potential for multiple DTP segments. Also updated 271 2110C DTP segment example to reflect that for 100% covered Part A services, HETS will return dates within a calendar year where no QMB enrollment is present Section 7.7.2 – Significant rewrite to this section to reflect changes included in this release, including QMB related changes Section 7.8 – Updated 271 2110C DTP segment examples to illustrate that HETS will return dates within a calendar year where no QMB enrollment is present Section 7.10 – Updated to include descriptions of new HETS supported HCPCS codes. Added note to explain that HETS may return IPPE preventive codes as ineligible. Added note to reflect that code G0202 will no longer be effective 01/01/2018 and that code 77067 would only become effective 01/01/2018. Added bullet to mention that HETS will not return preventive service financial details for Beneficiaries whose QMB Period lasts the entire year Section 7.16 – Updated to note that Hospice Occurrence Count will only be returned if the Medicare Beneficiary has Part A Entitlement Section 7.21 – Added to detail situations where HETS will return QMB Periods Tables 24-27 – Updated to add details related to handling of QMB Periods Table 28 – Added new table to illustrate how HETS will return a hospital DOEBA-DOLBA for all spells that intersect the calendar year(s) of the date request regardless of STC or HCPCS code present on the 270. Subsequent tables renumbered Table 29 – Updated to add details related to handling of QMB Periods Table 31 – Added 271 table to reflect HETS returning Part A Hospice Occurrence Count Table 32 – Updated to reflect that HETS can return IPPE HCPCS codes as ineligible services Table 42 – Removed reference to HETS returning Baltimore, MD address information on behalf of the MA Plan if no plan address information is available Table 43 – 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 44 – Added new table to detail 271 response for QMB Periods. Subsequent tables renumbered Appendix A & B – Updated sample transactions to more current examples Appendix C – Table 45. Added ‘QMB’ and ‘IPPE’ Minor grammatical and formatting updates throughout the document
10-3	08/24/2017	Changes include: Updated the linked address in Section 4.2.1 to reflect an updated URL. Section 7.20 – Updated the description of the MSP Policy Number to clarify that the returned number is the group coverage plan in which the Medicare Beneficiary is enrolled. Similar changes noted in Section 10.2, Table 41 and Appendix B

Version	Date	Description of Changes
10-2	12/05/2016	Changes include: Section 7.2 – Added HCPCS code 76706 to and removed HCPCS codes 77057 and G0389 from the list of HETS supported codes. HCPCS code 77057 is being removed from the list of supported codes effective 01/01/2017. HCPCS code 76706 is replacing HCPCS code G0389 effective 01/01/2017 Section 7.10 – Updated the seventeenth bullet in this section to reflect the removal of HCPCS code 77057 effective 01/01/2017. Updated the final bullet in this section to reflect the HCPCS code change of G0389 to 76706 effective 01/01/2017
10-1	06/21/2016	Changes include: Section 4.2.1 – Updated HETSHelp URL from http://www.cms.gov/HETSHelp to the new URL of http://go.cms.gov/hetshelp Section 7.2 – Added note that HETS will return a 999 error when a request is submitted with a dependent loop Section 10.2, Table 19 – Removed 2100A PER loop. HETS will no longer return a 2100A PER loop in each 271 response Appendix B – Removed 2100A PER loop from the sample response. HETS will no longer return a 2100A PER loop in each 271 response

Version	Date	Description of Changes
10-0	02/23/2016	Changes include: Section 1.3 – Updated to include reference to the HETS Trading Partner SOAP/MIME Connectivity Instructions Section 1.4 – Mentioned that repetitive sending of the same transaction in a single day is an aberrant behavior that will be monitored Section 4.3.1 – Figure 3 updated to include more current sample data Section 4.3.2 – Removed references to December 31, 2015 deadline to utilize TLS 1.2 and a SHA2-256 certificate as this deadline has passed Section 4.3.2.2 – Updated list of Entrust digital certificate types accepted by HETS Section 4.3.3.4 – Updated to reflect that the SOAP specific URL is available in the HETS Trading Partner SOAP/MIME Connectivity Instructions Section 4.3.3.6 – Tables 2-5 updated to include updated W3C URL. Tables 3 & 5 updated to include proper Payload Type code for TA1 situations. Titles of Tables 3 & 5 also updated Section 4.3.4.1 – Updated to reflect that the MIME specific URL is available in the HETS Trading Partner SOAP/MIME Connectivity Instructions Section 7.2 – Noted that the HETS 271 database is only updated once per day, therefore Trading Partners should not submit the same transaction multiple times per day expecting to receive updated results. Also added note that “child” components of STC 1, 30, 35, 47 and/or MH will not be returned when the Medicare Beneficiary is ineligible. Also added note with restrictions as to when STC 48 & 49 are not returned in the 271 response Section 7.3 – Added note that submitting a Beneficiary Middle Name or Initial in 270 2100C NM105, a Gender Code in 270 2100C DMG03 or a value of ‘SY’ in 270 2100C REF01 will result in a 999 response. Added general note that Trading Partners should not send additional Beneficiary data elements outside of items listed in Table 9. HCPCS code 90669 removed from the list of supported HCPCS codes Section 7.5 – Added clarifying notes regarding how HETS responds to supported STCs when the Medicare Beneficiary is deceased and the Date of Death is prior to the requested Date(s) of Service Section 7.10 – HCPCS code 90669 removed from the list of supported Preventive HCPCS codes Section 7.11 – Removed previous 2nd bullet stating that HETS will return a separate 2110C loop when STC 67 is submitted on the request for a deceased Medicare Beneficiary Section 7.12 – Added clarifying note to 3rd bullet Section 8.3 – Table 11 updated to reflect new AAA code “T4” and modified error message code descriptions for AAA03 04, 79, 41, 43, 51 and 72 reject reason code descriptions Section 8.4 – Tables 12 & 13 updated to reflect changes to Proprietary Error handling Section 8.5.2 – Table 14 updated to reflect new and updated Error Codes and Error Messages Section 8.5.3 – Table 15 updated to add a new Error Code and Error Message while deleting all previous Error Codes and Error Messages Section 8.5.4 – The previous Table 16 (MIME-Specific Processing Errors) was deleted. HETS will no longer return MIME-specific processing errors Section 10.1.3 – Table 19. Added notes specifying maximum allowable length for Subscriber Last Name and Subscriber First Name Section 10.2 – Table 22. Added note that HETS will return ‘MISSING’ in the 2100C NM109 if there is no HICN submitted in the 270 request Appendix C – Table 42. Added HDT/HETS Desktop Minor grammatical and formatting updates throughout the document including consistently using the term ‘Trading Partner’ in lieu of ‘Submitter.” Also updated sample data throughout the document to more current examples.

Version	Date	Description of Changes
9-4	08/25/2015	Changes include: Section 4.3 – Updated section including changing TLS version to 1.1 (and moving to TLS 1.2 in 2015), requiring SHA2-256 encryption in 2015, updating links to CAQH.org webpages, and updating the list of approved digital certificates in Section 4.3.2.
9-3	04/27/2015	Changes include: Section 1.4 – Added note clarifying that the HETS 270/271 application is not a claims processing or appeals system Section 2.2 – Added a direct link to the HETS 270/271 Trading Partner Agreement form Section 4.1.1 & Figure 1 – Updated to include reference to the annual HETS Trading Partner Recertification process Section 4.2.1 –Removed reference to the HETS Status website while adding link to the HETS Help website. Figure 3 – Updated TCP/IP Communication Transport Protocol Wrapper example to better match structure of a current HETS 270 request Table 3 & 5 – Updated description of the 271 ReceiverID field Section 7.1 – Added specific reference to X12 00510X231 TR3 Section 7.2 – Reorganized section. Clarified date(s) of service rule relevant to child STCs. Removed note that HETS will return a 999 error when a request is submitted with a dependent loop. Added notes defining STC and HCPCS acronym definitions. Section 7.7.1 – Removed Mental Health Coinsurance Percentage bullet and sample data Section 7.8 – Added bullet to describe condition where overlapping Hospital spells may occur due to changes in Medicare Beneficiary primary entitlement coverage Section 7.11 – Updated bullet to clarify business rules Section 8.2 – Added specific reference to X12 005010X231 TR3 Table 11 – Updated AAA03=52 Error to clarify that HETS 270/271 may require an overnight update after a new Submitter ID/NPI relationship is created in HPG Table 11 – Updated AAA03=62 Error condition to reflect searches beyond 12 months historical (previously 27 months historical) Table 13 – Removed a Proprietary Error code (HTS00106) that is no longer valid Updated hyperlinks throughout the document Table 23 – Update to reflect that HETS will return address information as Unknown if the address of file is missing or invalid Table 40 – Update to reflect that HETS will return address information as Unknown if the address of file is missing or invalid Table 41 – Update to reflect that HETS will return address information as Unknown if the address of file is missing or invalid Appendix A & B – Updated sample transactions to more current examples Minor grammatical and formatting updates throughout the document

Version	Date	Description of Changes
9-2	7/11/2014	Changes include: Section 4.2.1 – Updated hyperlink from the HETS Help index to the HETS Help Spotlight Section 4.3 – Updated section to include reference to the HETS SOAP/MIME Connectivity document Section 4.3.2.4 – Updated note to include reference to payload information in Table 2 Section 7.1 – Update section to include mention that CMS will return a standard set of delimiters on each 271 response regardless of the delimiters sent in the 270 request Section 7.4 – Updated supported historical Date of Service search from 27 months to 12 months to allow HETS to mirror the Medicare Fee-for-Service timely filing requirements that were enacted under the Patient Protection and Affordable Care Act (PPACA) in 2010 Section 7.6 – Updated DOEBA/DOLBA bullet to include +/- 60 days Section 7.9 – Updated to note that HETS will now return the Home Health Contractor number when the Home Health Contractor name is not available Section 7.16 – Updated to note that Medicare Beneficiary must have Part A Entitlement for Hospice information to be returned in the 271 response Section 8.1 – Updated to reflect that HETS returns a TA1 when the Trading Partner is not actively authorized to use HETS 270/271 Section 8.3 – Updated Table 11 to include new 2100A AAA03 = '04' error code. This condition currently returns a 999 error Section 9.0 – Updated to include reference to the annual Trading Partner Agreement recertification requirement Table 19 – Updated 2110C EQ01&02 note/comment to remove reference to STC 30 and include reference to Section 7.2 Tables 33-36 – Updated in-table 2110C EB comment to correct section reference names Table 37 – Corrected EB04 note/comment to properly note that STC 15 returns MA while STC 14 returns MB Table 41 – Updated 2120C N3 & N4 loops to reflect change in address information that will be returned if a MA plan address information is incomplete in the CMS plan database. Updated hyperlinks throughout the document
9-1	1/14/2014	2014Q100 Changes include: Section 7.2 and 7.10-Updated with Bone Density codes Updated examples throughout Section 7, Appendix A and B
9-0	12/30/2013	Updates for X12 verbiage
8-1	10/15//2013	Changes include: Table 31- Added new HH+H numbers 06001, 06014 Table 27 and Section 7.7.1- Updated DTP to be 291 for Plan Level Part B Coinsurance.

Version	Date	Description of Changes
8-0	7/18/2013	2013Q400 Changes include: Section 2.2- Updated wording Figure2- Removed URLs Table 2 and 4 - Updated Sender ID and payload Section 4.3 - Updated wording Section 7.2- Updated bullets for coinsurance Table 10- Updated the example Section 7.6- Updated the examples Section 7.7.1 – Updated bullets for coinsurance Section 7.8 – Updated for psych data and updated examples Section 7.16 – Updated for Hospice Occurrences and updated examples Table 27 and 30 – Updated EB03 Table 31- Added new HH+H numbers 06004, 14014 Table 39 –Updated for Hospice Occurrence Updated Appendix A and B for Coinsurance, Psych data and Hospice Occurrence
7-4	4/30/2013	Corrected delimiter in Appendix A example
7-3	04/08/2013	Changes include: Section 7.2- Updated the bullets for STC= 30.
7-2	04/1/2013	Changes Include: Section 7.2 – Added bullets for HCPCS, updated “child” component bullet for DOD. Section 7.5 – Updated EB01 = “6” bullet and example. Section 7.7 – Updated for HCPCS financials business rules. Section 7.10 – Removed G0442/0443 and added bullet for modifier and Professional/Technical Section 7.11 – Added bullet for base/remaining sessions = 8 Table 22 – Updated address elements for missing data. Added new tables 28 and 29 for HCPCS Deductible and Coinsurance information. Appendix A and B – Updated the 270/271 examples.
7-1	03/06/2013	Changes include: Section 4.3.2.4 – Updated URL for SOAP transactions. Section 4.3.3.1 – Updated URL for MIME transactions.
7-0	02/15/2013	Changes include: Section 1.2 – Updated to include internet protocols. Section 4.1.2 – Added Transaction Process for all communication protocols. Section 4.3 – Updated section and added sub-sections for SOAP and MIME. Section 4.4 – Updated for SOAP and MIME. Section 7.7 – Updated example for percentage format. Section 7.9 and Table 30 – Replaced colon with pipe for HC|G0180 and HC|G0179. Section 8.3 – Removed text reference to AAA code 74 since it was removed from the table in a previous release. Section 8.5 – Added section for SOAP and MIME errors. Table 29 – Corrected DTP01 code value for the Lifetime Benefit Reserve EB Loop