Cooperative Exchange
The National Clearinghouse Association

X12 7030™ Eligibility Benefit Inquiry and Response (270/271)

Overview of Changes

July 11, 2018

Panelists

Deb McCachern
Program Manager, Regulatory and Standards Compliance
Change Healthcare
dmccachern@changehealthcare.com

Steffi Silva
Director of EDI
Dorado Systems
steffi.silva@doradosystems.com

Beth Wolskij
Director Clearinghouse Product Manager
Experian Health
beth.wolskij@experianhealth.com

Purpose

The proposed version 7030™ of the X12N Eligibility Benefit Inquiry and Response (270/271) Technical Report Type 3 will be released for public comment and review on July 16, 2018, for a period of 120 days.

There are many major changes to the TR3 since version 5010 of the guide, which is the current version adopted under HIPAA.

This presentation is an overview of the changes having a major impact to the industry.

Structural Change

Cooperative Exchange
The National Clearinghouse Association

New Loop for Benefit Grouping

A new loop, 2105C/D, has been placed in the Eligibility Benefit 271 response between the Subscriber/Dependent loop (2100C/D) and the Eligibility and Benefit Information Loop (2110C/D).

Business Justification

In 5010, benefits are returned in any order, without significance to the order in which they are returned. The addition of the new loop allows Information Sources to group like benefits together, enhancing provider understanding.

- The 2105C/D LX loop, with a repeat of >1, contains these segments/elements:
  - **LX segment = repeat >1:** LX01 – Assigned number (counter to differentiate each occurrence of the LX loop).
  - **DTM Subscriber Date segment = repeat 20:** Used to establish default dates for EB loops within the LX loop. Can be overridden within the EB loops.
    - **DTM01 Date/Time Qualifier:** contains the majority of codes currently in 2100C/D DTP01 in 5010.
    - **DTM05 Date Time Period Format Qualifier:** specifies single date or date range.
    - **DTM06 Date Time Period:** date or range of dates.
- The number of 2110 loops allowed within one 2105 loop is >1.

Coverage and Benefit Requesting and Reporting

Cooperative Exchange
The National Clearinghouse Association

New Service Type Requirements

Service Type usage and reporting has changed.

Business Justification

Many of the Health Care Service Type Codes have, in the current version, been considered both plan coverage types and benefit types; for example, Service Type Code **1 – Medical** is used to report a type of coverage as well as a benefit. The addition of plan coverage type codes to the Service Types avoids this confusion.

- Service Type Codes have been moved to an external code set maintained by X12.
- Plan coverage type codes have been added. These codes begin with "F."
- Plan coverage type codes are:

F1 – Medical Coverage	**F5 – Prescription Drug Coverage**
F2 – Social Work Coverage	**F6 – Vision Coverage**
F3 – Dental Coverage	**F7 – Orthodontia Coverage**
F4 – Hearing Coverage	**F8 – Mental Health Coverage**

- Plan coverage type codes cannot be submitted in the request. Only **30 - Health Benefit Plan Coverage Request for Eligibility**, **60 - General Benefit Request for Eligibility**, or explicit benefit service types (such as **2 - Surgery**) can be submitted in 2110C/D EQ01.

New Service Type Requirements, cont.

- Service Type Codes **30** and **60** cannot be returned in the response. When a **30** or **60** are submitted in the request, each of the plan coverage types (“F” codes) listed above must be returned with one of the following values in EB01**:**
  - **1, 2, 3, 4, 5, 11** – **Active Status** (various iterations)
  - **6, 7, 8, 10, 12** – **Inactive Status** (various iterations)
  - **9 – Coverage Never Activated**
  - **I – Non-Covered/Not Active** (new usage in 7030)
- In response to a **30,** like in 5010, these “Baseline Response Service Types” must also be returned with a status of 1 through 5 or 11, along with patient responsibility and accumulators for each benefit:

1 – Medical Care

2 – Diagnostic X-Ray

5 – Diagnostic Lab

33 – Chiropractic

35 – Dental Care

47 – Hospitalization

86 – Emergency Services

88 – Retail/Independent Pharmacy

AL – Optometry

BY – Physician Visit-Sick

BZ – Physician Visit-Well

MH – Mental Health

UC – Urgent Care

New Service Type Requirements, cont.

- An explicit request for eligibility must be supported for all service types other than **30** or **60**. Plan coverage type codes, beginning with “F”, may not be submitted in the request.
- As in 5010 for an explicit request, coverage information as outlined on the prior slides must be returned, but only benefits for the submitted service type.
- All patient responsibility information, including accumulators, must be returned.
- An Information Source must support a minimum of 10 unique Service Type Codes in a single 270 inquiry.
  - **Benefit:** Providers will be able to obtain more information in a single request.
  - **Challenge:** Vendors and provider information systems may not be able to support multiple service types in a single request.

Service Type Descriptors

Service Type Descriptors have been added to the request to allow for greater specificity of benefits.

Business Justification

Providers need the ability to refine a service type response based on additional criteria; for example, the professional versus the technical component of a cardiology service.

- The 270 EQ01 element and the 271 EB03 Service Type Code element have been changed to a composite. The first component of the element is the Service Type Code (EQ01-01 and EB03-01) and the second component is the Service Type Code Descriptor (EQ01-02 and EB03-02).
- Service Type Descriptors are in a new external code list maintained by X12.
- On the 270, submission of the Service Type Code Descriptor is situational (based on the requestor's inquiry needs).
- On the 271, the return of the descriptor is required when the descriptor was submitted in the 270, along with the benefits associated with that descriptor.
- The descriptor may also be returned if it is relevant to the Service Type Code submitted by the requestor; for example, if the requestor submits an inquiry for cardiac services and benefits are different based on a technical or professional component of the service.

Tiered Benefits Reporting

A new segment, SBI – Tiered Benefit Information, has been added to satisfy the need to report tiered benefits.

Business Justification

Information Sources need a mechanism to report information about a benefit that is tiered.

- A tiered benefit is one that varies based on certain thresholds, as determined by the plan product.
- 2110C/D EB01, Eligibility or Benefit Information Code, must be set to **TB – Tiered Benefits**, in order to report tiered benefits.
- When EB01 is **TB**, use of the SBI – Tiered Benefit Information segment is required.
- The SBI – Tiered Benefit Information segment can repeat up to 10 times to allow for reporting of up to 10 tiers for the same benefit.
- Elements within the Tiered Benefit Information segment are:
  - **Eligibility or Benefit Information Code:** required, with values Co-insurance, Co-payment, Deductible, Out of Pocket (Stop Loss), Cost Containment, Spend Down**.**
  - **Benefit Percent:** situational, if tier threshold is based on a percentage.
  - **Tiered Benefit Name:** situational, if the tier is identified by name.
  - **Monetary Amount:** situational, if the tier threshold is based on a dollar amount.

First Dollar Coverage Reporting

A new segment, SBI – First Dollar Coverage Information, has been added to satisfy the need to report first dollar coverage benefits.

Business Justification

Information Sources need a mechanism to report a benefit in which a certain dollar amount is covered prior to the patient's liability.

- First Dollar Coverage is defined in the front matter as an employer arrangement with the insured that a certain dollar amount will be covered for either the overall plan or specific Health Care Service Type Codes prior to the patient being responsible for financial liability.
- 2110C/D EB01, Eligibility or Benefit Information Code, must be set to one of the following in order to report a first dollar benefit:
  - **FC – First Dollar Coverage, Applies to Entire Plan**
  - **FD – First Dollar Coverage**
  - **FG – First Dollar Coverage, Groups of Services**
  - **FS – First Dollar Coverage, Single Service.**
- When EB01 is populated with one of the above codes, the SBI – First Dollar Coverage Information segment is required.
- The SBI – First Dollar Coverage Information segment can repeat up to 5 times.

First Dollar Coverage Reporting, cont.

- Elements within the Tiered Benefit Information segment are:
  - **Eligibility or Benefit Information Code:** required, repeats same code as entered in the corresponding EB01**.**
  - **Time Period Qualifier:** required, defines the time period associated with the benefit.
  - **Benefit Percent:** situational, if the benefit is a percentage of the total amount.
  - **First Dollar Coverage Benefit Amount:** situational, situational, if a monetary amount is associated with the first dollar coverage benefit..
  - **Remaining or Maximum Benefit Amount:** situational, if there is a remaining monetary amount available.
  - **Benefit Maximum Indicator:** situational, used when there is a benefit maximum to identify whether it has been met.

SBI Segment (Tiered Benefit and First Dollar)

Benefits

Benefit structures not codifiable in 5010 can now be reported in 7030 in dedicated segments versus Message segments.

Challenges

Vendors and provider information systems may not be able to support these specific benefit structures.

Enhanced In/Out of Network Reporting

The request and response support reporting specific to a provider's in or out of network status.

Business Justification

Providers need to be able to obtain benefits specific to their in- network or out-of-network status with the payer plan. Payers need a way to report when the requesting provider is not the same status as the network status requested.

- In the 270, 2110C/D EQ06, Plan Network Indicator, allows the provider to request in-network or out-of-network benefits only. Requesting a specific network status is not required.
- In the 271, the Information Source must respond only with benefits for the requested network status.
- If the network status requested does not match the provider's network status on file, the Information Source must return the appropriate 2100C/D INS19, Provider Network Status Information Code, from among the following:
  - **1 – Provider Network Status Mismatch – Both In and Out of Network Returned**, along with benefits for both in and out of network.
  - **2 – Provider Network Status Mismatch – Correct Network Returned**, along with benefits for the network status on file, with EB12, Plan Network, value of **Y**.
  - **3 – Provider Network Status Not Determined** is used when the provider's network status cannot be determined. Both in and out of network benefits must be returned.
  - **4 – Provider Network Status Not Applicable** is used when the plan does not have in/out of network designations. Plan benefits must be returned.

Enhanced In/Out of Network Reporting, cont.

- **When the 270 EQ06 is not sent, and a plan network applies, the information source must return one of the following:**
  - **In the 2100C/D INS19, Provider Network Status Information Code:**
    - **3 – Provider Network Status Not Determined**, with benefits for both in and out of network.
  - **In 2110C/D EB12, Network Indicator:** either**.**
    - **Y – Yes,** if the Information Source determines the provider is in network for the patient's plan.
    - **N – No**, if the information source determines the provider is out of network for the patient's plan.

Challenges

Vendors and provider information systems may not be able to support the multiple NPI requirements.

Insurance Product Code

The 2110C/D EB04, Insurance Product Code, now points to an external code list.

Business Justification

In the rapidly changing health care environment, flexibility is needed to add and modify the list of insurance products.

- In the 271, 2110C/D EB04, formerly named Insurance Type Code, is now named Insurance Product Code. It points to a new data element from the X12 Standard and utilizes an external code list.

Prior Authorization Requirements

Prior Authorization requirements have been expanded to more explicitly detail the kind of authorization or certification required for the services requested.

Business Justification

Providers need more specific information about the type of health care services review required for a service.

- 2110C/D EB11, Authorization or Certification Indicator, has been changed to Not Used and a new element, 2110C/D EB16, Health Care Services Review Requirement Code, has been added.
- EB16 is a repeating data element, up to 10 repeats.
- The following types of required services review can be reported:

A – Authorization

C – Authorization or Certification

AD – Admission

C – Certification

N – Notification

R – Referral

SP – Specialist Referral

SR – Service Referral

U – Unknown

Cooperative Exchange
The National Clearinghouse Association

Benefit Pool Shared Across Services

An Information Source must report whether the benefit or patient liability reported in the services returned in a 2110C/D Eligibility or Benefit Information (EB) segment, such as a deductible, is shared among those services or whether the benefit must be satisfied separately.

Business Justification

Providers need to have insight into whether services reported in a 2110C/D EB segment fall under the same benefit pool.

- 2110C/D EB15, Shared Benefit Indicator, added as a required element, with one of the following responses:
  - **Y – Yes:** The services reported in the 2110C/D EB segment satisfy the same benefit or liability pool, such as a deductible.
  - **N – No:** The services reported in the 2110C/D EB segment must satisfy the benefit individually.

Benefits

Providers will have a more accurate view of patient responsibility.

Challenges

Vendors and provider information systems may not be able to parse this information.

Services and Procedures Allowed in Same Segment

In both the request and response, it is acceptable to request and return both a service type and a procedure code in the same segment.

Business Justification

Providers can request benefits for specific procedures, and Information Sources can respond appropriately if they support procedure codes; otherwise they can return coverage and benefits for the service type requested.

- In the 270 Inquiry, 2110C/D EQ01 is for the Service Type and EQ02 is for the Procedure Code. In the 271 Response, 2110C/D EB03 is the Service Type and EB13 is the Procedure Code.
- The Procedure Code elements can repeat up to 99 times.
- There is no requirement that the Information Source support procedure code inquiries.

Error Reporting

Cooperative Exchange
The National Clearinghouse Association

AAA Segment Changes

AAA segments across the 271 have been reconstructed to (1) externalize the error reason codes and (2) allow for non-critical errors when the Information Source wishes to return lower level loops.

Business Justification

Externalizing Error Reason Codes allows flexibility in creating new codes. Non-critical error reporting allows Information Sources to elect to return lower level segments when lower level segments can be returned: for example, an Information Source wants to indicate that the provider is not the patient's PCP but advise them that the member has active coverage and who their PCP is under the plan.

- AAA03 Reject Reason Code, changed to Not Used. AAA05, Error Reason Code, added: uses external code list.
- AAA04, Follow-up Action Code, changed to Situational:
  - Must be populated when the error is severe enough to prevent the Information Source from returning lower loops.
  - Must not be populated when the Information Source chooses to return lower loops, including 2110C/D.

Date Changes and Enhancements

Cooperative Exchange
The National Clearinghouse Association

Extended Date/Date Range Support

Information Sources must support request dates and date ranges up to the end of the current month and as far in the past as their timely filing requirements, or up to 12 months, whichever is greater.

Business Justification

Providers need access to eligibility and benefit information to file aging claims that are within the payer's timely filing timeframe.

- An Information Source may require providers to divide a request exceeding a date range of over 12 months into separate 270 requests.
  - Information Sources are encouraged to return an appropriate AAA05 Error Reason Code, along with coverage and benefit information for first 12 months.
- If the requested date or date range falls outside of the timely filing timeframe, Information Sources are encouraged to return:
  - AAA05 Error Reason Code Value **24 – The request date(s) is not within the allowable inquiry period**, and
  - For date ranges exceeding the timely filing requirements period, eligibility and coverage information falling within the timely filing timeframe.

Extended Date/Date Range Support

Challenges

Provider contracts with payers may specify different timely filing requirements, or different plans offered by the same payer may have different requirements.

Request Dates

The Subscriber or Dependent Date (2100C/D DTP) is now reserved specifically to convey the date or date range for which the provider is requesting eligibility benefit information.

Business Justification

The 5010 response is not able to return back to the provider the date requested. The advent of the 2105C/D loop in the 271 allows different types of dates related to coverage to be conveyed in the 271 2105C/D DTM.

- In the 270, the 2100C/D DTP01 date qualifiers are now limited to **882 – Request**, and **102 – Issue** (ID card issue date).
- In the 271, the 2100C/D DTP01, all date qualifiers have been moved to the 2105C/D DTM01 element, except for **882 – Request**, **102 – Issue** (ID card issue date), and **442 – Date of Death.**
- An Information Source must return the request date sent in the request, or the processing date of the transaction, if no request date was sent, using DTP01 qualifier **882 – Request**.

False Dates Not Permitted

False dates, such as dates containing “9999” as the century for open-ended coverage, are explicitly no longer permitted.

Business Justification

The use of false dates is confusing, not informational, and can cause errors within third party validators.

Grace Period Reporting

A premium payment grace period applies to ACA Marketplace health plans. The 7030 271 Eligibility Benefit response provides the means to report grace period status and related dates.

Business Justification

There is a need to be able to report that the patient is within the premium payment grace period allowable by law for ACA Marketplace plans, and whether coverage within the grace period is active or inactive.

- Grace period date qualifiers added to the 271 2105C/D DTM01 and 2110C/D 2110C/D DTP01 (Date Time Qualifier) as follows:
  - **BGP – Beginning of Grace Period**
  - **756 – End of Grace Period**
- Grace period 2110C/D EB01 code values added:
  - **10 – Inactive-Premium Payment Not Received**
  - **11 – Active-Pending Receipt of Premium Payment**
  - **12 – Inactive-Pending Receipt of Premium Payment**

Patient Matching and Data Variances

Cooperative Exchange
The National Clearinghouse Association

Cascading Search Logic

Information Sources must support the prescribed cascading search logic when a search results in an error based on the patient's information submitted or if the patient is not found. The search logic also prescribes AAA05 Error Reason Code usage at each step of the search logic cascade when no match is found or when duplicate records are found.

Business Justification

Cascade search logic requirements ensure proper patient matching while reducing rejections that require matching on more than three identifying elements. Standardized error reporting assists providers in understanding the source of data mismatch.

- Cascading search logic requirements apply when the provider submits all elements required to satisfy either the Required Primary Search Option or the Required Alternate Search Option. See table Required Primary and Alternate Search Options.
- The Information Source is given flexibility in the order in which the identifying elements are used.

Cooperative Exchange
The National Clearinghouse Association

Required Primary and Alternate Search Options

Required Primary Search Options			
Subscriber ID 2100C NM109	Patient Last Name 2100C/D NM103	Patient First Name 2100C/D NM104	Patient Date of Birth 2100C/D DMG02
Required Alternate Search Options			
Subscriber ID, Last Name, First Name			
Subscriber ID 2100C NM109	Patient Last Name 2100C/D NM103	Patient First Name 2100C/D NM104	
Subscriber ID, Last Name, First Name			
Subscriber ID 2100C NM109	Patient Last Name 2100C/D NM103	Patient Date of Birth 2100C/D DMG02	

Cooperative Exchange
The National Clearinghouse Association

Change in Identifying Elements

The 271 2100C/D INS Subscriber/Dependent Relationship Segments provide enhanced reporting when a patient's identifying elements submitted in the request differ from the information on file.

Business Justification

Enhanced reporting provides more specific information about identifying elements which differ from what the provider sent and what the Information Source has on file.

- 2100C/D INS18, Changed Identifying Information Code, added with a repeat of 20.
- Use each iteration to specify the piece of data that is different on the response from that which the provider submitted, from the following list:

1 – First Name	**8 – Policy Number**
2 – Middle Initial	**9 – Case Number**
3 – Last Name	**A – Gender**
4 – Name Suffix	**B – Birth Sequence Number**
5 – Date of Birth	**C – Changed From Dependent to Subscriber**
6 – Member ID Number	**D – Changed from Subscriber to Dependent**
7 – Group Number	**E – Address**

- Note that codes C and D indicate that the patient information was returned in a different loop than submitted (submitted as subscriber, returned as dependent or vice versa).

Dental Usage

Cooperative Exchange
The National Clearinghouse Association

Guidance for Dental Industry Usage

A section has been added to the front matter specifically to address use of the 270/271 in the dental industry.

Publication Related Changes

Cooperative Exchange
The National Clearinghouse Association

Technical Reports and External Code Lists

Because code lists critical to compliance to the 007030X332 270/271 TR3 have been externalized (for example, Service Type Codes and AAA05 Error Reason Codes), an accompanying Technical Report Type 2 (TR2) will be published, to be used in conjunction with the TR3.

- External code lists are subject to update three times per year and are not dependent on a version of the X12 Standard, as is the TR3. Therefore all code references are contained in a separate TR2, which must be used in conjunction with the TR3 and which can be updated as needed.
- TR2 will be available for public comment review along with the TR3.
- All code lists maintained by X12 can be viewed from the X12 website at http://www.x12.org/codes/, or downloaded via subscription.

In Conclusion

Based upon the changes outlined in this presentation, the transition to 7030 will require payers, clearinghouses, vendors, and provider information systems to rewrite their processing and support of this transaction.

We do not envision the ability to up or down convert 5010 to 7030.


Cooperative Exchange
The National Clearinghouse Association