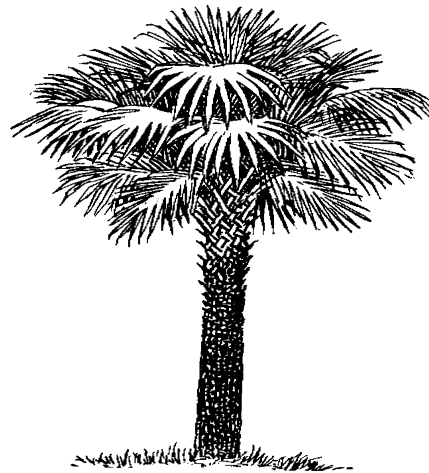




PGBA, LLC

Tricare Companion Document



**270/271 Health Care Eligibility
Benefit Inquiry and Response- 005010X279A1**

ANSI ASC X12N

Revised: April 2011



Table of Contents

Introduction	3
ANSI ASC X12N 270/271 Health Care Eligibility Benefit Inquiry and Response (005010X279A1) – Reporting Instruction Clarifications.....	5
Overview.....	5
Hierarchical Structure.....	6
Supported Business Functions.....	6
Information Linkage	6
HIPAA Usage	7
Search Options.....	8
USER TIPS	9
Rejected Transactions.....	10
Disclaimers with the Transactions.....	10
Type of Service	11
Eligibility Inquiry and Response 270/271 Interchange Envelope and Functional Group Structure.....	11
Eligibility Inquiry 270 Transaction Set Data Clarifications.....	12
Eligibility Response 271 Transaction Set Data Clarifications.....	13
EDIG Glossary of Terms	16

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Introduction

Note: Production files of the HIPAA implementation standard 270/271 Eligibility and Response transactions will not be accepted prior to January 01, 2011. This Companion documentation only addresses Eligibility Inquiries and Responses. The 270/271 transactions to PGBA, for TRICARE beneficiaries, should only be used to determine eligibility. Although some benefit information is returned, use of the 270/271 transactions for benefit information is not supported at this time.

This document is the property of PGBA, LLC and is for the use solely in your capacity as a Trading Partner of health care transactions with PGBA, LLC.

This document provides information related to specific elements with the ANSI ASC X12 270/271 transactions. It does not change the definition, data conditions, or use of the data elements or segments in a standard. Nor does it add data elements or segments to the maximum defined data set. It will not use any code or data elements that are marked “not used” in the standard’s implementation specifications or are not in the standard’s implementation specification(s), or change the meaning or intent of the HIPAA standards implementation specifications. (Refer to Standards for Electronic Transactions, *Federal Register*, Vol. 75, No. 197, October 13, 2010.

This document is intended solely for use as a companion to the Health Insurance Portability and Accountability Act (HIPAA) mandated ANSI ASC X12 Health Care Eligibility Benefit Inquiry and response 270/271 transaction set Implementation Guides (IG). Specific Eligibility instructions contained in this document are provided for clarification purposes only. This document should be used in conjunction with the applicable HIPAA Implementation Guides published by Washington Publishing Company, and the Legacy Crosswalk for Provider Eligibility Inquiries & Responses prepared for The Office of the Under Secretary of Defense (Personnel and Readiness) and Defense Manpower Data Center dated February 28, 2003.

The Final Rule adopting updated versions of the standards for electronic transactions was published in the Federal Register on January 16, 2009. The URL Link to the Federal Register is: <http://www.access.gpo.gov>. This final rule also adopts a transaction standard for Medicaid pharmacy subrogation. In addition, this final rule adopts two standards for billing retail pharmacy supplies and professional services, and clarifies who the “senders” and “receivers” are in the descriptions of certain transactions. The updated versions are available and can be downloaded through the Washington Publishing Company website at <http://www.wpc-edi.com>.

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This document is incorporated by reference in the Trading Partner Agreement. All instructions were written as known at the time of publication and are subject to change. Changes will be communicated in future letters and on the TRICARE web site: www.mytricare.com.

Appropriate steps must be taken before submitting production ANSI ASC X12N transactions, such as testing, completion of an EDIG Trading Partner Agreement validation and demographic confirmation with our customer support staff. To begin the process, receive more information or ask questions, please contact the Tricare EDI Help Desk at 1-800-325-5920 (Menu Option 2).

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ANSI ASC X12N 270/271 Health Care Eligibility Benefit Inquiry and Response (005010X279A1) – Reporting Instruction Clarifications

Overview

The Health Insurance Portability and Accountability Act (HIPAA) requires that all health insurance payers in the United States comply with the EDI technology standards for health care as established by the Secretary of Health and Human Services for Administrative Simplification. The use of standard transactions and code sets will improve Federal and Private health care programs, and the effectiveness and efficiency of the health care industry. The ANSI ASC X12N 270/271 transaction set has been selected as the format to meet HIPAA requirements for the electronic submission of Eligibility Benefit Inquiries and Responses. They were designed so that inquiry submitters (Information Receiver) can determine:

- Whether an information source organization (e. g. payer) has a particular subscriber or dependent on file.
- The Healthcare eligibility and/or benefit information about that subscriber and/or dependent(s).

The data available through these transaction sets is used to verify an individual's eligibility and benefits, but cannot provide a history of benefit use.

PGBA has chosen to implement exchange of the 270/271 transaction sets as a real-time for single request and as a batch application for multiple requests. Eligibility verification will only be supported for Health benefit Plan Coverage (Service Type Code = 30).

- ✓ PGBA, LLC may edit data submitted beyond the requirement defined in the HIPAA Implementation Guide.
- ✓ PGBA, LLC shall reject interchanges, functional groups or segments that do not follow all HIPAA Implementation Guide and PGBA, LLC Companion Document requirements
- ✓ PGBA, LLC shall reject an interchange that is submitted with a submitter identification number that is not authorized for electronic submission.

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Hierarchical Structure

The hierarchical structure identifies relationships between the information source, information receiver, subscriber and dependent and can eliminate repetitious reporting of data.

- The information source is the entity that has the answer to the questions being asked in the inquiry. It is typically an insurer or payer.
- The information receiver is the entity that is asking the questions in an inquiry. It is typically the medical service provider.
- The subscriber is a person who can be uniquely identified to an information source. The subscriber may or may not be the patient.
- The dependent is a person who cannot be uniquely identified to an information source, but can be identified when associated with a subscriber.
- The patient can be either the subscriber or the dependent. When a unique identifier exists for an individual then they would be considered the subscriber. Otherwise, related dependents are identified through the subscriber.

Supported Business Functions

The 270/271 transaction sets support general, categorical and specific requests and responses. The detail of the health care eligibility information being requested by the inquiry submitter from the information source organization is identified in an inquiry data segment. The response is based on a business agreement with the inquiry submitter and what information is available to provide. The content of the 271 transactions varies, depending on the level of data made available by the information source organization

Information Linkage

The Submitter Transaction Identifier is used to identify the transaction at a high level. It is particularly useful in reconciling 271 reject transactions that may not contain all of the hierarchical loops and must always be returned.

The information receiver may create one occurrence of the trace (TRN) segment at the lower of the subscriber/patient levels. These segments are optional for the information receiver, however if the information source receives them, they must be returned in the 271 response transaction.

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The information source may also create one occurrence of the trace (TRN) segment at the lower of the subscriber/patient levels. It is optional, but gives the information source a mechanism to pass a transaction reference number to the information receiver to use if there is a need to follow up on the transaction. PGBA does not plan to create a trace segment.

A clearinghouse may also create one occurrence of the trace (TRN) segment at the lower of the subscriber/patient levels. If the information source receives them, they must be returned in the 271 response transaction. In the event that the 270 transaction passes through more than one clearinghouse, the second (and subsequent) clearinghouse may choose one of the following options. Option One: Replace the trace number with their own and remove it on the 271 response prior to returning it to the originally reported trace number or report it back as an original trace number. Option Two: Do not assign their own trace number.

HIPAA Usage

The HIPAA defined implementation guide represents its full functionality but does not necessarily represent the business needs of an individual provider, payer or other trading partner. The guide identifies the framework an information source can utilize. HIPAA requires information sources to support an eligibility transaction, either directly or through a clearinghouse. The guide also identifies the minimum an information source or clearinghouse is required to support in order to offer a compliant 270/271 transaction set. The minimum requirements are detailed below:

- 270** – The information source must support a generic request for Eligibility.
- 271** – The information source must respond with either an acknowledgement that the individual has active or inactive coverage or that the individual was not found in their system. If the individual is found in the payer’s system, then the minimum requirements as outlined in the implementation guides will be supported by PGBA, LLC.



Search Options

If the patient is the subscriber, the maximum data elements that can be required by an information source to identify the patient are:

- Patient's Member ID
- Patient's name
- Patient's date of birth

If all four of these elements are present, the information source must generate a response if the patient is in their database. All information sources are required to support this search option.

If the patient is a dependent of a subscriber, the maximum data elements that can be required by an information source to identify the patient are:

Loop 2100C

- Subscriber's member ID

Loop 2100D

- Patient's name
- Patient's date of birth

If all four of these elements are present, the information source must generate a response if the patient is in their database. All information sources are required to support this search option if their system does not have unique member identifiers assigned to dependents. There may be some situations when not all of the above listed pieces of information are available. In that case, the 270 inquiry may be sent with as many of those pieces of information that are available as well as any other items identified in the transaction. The information source should attempt to look up the patient if there is a reasonable amount of information present. An information source may outline additional search options available in their trading partner agreement; however under no circumstances may they require the use of a search option that differs from those outlined above. Minimally, the member ID, patient's date of birth, and patient name are needed.

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USER TIPS

For **subscriber searches** send subscriber loop with member name, ID (SSN) and DOB of subscriber.

```
NM1*IL*1*DOE*JOHN****MI*123456789~  
DMG*D8*19750721~
```

For **dependent searches** send the subscriber loop as stated above, and a dependent loop with the patient's first name, last name, and DOB. Use the INS segment only if any of the identifying information from either the subscriber or dependent loop is missing. Examples below:

ALL IDENTIFY INFO PRESENT

SUBSCRIBER LOOP

```
NM1*IL*1*DOE*JOHN****MI*123456789~  
DMG*D8*19750721~
```

DEPENDENT LOOP

```
NM1*03*1*DOE*JANE~  
DMG*D8*19780810~
```

SOME IDENTIFY INFO MISSING: Member ID missing from subscriber loop.

SUBSCRIBER LOOP

```
NM1*IL*1*DOE*JOHN~  
DMG*D8*19750721~
```

DEPENDENT LOOP

```
NM1*03*1*DOE*JANE~  
DMG*D8*19780810~
```

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INS*N*01~

When coding the INS segment only send INS01 and INS02. No other information is required or needed in this segment.

When submitting an inquiry for a **twin** it is recommended that the subscriber name be included in the subscriber loop.

With 5010 – if a search is done for a birth date on a twin – or with multiple matches, the system must not return all matches found. Rather it will return a 271 AAA segment identifying missing data in order to provide an exact match.

See page 33 of Implementation Guide.

Rejected Transactions

- A 271 response will include at least one Eligibility Information (EB) segment or one Request Validation (AAA) segment. This is assuming that the 270 inquiry passed standard compliance error checking.
- A TA1 (Interchange Acknowledgement) transaction will be returned when the Sender ID (ISA06) is invalid on the inbound interchange
- The AAA Request Validation segment is used to identify why an EB Eligibility or Benefit Information segment has not been generated or in essence, why the 270 Eligibility, Coverage or Benefit Inquiry has been rejected. Typically an AAA segment is generated as a result of either an error in the data being detected (e.g. Missing Subscriber ID) or no matching information in the database (e.g. Subscriber Not Found).

Disclaimers with the Transactions

The following disclaimers apply to the 270/271 transaction sets exchanged between PGBA and their trading partners:

- Each transaction can contain only one Eligibility inquiry (EQ) segment can be reported for either the subscriber or a dependent.
- The response is based on information obtained by PGBA from DEERS records at the time of the inquiry and is not to be considered a guarantee of payment.
- At this time, PGBA is only supporting the eligibility portion of the 270/271 transaction.

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Type of Service

The only acceptable inquiry Service Type Code is “30”, which is used to identify Health Plan Coverage inquiries.

Eligibility Inquiry and Response 270/271 Interchange Envelope and Functional Group Structure

Trading partners should follow the Interchange Control Structure (ICS), Functional Group Structure (GS), Interchange Acknowledgement (TA1) and Functional Acknowledgement (999) guidelines for HIPAA that are located in the HIPAA Implementation Guides in Appendices A and B. Trading partners should also follow the basic character set guidelines as set forth in the implementation guide. The interchange cannot contain non-HIPAA version functional groups. For unique instructions for transmitting to PGBA, LLC EDIG refer to the **EDI Gateway Technical Communications Manual**.

Note: The Functional Acknowledgment (999) transaction is not required as a response to receipt of a batch transaction compliant with this implementation guide.

The Functional Acknowledgment (999) transaction is not required as a response to receipt of a real-time transaction compliant with this implementation guide.

Addition: The Implementation Acknowledgment (999) transaction is required as a response to receipt of a batch transaction compliant with this implementation guide. The 999 Implementation Acknowledgement will also report Implementation Guide errors that cannot otherwise be reported in a 271 AAA segment if the transaction is rejected.

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Eligibility Inquiry 270 Transaction Set Data Clarifications

Loop	Seg Pos	Data Element	Req or Sit	Segment/Element	Instruction	Industry/Element Name	Attributes	IG Page No.
Header	010	1705	R	ST03	Implementation Convention Reference required.	Implementation Convention Reference	O AN 1/35	62
Header	020	1005	R	BHT01	Code value 0022 must be used. It signifies that the dependent level may or may not be present for each subscriber.	Hierarchical Structure Code	M ID 4/4	63
Header	020	353	R	BHT02	Code value 13 (request) is the only transaction set purpose code that will be recognized.	Transaction Set Purpose Code	M ID 2/2	64
Header	020	640	S	BHT06	This segment must not be used.	Transaction Type Code	O ID 2/2	65
2100A	030	1035	R	NM103	At a minimum the information source last name or organization name is required by PGBA, LLC.	Name Last or Organization Name	O AN 1/35	70
2100B	030	1035	R	NM103	Changed from situational to required	Name Last or Organization Name	X AN 1/60	76
2100B	070	1715	S	N407	Usage changed from Not Used to Required	Country Subdivision Code	X ID 1/3	83
2100B	090	128	S	PRV02	Value ZZ replaced by PXC (Provider Healthcare Taxonomy Code) HPI – National Provider Number	Reference Identification Qualifier	X ID 2/3	85

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Loop	Seg Pos	Data Element	Req or Sit	Segment/Element	Instruction	Industry/Element Name	Attributes	IG Page No.
2100B	090	127	S	PRV03	Usage changed from required to situational	Reference Identification	X AN 1/50	85
2100C	030	1035	S	NM103	The subscriber's last name is required by PGBA, LLC.	Subscriber's Last Name	O AN 1/35	93
2100C	030	1036	S	NM104	The subscriber's First name is required by PGBA, LLC.	Subscriber's First Name	O AN 1/25	93
2100C	040	128	R	REF01	Code value '49' REMOVED	Reference Identification Qualifier	M ID 2/3	98
2100C	040	127	R	REF02	A valid nine-position Social Security number is the only acceptable Reference Identification.	Reference Identification	X AN 50	99
2110C & 2110D	130	1365	S	EQ01	Service Type of value "30" for Health Benefit Coverage is the only valid Service Type Code at this time.	Service Type Code	X ID 1/2	125 & 187

Eligibility Response 271 Transaction Set Data Clarifications

Note: Multiple EB loops may be returned in response to successful inquiries

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Loop	Seg Pos	Data Element	Req or Sit	Segment/Element	Instruction	Industry/Element Name	Attributes	IG Page No.
2100B	085	901	R	AAA03	The following Reject Reason Code will be returned when applicable. 45 Invalid/Missing provider ID	Reject reason Code	O ID 2/2	239
2100C & 2100D	085	901	R	AAA03	One of the following Reject Reason Codes will be returned when applicable. 15 Required application data missing 41 Critical PIMS read error 42 Unable to respond at current time 43 Invalid/Missing Provider Identification 44 Blank Information Receiver name 57 Invalid/Missing Date(s) of Service 58 Invalid/Missing Date-of-Birth 60 Date of Birth Follows Date(s) of Service 61 Date of Death Precedes Date(s) of Service 62 Date of Service Not Within Allowable Inquiry Period 63 Date of Service in Future 64 Invalid/Missing Patient ID 65 Invalid/Missing Patient Name 66 Invalid/Missing Patient Gender Code 67 Patient Not Found 68 Duplicate Patient ID Number 71 Patient Birth Date Does Not Match That for the 72 Invalid/Missing Subscriber/Insured ID Patient on the Database 73 Invalid/Missing Subscriber/Insured Name	Reject reason Code	O ID 2/2	263 & 367

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Loop	Seg Pos	Data Element	Req or Sit	Segment/Element	Instruction	Industry/Element Name	Attributes	IG Page No.
					74 Invalid/Missing Subscriber/Insured Gender Code 75 Subscriber/Insured Not Found 76 Duplicate Subscriber/Insured ID Number 77 Subscriber Found, Patient Not Found			
2110C & 2110D	130	1390	R	EB01	One or more of the following Eligibility Information Codes may be returned when Applicable. 1 Active Coverage G Out Of Pocket (Stop Loss) I Non-Covered N Services restricted to Following Provider R Other Payor or Additional Payor W Other Source of Data 4 Active – Services Capitated to Primary Care Physician	Eligibility or Benefit Information	M ID1/2	290 & 395
2110C & 2110D	130	1207	S	EB02	One or more of the following Coverage Level Codes may be returned when Applicable. IND – Individual FAM – Family	Coverage level Code	O ID 3/3	292 & 396

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R	Decimal Real Number	Used for numeric values that have a varying number of decimal positions. For negative values, the leading (-) minus sign is used. Absence of a sign indicates a positive value. The (+) plus sign should not be transmitted.
ID	Identifier	Always contains a value from a predefined list of codes.
AN	Alphanumeric string	Sequence of any characters from a basic or extended character set.
DT	Date	States the standard date in either YYYYMMDD or CCYYMMDD. CC (first two digits of calendar year), YY (last two digits of calendar year), MM (month 01 – 12), DD (day in the month 01 – 31)
TM	Time	The ISO standard time HHMMSSd, 24-hour clock. HH (Hour 00 - 23), MM (minute 00 – 59), SS (second 00 – 59), d (decimal seconds)

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Delimiter

A character used to separate two data elements (or sub-elements) or to end a segment. They are specified in the interchange header segment (ISA). Once specified in the ISA, they should not be used in the data elsewhere other than as a separator or terminator.

EDI

An acronym for Electronic Data Interchange.

EDIG

An acronym for Electronic Data Interchange Gateway.

Electronic Data Interchange

The application-to-application transfer of key business information transacted in a standard format using a computer-to-computer communications link. There are typically 6 components used in order to do EDI. They are: an EDI file, a trading partner agreement, an application file/form, translator (mapper), communications and value-added service provider.

Implementation Guides

Documents that provide standardized data requirements and content permitting the specification of consistent implementation of a standard transaction set. HIPAA implementation guides are published by the Washington Publishing Company on their web site: www.wpc-edi.com.

Interface

The connection point that two systems pass data.

Loops

Loops are groups of semantically related segments. Data segment loops may be unbounded or bounded.

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Routing

Separation of data based on specific criteria for subsequent transfer to an internal or external system.

Trading Partners

Entities that exchange electronic data files. Agreements are sometimes made between the partners to define the parameters of the data exchange and simplify the implementation process.

Translation Software

Commercial computer software that with input instructions converts a standard format to an application format and vice-versa. Most translation software products also compliance check standard format files and automatically create interchange/functional acknowledgements to identify receipt of translation status of a file. Some products also offer translation capability from any format to any format.

X12 Transaction Set

A transactions set is considered one business document which is composed of a transactions et header control segment, one or more data segments, and a transaction set trailer control segment.

X12N

An Accredited Standards Committee (ASC) commissioned by the American National Standards Institute (ANSI) to develop standard for Electronic Data Interchange (EDI). While X12 indicates EDI, the N identifies the Insurance Subcommittee that is responsible for developing EDIO standards for the insurance industry. There is a special health care task group within this subcommittee responsible for the development of health care insurance transactions.

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