HIPAA EDI Companion Guide

For

270/271 Eligibility Inquiry & Response

Companion Guide Version: 3.0

ASCX12N National Electronic Data Interchange Transaction
Set Implementation and Addenda Guides, Version 005010A1

Updated October 2024

Disclosure Statement

This document is intended to be a companion guide for use in conjunction with the ASCX12N National Electronic Data Interchange Transaction Set Implementation and Addenda Guides. The information in this document is provided for Jefferson Health Plans and its associated Trading Partners.

This document contains clarifications as permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Standard for Electronic Transactions. This document is not intended to convey information that exceeds the requirements or usages of data expressed in the ASCX12N National Electronic Data Interchange Transaction Set Implementation and Addenda Guides defined by HIPAA.

> **This document is not intended, and should not be regarded, as a substitute for the ASCX12N National Electronic Data Interchange Transaction Set Implementation and Addenda Guides.**

Jefferson Health Plans may make improvements and/or changes to the information contained in this document without notice.

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Preface

This companion guide is intended to convey information that is within the framework of the ASC X12N Implementation Guides adopted for use under HIPAA. This companion guide to the ASCX12N National Electronic Data Interchange Transaction Set Implementation and Addenda Guides adopted under HIPAA will clarify and specify Jefferson Health Plans communication protocols, business rules, and information applicable to the 270/271 Eligibility Inquiry & Response transaction. Transmissions based on this companion guide, used in tandem with the X12N Implementation Guides, are compliant with X12 syntax, those guides, and HIPAA.

Document Control - Version History

The following version history is provided to easily identify updates between Companion Guide versions. Each update is numbered. All corresponding areas of the document related to this update are also numbered.

#	Version	Date	Author	Updates
1	1.0	8/25/04	HP Operations Support	• Initial version of 270/271 Companion Guide Document. This version was also posted to the plan's external website.
2	2.0	1/27/07	HP Operations Support	• Added new company logo • Updated ANSI fields tables to include NPI required data
3	3.0	10/17/13	Claims Department	• Added new plan name and logo.
4	4.0	10/9/2024	Claims Department	• Updated naming and contact information

Introduction

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 is intended to provide better access to health insurance, limit fraud and abuse, and reduce administrative costs of the health care industry. The provisions for administrative simplification contained within HIPAA require the Secretary of the Department of Health and Human Services (HHS) to adopt standards to support the electronic exchange of administrative and financial health care transactions.

These transactions primarily occur between health care providers and health insurance plans or clearinghouses. HIPAA directs the Secretary of HHS to adopt standards for transactions to enable health information to be exchanged electronically and to adopt specifications for implementing each standard.

Scope
This companion guide explains the procedures and requirements necessary for trading partners of Jefferson Health Plans to transmit the following HIPAA standard transactions:
- 270/271 Eligibility Inquiry & Response

This companion guide is intended to convey information that is within the framework of the ASC X12N Implementation Guides adopted for use under HIPAA. Transmissions based on this companion guide, used in tandem with the X12N Implementation Guides, are compliant with X12 syntax, those guides, and HIPAA.

References
Additional information on the HIPAA Final Rule for Standards for Electronic Transmissions and the endorsed Implementation Guides can be found at:
- httpp://www.cms.gov/hipaa/hipaa2 (HIPAA Administrative Simplification)
- http://www.wpc-edi.com (Washington Publishing Company)

Contact information

EDI Customer Service and Technical Assistance
Electronic Data Interchange (EDI) customer service and technical assistance requests focus solely on the generation, processing, and/or transmission of a HIPAA standard transaction. EDI customer service and technical assistance requests will not focus on transaction results, such as claim payment and remittance results.

Please contact Jefferson Health Plans EDI Department at EDI@jeffersonhealthplans.com for technical assistance.

Non-EDI Customer Service and Assistance
Non-EDI customer service and assistance requests focus solely on transaction results such as claim payment and remittance advice, member maintenance, or member eligibility. Non-EDI customer service and assistance requests will not focus on the generation, processing, and/or transmission of a HIPAA standard transaction.

Please contact Jefferson Health Plans Provider Services for non-EDI customer service and assistance.

Eligibility Benefit Inquiry and Response (270/271)

Eligibility Status Request (270)

The only data elements that are required by Jefferson Health Plans to identify the member are:

- Member ID
- Provider ID

The other fields on the Eligibility Request screen will be the Eligibility Start Date and Provider ID fields. If submitted, the eligibility date field will be used to determine if the member is/was eligible specifically on that date. If the eligibility start date is not submitted, the eligibility date will default to the transaction date. The provider ID identifies the provider making the inquiry.

Data Necessary for Processing 270 Requests

Loop	Segment	Data Element	Field Description	Length	Mapping Comments
IC Header	ISA	06			Trading Partner ID
Header	BHT	02	Transaction Set Purpose	2/2	'13' = Request
2100B	NM1	01	Entity Identifier Code	2/3	'1P' = Provider
2100B	NM1	02	Entity Type Qualifier	1/1	'1' = Person, '2' = Non-person
2100B	NM1	08	Identification Code Qualifier	1 / 2	'XX'
2100B	NM1	09	Identification Code	2/80	Use appropriate NPI
2100B	REF	01	Reference Identification Qualifier	2/3	N5
2100B	REF	02	Reference Identification	1/30	Jefferson Health Plans Provider Identification Number (Up to 14 Digits)
2100C	NM1	03	Last Name	1/35	Member Last Name
2100C	NM1	04	First Name	1/25	Member First Name
2100C	NM1	08	Identification Code Qualifier	1 / 2	'ZZ'
2100C	NM1	09	Identification Code	2/80	Member ID
2100C	DTP	01	Date Time Qualifier	3/3	'307'= Eligibility
2100C	DTP	02	Date Time Period Format Qualifier	2/3	'D8' = Format CCYYMMDD
2100C	DTP	03	Date Time Period	1/35	Date for Eligibility inquiry (if not sent, then the transaction date will be used)
2110C	EQ	01	Eligibility or Benefit Inquiry	1/2	'30' = Health Benefit Plan Coverage

Eligibility Status Response (271)

The following are the Eligibility Response Values utilized by Jefferson Health Plans:
- Member is Eligible
- Member is Not Eligible
- Member is Not Found
- Member is Invalid

For valid, eligible members, Jefferson Health Plans will return the member's ID along with selected demographic information, including the member's name and date of birth, PCP information (provider ID, name, effective date), Ob/Gyn information (same information as PCP, as available), and the member's hospital affiliation.

In the event of a member who has been terminated (not eligible), Jefferson Health Plans will return the member's ID, the member's name, and the termination date.

In the event that the member is not found in Jefferson Health Plans' database, Jefferson Health Plans will return a 271 transaction set containing an AAA segment identifying that the member was not found.

If the member is found in Jefferson Health Plans' database but determined to either be an invalid member – either a "dummy member" (these are fictitious member numbers that are used for testing) or members who have been only partially entered, etc. – Jefferson Health Plans will return a 271 transaction set containing an AAA segment identifying that the member was invalid.

Sample Eligibility Response Screen

The following is an example of what the Eligibility Response screen might look like:

Patient :		Plan
Member ID :		
Plan Network ID :		**Coverages**
Plan Network ID Description :		Health Benefit Plan Coverage
DOB :		
Gender :		

Submitter Info
Submitter Type : Provider
Service Provider # :

Coverage : **Health Benefit Plan Coverage**	
Benefits	**Additional Info**
Coverage Level :	
Active Coverage	
Eligibility Begin :	
Coverage Level :	
Active Coverage	
Eligibility Begin :	
PCP Name :	
PCP # :	

Data Necessary for Sending 271 Response

Loop	Segment	Data Element	Field Description	Length	Mapping Comments
Header	BHT	02	Hierarchical Structure Code	2/2	'11' = Response
2100C	NM1	03	Last Name	1/35	Member Last Name
2100C	NM1	04	First Name	1/25	Member First Name
2100C	NM1	08	Identification Code Qualifier	1 / 2	'ZZ'
2100C	NM1	09	Identification Code	2/80	Member ID
2100C	AAA	01	Condition or Response Code	1/1	'N' = Request not valid
2100C	AAA	03	Reject Reason Code	2/2	'64' = Invalid Member ID '67' = Member not found
2100C	DMG	01	Date Time Period Format Qualifier	2/3	'D8' = Format CCYYMMDD
2100C	DMG	02	Date Time Period	1/35	Member's DOB
2100C	DMG	03	Gender Code	1/1	'F'= Female, 'M' = Male, 'U' = Unknown
2110C	EB	01	Eligibility or Benefit Information	1 / 2	'1' = Active Coverage, '6' = Inactive, 'A'= Co-Insurance, 'B'= Co-Payment, 'C' = Deductible
2110C	EB	03	Service Type Code	1 / 2	'30' = Health Plan Coverage
2110C	DTP	01	Date/Time Qualifier	3/3	'356' = Eligibility Begin, '357' = Eligibility End
2110C	DTP	02	Date Time Period Format Qualifier	2/3	'D8' = Format CCYYMMDD
2110C	DTP	03	Date Time Period	1/35	Eligibility Date (Effective or Termination Date)
2120C	NM1	01	Entity Identifier Code	2/3	'P3' = PCP, '73' = Other Physician
2120C	NM1	03	Last Name	1/35	Provider Last Name
2120C	NM1	04	First Name	1/25	Provider First Name
2120C	NM1	08	Identification Code Qualifier	1 / 2	'XX'
2120C	NM1	09	Identification Code	2/80	Use appropriate NPI