

NEBLUE *connect*



Health Care Eligibility
Benefit Inquiry and Response
ANSI X12N 270/271

Companion Document
Health Insurance Portability and Accountability Act



**BlueCross BlueShield
of Nebraska**

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ANSI ASC X12N 270/271 Health Care Eligibility Inquiry and Response

Companion Document

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The Health Insurance Portability and Accountability Act (HIPAA) requires that all health insurance payers in the United States comply with the electronic data interchange (EDI) standards for health care as established by the Secretary of Health and Human Services (HHS). The ANSI X12N 270/271 implementation guide has been established as the standards of compliance for eligibility transactions. The implementation guides for each transaction are available electronically at www.wpc-edi.com.

The following information is intended to serve only as a companion document to the HIPAA ANSI X12N 270/271 implementation guide. The use of this document is solely for the purpose of clarification. This companion document supplements, but does not contradict any requirements in the X12N 270/271 implementation guide.

This document is subject to change as new information is available. Please check the BCBSNE Provider Web Site at www.bcbsneprovider.com for updated documents. Just click on the NEBLUECONNECT link to find all of the BCBSNE Companion Guides.

BCBSNE Requirements - 270

General Information

The type of 270 transaction is not designated in the Implementation Guide (IG), but rather by the data presented in the transaction.

BCBSNE has identified three types of 270 transactions:

1. GENERAL - 270 transactions that contain EQ segments with an EQ01 Service Type Code of "1" (medical care), "30" (health benefit plan coverage).
2. CATEGORICAL - 270 transactions that contain EQ segments with an EQ01 Service Type Code other than "1", "30".
3. SPECIFIC - 270 transactions that contain EQ segments that contain EQ02 (Procedure Code) data instead of Service Type Code data.

Due to IG limitations, if BCBSNE receives an Institutional Specific 270 request, BCBSNE will be unable to answer specifically and will provide a General response. If we receive an Institutional Categorical request, BCBSNE will respond with a Categorical answer whenever possible.

BCBSNE will not accept 270 transactions for Medicare recipients. Medicare eligibility inquiries must be sent directly to your Medicare carrier or Fiscal Intermediary.

IMPORTANT NOTICE: Providers must separate Dental and Medical Benefit inquiries, as well as, General, Categorical and Specific Inquiries into separate Benefit Inquiry questions. BCBSNE will reject any mixed requests received within the same patient loop. General, Categorical and Specific request should be submitted separately.

Header Information

ISA and GS Segments - Interchange Sender and Receiver ID Requirements

ISA05 = ZZ

ISA06 = Seven digit BCBSNE Trading Partner Number (Note: For real time transactions please add "R" on end, for example 1234567R)

ISA07 = ZZ

ISA08 = NEBLUECONNECT (Batch Transactions)
BCBSNE (Real Time Transactions)

GS02 = Seven digit BCBSNE Trading Partner Number (Note: For real time transactions please add "R" on end)

GS03 = NEBLUECONNECT (Batch Transactions)
BCBSNE (Real Time Transactions)

BHT Segment - Beginning of Hierarchical Transaction

BHT02 BCBSNE will only accept 270 transactions have a transaction set purpose code of 13 - Request.

If purpose code 36 is submitted, BCBSNE will reject with reason code 15 (required application data missing) in the AAA segment.

Information Source Name 2100A Loop

NM1 Segment - Name Information

- NM101 Use qualifier PR for BCBSNE.
- NM102 Use 2 (Non-Person Entity) for BCBSNE.
- NM103 Submit 'Blue Cross Blue Shield of Nebraska' in Information Source Organization Name.
- NM108 Please use qualifier NI for BCBSNE.
- NM109 Please use 77780 for BCBSNE.

Information Receiver Name 2100B Loop

NM1 Segment - Name Information

- NM101 Use qualifier 1P if you are a Professional Provider sending the 270 transaction
Use 80 if you are a Hospital or Institutional Provider sending the 270 transaction.
- NM102 Use 1 if you submitted the 1P qualifier in NM101 and are using a provider name in NM103.
Use 2 if you submitted the 1P qualifier in NM101 and are using a firm name in NM103.
Use 2 if you submitted the 80 qualifier in NM101
- NM108 Use qualifier XX.
- NM109 Please use your NPI number with no spaces, hyphens or special characters.

REF Segment - Additional Identification

- REF01 Use qualifier TJ for the Federal Taxpayer's Identification Number.
- REF02 Please use your Federal Taxpayer's Identification Number with no spaces, hyphens or special characters.

Subscriber Name 2100C Loop

NM1 Segment - Subscriber Name Information

The provider must include the entire Member ID from the Member ID card including the Plan Prefix, ID# and Member Suffix

When submitting multiple parts of an ID, the data must be provided to BCBSNE as a string with no dashes, spaces, commas, slashes, etc in between the elements of the ID.

When the Member Suffix is provided, no Dependent information or 2100D loop should be submitted with the transaction.

If the Member Suffix is not available, both the Subscriber and Dependent information (loops 2100C and 2100D) are required if the patient is not the Subscriber.

If available, always provide both first name and date of birth of the patient.

Without the Plan Prefix, BCBSNE may not be able to match correctly or route the patient's request to the appropriate location for processing. For example, if an Inter-Plan Teleprocessing Services (ITS) Member ID is submitted on a 270 Benefit Eligibility Transaction without the prefix, we may not be able to correctly route the request to Blue Exchange for processing. An example of the Member Suffix for a Member ID is below: For a Member ID card containing an ID#: YES123 45 6789 with the following names below that:

John Q Public 01
Jane A Public 02

The suffix for John is 01 and the suffix for Jane is 02. Then entire Member ID for Jane would consist of YES12345678902 with no dashes, spaces, commas, or slashes specified. In the example above the Plan Prefix = YES, the ID# = 123456879. Additional reference information specific to the 270: The first name, date of birth and relationship code are situational on the 270 request but will be used to verify that BCBSNE has the correct member information. Pages 21 and 22 of the IG discuss the matching or search options.

NM104 BCBSNE requires first name when no Member Suffix is included in the ID (NM109) and recommends that it always be provided. Accuracy in providing this information will result in correct response information.

NM108 BCBSNE requires qualifier MI - Member Identification Number including prefix and suffix.

NM109 BCBSNE requires the Member Identification Number including Plan prefix, ID# and Member suffix. This data must be provided as a string with no dashes, spaces, commas, slashes, etc. in between the parts of the full ID.

Without the Plan prefix, BCBSNE may not be able to match correctly or route the request to the appropriate location for processing.

If the Member suffix is provided, it is not necessary to provide the dependent loop.

If the Member suffix is not provided and the patient is not the subscriber, both the subscriber and dependent loops must be completed.

DMG Segment - Demographic Information

DMG02 BCBSNE requires date of birth when the Member Suffix is not included in the NM109 ID and recommends that it always be provided when the Subscriber is the patient. Accuracy in providing this information will result in correct response information.

DTP Segment - Date Information

DTP01 BCBSNE accepts qualifiers 307(Eligibility), 435 (Admission), 472 (Service), and 102 (Date of Issue). The 271 response provided applies to the date requested as long as the date is not older than 24 months from current date. When a future date or one that is older than 24 months is provided, the 271 response provided is answered as of current date.

Subscriber Eligibility or Benefit Inquiry Information

2110C Loop

EQ Segment - Eligibility or Benefit Inquiry

The following X12 service type codes will answer as General: 1, 9, 15, 17, 30, 32, 35, 37, 47, 54, 55, 60, 61, 67, 70, 82, 83, 87, 93, 96, A9, AQ, AR, BA, BJ, BL, BM, BN, BP, BQ, BS.

The following X12 service type codes will answer as Categorical: 2, 3, 4, 5, 6, 7, 8, 10, 11, 12, 13, 14, 16, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 33, 36, 38, 39, 40, 41, 42, 43, 44, 45, 46, 48, 49, 50, 51, 52, 53, 56, 57, 59, 62, 63, 64, 65, 66, 68, 69, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 84, 85, 86, 88, 89, 90, 91, 92, 94, 95, 97, 98, 99, A0, A1, A2, A3, A4, A5, A6, A7, A8, AA, AB, AC, AD, AE, AF, AG, AH, AI, AJ, AK, AL, AM, AO, BB, BC, BD, BE, BF, BG, BH, BI, BK, BR.

EQ02 BCBSNE does not allow this element for a Specific request if EQ01 (generic request) is requested in the same loop.

EQ02-1 Qualifier = AD

Specific Dental requests are requests with AD as the procedure code qualifier and Product/Service Code that is a valid ADA code. BCBSNE is currently unable to answer any Dental Inquiries and will reject with the reason code 42 (Unable to Respond at Current Time) in the AAA segment. For Dental benefit information the provider should request an 837D Pre-Estimate Transaction.

III Segment - Additional Information

On a 270 Specific inquiry, the requestor must include at least one diagnosis code to receive a 271 Specific response.

A more accurate response will be provided if the Principle Diagnosis Code is submitted. BCBSNE will not be able to provide benefit information without a valid diagnosis.

If more than 3 diagnosis codes are provided for a patient question, BCBSNE will search to find the Principal Diagnosis codes to use for pricing purposes.

For specific PPO/Indemnity requests, the maximum number of diagnosis codes that will be used for providing a response is 3. If more than 3 diagnosis codes are submitted for one 270 transaction, only 3 diagnosis codes can be utilized by BCBSNE. BCBSNE suggests that the Principle Diagnosis codes be input in the first 3 occurrences of the III segment of each PPO/Indemnity patient question.

For a General or Categorical 270 request, if the Facility Type Code is not supplied, it will default to a value that corresponds to the X12 Service Type Code.

Dependent Level

Use this level only if the patient is a dependent of the member and cannot be uniquely identified in the Information Source Information in the Subscriber Level segments. If you use the member ID plus suffix in the Subscriber Loop, then the Dependent Loop should not be sent.

The same BCBSNE requirements identified in the Subscriber Loop applies to Dependent Level data also.

BCBSNE Requirements - 271

Information Receiver Name 2100B Loop

AAA Segment - Request Validation

AAA03 If the 271 response contains a AAA reject reason code of 43, it means that one of the Provider IDs was missing OR that BCBSNE could not determine a unique provider from the information provided to us.

Subscriber Name 2100C Loop

NM1 Segment – Subscriber Name

- NM103 BCBSNE provides the last name stored for the patient if found. The value provided may be different than the last name submitted with the 270.
- NM104 BCBSNE provides the first name stored for the patient if found. The value provided may be different than the first name submitted with the 270.

N3 Segment - Subscriber Address

- N301 All information on the 270 will be returned on the 271 response excluding patient address information and other elements where noted.

AAA Segment - Subscriber Request Validation

- AAA03 If the 271 response contains a AAA Reject Reason Code of 52, this message indicates the provider no longer has an active provider contract with BCBSNE and therefore cannot receive benefit information.
- HIPAA 270 transactions cannot respond to requests for members whose BCBSNE coverage is secondary. This reason code will be returned by BCBSNE.

DMG Subscriber - Demographic Information

- DMG BCBSNE provides the patient date of birth if the patient is found. This value may be different than the value input on the 270.
- When a Dependent loop exists and a Subscriber Date of Birth was input on the 270, the 271 will not include the Subscriber's date of birth.

Subscriber Benefit Information 2110C Loop

EB Segment - Benefit Information

- EB01 The following pattern of response lines will be provided in all responses created by BCBSNE. BCBSNE has no means of guaranteeing that 271 responses returned by other Plans will follow this pattern. Each new set of response lines will begin with an eligibility information code of: the 1st - 1 (active coverage)

Most questions or EQ segments input with the 270 result in multiple lines of response information on the 271. In order to identify the beginning of each separate answer, each new set of response lines will begin with any one of the following codes. When reviewing 271 responses, one of the values below will exist for each EQ supplied within the 270.

- 1 (Active Coverage)
- 6 (Inactive Coverage)
- I (Non-Covered)
- V (Cannot Process)

All Blue Preferred and Blue Classic General and Categorical new coinsurance remaining response information are individual amounts only.

A claim may have different results for benefits than those originally provided on the 271 response. For example, the 271 response may indicate that a \$100 deductible is applicable to the individual's benefits. Upon receipt of an office visit claim for that individual, the claim may not take a deductible but instead take a \$25 office visit copay and pay the remainder on the charge at 100%.

- EB01 A Co-Insurance
The Co-Insurance percents for both participating and non-participating benefits are provided for active PPO members. The Co-Insurance is the percentage for which the patient is responsible. When Co-Insurance is not applicable at the Benefit Group level, the Co-Insurance EB segment is omitted indicating that there is no Co-insurance for that segment.
- EB01 B Co-Pay
The set dollar amount the patient must pay for covered services. When Co-Pay is not applicable at the Benefit Group level, the Co-Pay EB segment is omitted indicating that there is no Co-Pay for that segment.
- EB01 C Deductible
The amount the patient must pay in a specified period for covered services before BCBSNE will begin to pay benefits. When deductible is not applicable at the Benefit Group level, the Deductible EB segment is omitted indicating that there is no deductible for that segment.
- EB01 F Benefit Limits
A maximum or limit on the amount of services that may be provided.
- EB01 G Out of Pocket (Stop Loss)
A limit on the out of pocket expenses that the patient is responsible for in a specified period. All Out of Pocket remaining amounts for both participating and non-participating benefits are provided for active PPO members. When a claim is actually submitted for that individual, the diagnosis and any claim activity for that individual or family will affect the actual deductible, deductible remaining, and Out of Pocket amounts.
- EB01 P Disclaimer
This segment is used to advise that the benefits and eligibility information returned on the 271 response are not a guarantee of coverage and/or benefits.
- EB03 When reviewing the returned 271 Response, you must examine the Service Type Code carefully. There are instances when BCBSNE will have to modify the Service Type Code in the response to reflect the type of Benefits information being provided.
- When a X12 Service Type Code comes in on a 270 inquiry, BCBSNE may return multiple X12 Service Type Codes that are associated with the X12 Service Type Code on the 270 Inquiry.

For example, if a 270 request is received for an X12 Service Type Code of 2 (Surgical) , the 271 response will include benefit information for X12 Service Type Code of 2, and benefit information for X12 Service Type Codes of 7 (Anesthesia), 8 (Surgical Assistance), and 20 (Second Surgical Opinion).

An additional example would be if a request is received for an X12 Service Type Code of 1 (Medical Care), the 271 response will include benefit information for X12 Service Type Code of 1 and benefit information for X12 Service Type Codes of 98 (Professional Physician Visit – Office), 48 (Hospital – Inpatient), 50 (Hospital – Outpatient), 52 (Hospital – Emergency Medical), A7 (Psychiatric – Inpatient), and A8 (Psychiatric – Outpatient).

EB11 In the 271 response provided, pre-certification required may be returned with a value of "Y" indicating that pre-certification is required for that member's coverage. Please keep in mind that this requirement only applies to inpatient hospitalizations and is for all types of BCBSNE coverage.

III Segment - Additional Information

BCBSNE will report place of service data when place of service variations are present. All variations by place of service will be included in the 271 response with the corresponding III segment (place of service) after the applicable EB segment to show benefit differences.

The following X12 Service Type Codes will return III segment when the benefits differ based upon the place of service for Co-pay, Out of Pocket (Stop Loss), Coinsurance, Deductible and Benefit Limits:

2, 4, 5, 6, 7, 8, 12, 13, 18, 20, 33, 40, 42, 45, 47, 48, 50, 51, 52, 53, 61, 62, 65, 68, 69, 73, 75, 78, 80, 81, 82, 83, 84, 86, 93, 98, 99, A0, A3, A6, A7, A8, AD, AE , AF, AG, AI, BG, BH

If there is one occurrence of place of service a III segment is returned, otherwise a MSG segment is returned with all place of service variations listed.

AAA Segment - Request Validation

AAA03 If AAA Reject Reason Code 54 is returned for a procedure identified via a specific request, the error may indicate that an invalid procedure code, place of service or type of service was received. There may be other instances (i.e. surgical assistance related procedures), which may result in this error being returned even though a valid procedure, place of service and type of service is received but is not covered by the member's contract with BCBSNE.

Dependent Level

Same information is given back at dependent level.