Program Memorandum Intermediaries

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal A-02-029 **Date: APRIL 17, 2002**

CHANGE REQUEST 2111

SUBJECT: Implementation of the Health Insurance Portability and Accountability Act (HIPAA) Health Care Eligibility Benefit Inquiry/Response Transaction (270/271) Standard

This Program Memorandum (PM) provides additional instructions for fiscal intermediaries (FIs) and their standard systems regarding Medicare requirements for implementation of version 4010 of the Accredited Standards Committee (ASC) X12N 270/271 Health Care Eligibility Inquiry and Response format as established in the 004010X092 Implementation Guide. **See also Transmittal Number A-02-013, CR 2009, issued February 8, 2002.**

CWF Data Flow Documents

The CWF data flow documents may be found at the following web site: www.hcfa.gov/medicare/edi/edi3.htm.

1. Map 270/271 elements – Breakdown of all 270/271 data elements;
2. Map 270 997 & TA1 – Breakdown of all 270, 997, and TA1 data elements;
3. Map CWF Format 270 – Mapping of current CWF HUQA inquiry layout data elements to 270;
4. Map CWF Format 271 – Mapping of current CWF HUQA response layout data elements to 271;
5. Map 271 EB 2110C – Detail mapping of all the EB fields (CWF data being sent back on 271 response);
6. Map Disp Codes – Current CWF disp/error codes;
7. HIPAFLOW – High level view of the new 270 and ELGA process.

CWF HIPAA Changes

The following changes will be made by CWF:

- The existing HUQA, HIQA, and HIQH data files that go through HIPSAT1 will not be modified at this time, and will continue to operate until October 6, 2003. On October 6, 2003, these transactions will be removed from the system. HIPSAT1 will continue to reside at the FI until October 6, 2003.

- CWF will create five types of 271 responses (two for HMOs) depending on provider type:

1. All hospitals and skilled nursing facilities will receive the same information. The data elements are:

Data Elements Returned on the Response (271) – Basic Data Set

Intermediary number;
Provider number;
Requester ID;
Date & time stamp;
Surname;
First initial;
HICN;
Zip code;
Date of birth;
Date of death;
Sex code;
Applicable date;
Current Part A entitlement date;
Current Part A termination date;
Current Part B entitlement date;
Current Part B termination date;
HMO ID code;
HMO option code;
HMO entitlement date;
HMO termination date;
Other program entitlement;
- Workers compensation;
- Black lung;

MSP Data (can occur up to 5 times):
- MSP code;
- MSP effective date;
- MSP termination date;
- MSP insurers name;
- MSP insurers address;
- MSP insurers city;
- MSP insurers state/zip;

Lifetime reserve days;
Part A Spell Data;
- Hospital days remaining;
- Co-insurance hospital days remaining;
- SNF days remaining
- Co-insurance SNF days remaining;
- Inpatient deductible remaining;
- Date of earliest billing action;

Date of latest billing action;
Part B Spell Data:
- Most recent Part B year;
- Part B cash deductible remaining;
- Part B physical/speech therapy limit remaining;
- Part B occupational therapy limit remaining;

Hospice period number;
Hospice start date;
Hospice termination date;
Pap risk indicator;
Pap date;
Mammo risk indicator;
Mammo date;
Screening Data
- Screening risk indicator;
- Tech or prof;
- Recent dates;

ESRD first code;
ESRD effective date;
Transplant indicator;
Transplant discharge date;
HHEH data (current two episodes):
- HHEH start date;
- HHEH end date;
- HHEH date of earliest billing action; and
- HHEH date of latest billing action;

HHBP Data (current two episodes):
- HHBP start date;
- HHBP end date.

2. All psychiatric providers will receive the basic data set (above) plus additional psychiatric information. The additional data elements are:

   Lifetime psych days remaining;
   Part B psych limit remaining.

3. All home health providers will receive the following information:

   Intermediary number;
   Provider number;
   Requester ID;
   Date & time stamp;
   Surname;
   First initial;
   HICN number;
   Date of birth;

Sex code;
Applicable date;
Date of death;
Current Part A entitlement/termination date;
Current Part B entitlement/termination date;
HMO data:
- HMO ID code;
- HMO option code;
- HMO entitlement date;
- HMO termination date.

Other program entitlement (black lung, workers compensation);
MSP data:
- MSP code;
- MSP effective date;
- MSP termination date.

Hospice data (last four occurrences):
- Hospice period number;
- Hospice start date;
- Hospice termination date.

HHEH data (current two episodes);
- HHEH start date;
- HHEH end date;
- HHEH DOEBA;
- HHEH DOLBA.

HHBP data (current two periods):
- HHBP A visits remaining;
- HHBP B visits applied;
- HHBP earliest billing date;
- HHBP latest billing date.

4. The managed care plans will receive two separate types of eligibility responses depending on whether the beneficiary is a member of the plan. They are the HMO Eligibility Response and the HMO Eligibility/Utilization Response. The data elements for each response are:

<u>HMO Eligibility Response</u>:

Intermediary number;
Provider number (HMO Plan ID);
Requester ID;
Date & time stamp;
Surname;
First initial;

HICN;
Date of birth;
Sex code;
Applicable date;
Date of death;
County/State code;
Current Part A entitlement/Termination date;
Current Part B entitlement/Termination date;
MSP data (can occur up to 5 times):
- MSP code;
- Effective and termination date;
- Insurers name, address, city, state, zip code;
- Validity/delete indicator;
- Original contractor;
- Updating contractor;
- Date of accretion;
- Patient relationship code;
- Policy number;
- Group number;
- Group name;
- Maintenance date; and
- Insurer type.

Hospice data (last 4 occurrences):
- Hospice period number, start and termination date;

ESRD (yes or no).

HMO Eligibility/Utilization Response

HMOs will receive the HMO Eligibility Response above plus the following:

Lifetime reserve days;
Lifetime psychiatric days remaining;
Home Health Agency visits (A remaining, B applied);
Spell of Illness (Part A):
- Hospital days remaining;
- Co-insurance hospital days remaining;
- SNF days remaining;
- Co-insurance SNF days remaining;
- Inpatient deductible remaining;
- Date of earliest billing action;
- Date of latest billing action.

Incoming Part A Data Elements (270)

HICN;
Surname;
First name;
Date of birth;
Sex;
Intermediary number;
Provider number;
Requester ID (submitter ID);
Usage indicator (Production or Test);
Applicable date; and
Host ID.

The first three data elements must be entered correctly to receive a response.

- CWF will create two new DDE screens that will match the 271 data content for that provider type:

    1. ELGA will replace HIQA: and
    2. ELGH will replace HIQH.

- CWF will modify the current HIHO screens to match the data content for the 271.

Search Requirements for DDE – HIQA, HIQH, and HIHO

HICN;
Surname (first 6 characters);
First initial; and
Date of birth.

The first three data elements must be entered correctly to receive a response.

Security File Requirements

The security check module will read the eligibility security file and validate the existence of submitter data. The file will contain the following information:

1. Provider number;
2. Submitter number;
3. Submitter name;
4. Submitter contact name;
5. Date created;

6. Time created;
7. Date last updated;
8. UserID last update;
9. EDI enrollment form (Y or N); and
10. Network service agreement (Y or N).

Audit File Requirements

The audit trail module will create an audit record for every incoming 270. The file will contain the following information:

1. Audit date;
2. Audit time:
3. SubmitterID;
4. ProviderID;
5. HICN;
6. Record type;
7. Transaction ID;
8. CWF host site; and
9. Status information (successful/unsuccessful).

The standard system will distribute information regarding the program that will be used which will allow FIs to produce a quarterly report that will compare inquiry volume to "**finalized**" claim volume.

Advise Your Providers

- Of all CWF HIPAA changes outlined in this PM as explained in CR 2009; and

- That a new "inquiry to claim ratio" safeguard will be implemented with this implementation. If a provider has multiple provider numbers, the provider must make sure that the same number used to submit claims for a beneficiary is also used to submit eligibility inquiries. Otherwise, your ratio will be off and there will need to be work done to investigate.

- When implementing the "inquiry to claim ratio," all sources of eligibility requests must be considered during migration; i.e., current and new.

The effective date for this PM is July 1, 2002.

The implementation date for CWF and FISS is July 1, 2002.

The implementation date for APASS is October 1, 2002.

See Transmittal Number A-02-013 for implementation cost information.

This PM may be discarded after October 31, 2004.

Medicare contractor questions concerning this PM may be directed to Jean Gross, (410) 786-6159, or e-mail JGROSS3@CMS.HHS.GOV**.**

Any provider, clearinghouse or other vendor questions related to this PM should be directed to their servicing Medicare intermediary.