Program Memorandum Carriers

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

Transmittal B-02-051 **Date: JULY 31, 2002**

CHANGE REQUEST 2223

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 instructions for carriers, durable medical equipment regional carriers), data centers, their shared systems and the Common Working File (CWF) on Medicare requirements for implementation of version 4010 of the Accredited Standards Committee X12N 270/271 Health Care Eligibility Inquiry and Response format as established in the 004010X092 Implementation Guide. In order to implement the HIPAA administrative simplification provisions, the 270/271 has been named under 45 CFR 162 as the electronic data interchange (EDI) standard for Health Care Eligibility Benefit Inquiry/Response. All other real time and batch formats for health care eligibility inquiry and response, other than DDE, become obsolete October 16, 2003.

I. X12 Documentation

The version 4010 implementation guide for the 270/271 standard may be found at the following Web site: www.wpc-edi.com/HIPAA. The 270/271 is a "paired" transaction (the 270 is an in-bound eligibility inquiry and the 271 is an out-bound eligibility response).

II. Implementation Requirements

Medicare will implement the 270/271 in an interactive real-time response mode by January 1, 2003. This means that a provider will be able to send a compliant X12N 270 version 4010 inquiry, one inquiry at a time, and receive a compliant 271 response one response at a time, within seconds. CMS will not offer a batch process.

Provider/vendor/clearinghouse 270 eligibility inquiries must be sent directly to the applicable CICS region at the claims processing data centers. Further information about routing of these inquiries and the days and hours when the eligibility data will be available will be supplied in a PM to be issued by October 1, 2002. The claims processing data centers will install a CWF-supplied module that will be used to process and respond to eligibility inquiries submitted via the 270, DDE, automated response unit, in person, or by another means.

Claims processing data center references in this PM apply also to the MDC1 and MDC2 data centers that operate under direct CMS control. The MDC1 and MDC2 contracts will be modified to provide for completion of these requirements and for support of TCP/IP connections related to this work.

A. Medicare Data Communication Network (MDCN)

The provider/clearinghouse/vendor 270/271 transactions will be channeled to the claims processing data centers via the MDCN. Carriers must notify their providers, clearinghouses and vendors what they need to do to access the MDCN, and assist those who intend to use the 270/271 to establish and maintain their MDCN connection. Carriers may need to refer parties experiencing MDCN technical connection problems that fall outside of carrier jurisdiction directly to the MDCN maintainer for resolution. Use of the MDCN eliminates any need for carriers to furnish lines or redesign their front ends to receive or route these inquiries and responses.

Carriers that have an existing private network such as the Insurance Value Added Network (IVANS) may use that network to route version 4010 270 inquiries to and 271 responses from their data center for providers, clearinghouses and vendors already established on that network, but they may not add additional clearinghouses, vendors or directly submitting providers to that private network after use of the NDCM for this purpose is effective. Carriers that elect to use their private network to transmit this traffic must also support MDCN connections for these new partners or for existing entities who prefer to use the MDCN.

Carriers that do not currently use a private network will not be funded to establish such a network, or to begin to use such a network if established by their corporate parent. For consistency sake, CMS anticipates elimination of use of non-MDCN private networks for this function at some point post-October 2003, but carriers may continue to use existing private networks as specified until notified otherwise by CMS. Adequate advance notice will be provided of the change if and when that decision is made.

Carriers that currently support 270/271 eligibility inquiries via asynchronous or LU6.2 technology connections may continue to do so for those providers/clearinghouses/vendors, but may not begin to receive traffic for additional providers/clearinghouses/vendors via those means. These carriers must also support MDCN connections for the additional providers/clearinghouses/vendors that wish to begin use of the 270/271, and for any current users that may prefer to begin using the MDCN. Carriers that do not currently use asynchronous or LU6.2 connections for eligibility inquiries will not be funded to begin doing so. For consistency sake, CMS also anticipates elimination of use of asynchronous and LU6.2 connections for this function at some point post-October 2003, but carriers may continue to support asynchronous and/or LU6.2 connections for this until notified otherwise by CMS. Adequate advance notice will be provided of the change if and when that decision is made. By October 16,2003, these asynchronous and LU6.2 links may support 270/271 version 4010-compliant eligibility transactions only.

Providers/vendors/clearinghouses must send a 270 over the MDCN, or other private network as described, via a TCP/IP socket to the appropriate CICS region of their claims processing data center. The 271, 997, TA1, or proprietary response (see B.1 below) will be returned via a TCP/IP socket through the same connection. Providers/vendors/clearinghouses must supply the software they will use for the 270/271 and for receipt of a 997, TA1, and the additional implementation guide error report.

The CWFM will develop documentation for the client and host side TCP/IP transmission capability that must be maintained by the claims processing data centers. The CWFM documentation will include instructions for creation of the client side module that will have to be developed by the provider/vendor, and technical documentation on TCP/IP rules of protocol (streaming socket, etc.). The CWFM will also provide information to establish connections using TCP/IP, MDCN, LU6.2, and asynchronous technology. The CWFM will provide technical information on other private networks as necessary, as well as information concerning help desk support related to the CWF modules. The CWFM will distribute this documentation and information to the claims processing data centers by October 1, 2002.

B. <u>CWF Modules</u>

1. The CWF maintainer (CWFM) will develop and maintain an eligibility software module to be used by the claims processing data centers. This module will translate the 270-transaction into the Part B inquiry CWF flat file, and translate the CWF Part B flat file response into a compliant 271 transaction. The CWFM will issue these flat file specifications to the data centers By October 1, 2002. The module will not translate the data to be used to feed ARU, DDE, and other possible carrier internal means of accessing eligibility data. The data will be supplied in flat file format for carrier use for non-270/271 eligibility applications, such as automated response units and direct data entry screens.

This module will perform standard syntax edits as well as implementation guide edits for the 270 inquiries, and will produce a 271 response to either report eligibility data or to report standard or implementation guide errors detected in the 270. The 271 was designed to report most standard and

implementation guide errors that might occur in a 270. The module will also produce a TA1 response to report any enveloping errors, an X12 997 if the query cannot be translated, and a separate report of any implementation guide errors detected that are beyond the 271's reporting capability.

The CWFM will evaluate use of the X12N 824 version 4050 draft implementation guide available at www.wpc-edi.com/HealthCare_40.asp to report implementation guide errors that may exceed the reporting capability of the 271-version 4010 format, rather than develop a separate proprietary report. Details of the vehicle for the module's implementation guide error reporting will be distributed by the CWFM through the claims processing data centers by October 1, 2002. All 270 inquiry responses, whether with the requested data, to report errors, to indicate non-availability of the system, or for any other purpose must be issued in real-time.

The eligibility module will retain a per provider count of each 270/271 and DDE eligibility inquiry. Provider inquiries channeled through vendors or clearinghouses will be counted on a per provider, not per clearinghouse/vendor, basis. This count must be used by carriers to calculate the claim to inquiry ratio.. ARU eligibility inquiries will not be included in this ratio calculation and will not be tracked by the eligibility module. The standard systems maintainers must write and issue software to the data centers by January 1, 2003 for carrier use to calculate the claim to inquiry ratio. See the Audit Trail Requirements section later in this PM for further information.

2. The CWFM must also develop an eligibility security module to be installed at each claims processing data center that will operate with the eligibility module to validate that clearinghouses, vendors, and providers submitting a 270 inquiry are authorized to obtain the requested data for the specified provider. See the Security section later in this PM for additional information.

The CWFM will furnish the eligibility security module flat file specifications to the standard system maintainers and the data centers by October 1, 2002. The carrier standard systems must establish a link between the provider control files and the eligibility security module to enable the automated update of provider security data in the module where common data elements exist. The provider control files are located at the data centers, identify whether a provider is approved to obtain Medicare eligibility data, identify any clearinghouse or vendor authorized to obtain eligibility data on a provider's behalf, and are maintained by the carriers.

Provider control file data elements may vary among standard systems, necessitating design of a separate map and link by each standard system. This link must either directly feed the eligibility security module on a real-time basis or provide for a batch update at least once each business day to assure current data is used by the eligibility security module. Each standard system must also establish a screen to enable carriers to populate and maintain any supplemental data elements in the eligibility security module that are not already contained in their provider control files.

C. Automated Response Unit (ARU) Requirements

If a carrier operates an automated response unit (ARU) for providers to request and receive eligibility information, the carrier must continue to do so. ARUs are not considered EDI and are not affected by the HIPAA requirements. Nor do they impact response-time requirements for the standard transactions implemented under HIPAA. However, the information provided by ARUs must be obtained from the CWF software module by October 16, 2003. This means that the interface from ARU scripts must connect to the same CWF flat file that will produce information for the 271 and for DDE. ARU eligibility data may not come from any alternate source.

The CWF eligibility module will produce more eligibility data than is currently furnished by most ARUs. Carriers are not required to expand their ARUs to enable reporting of the additional data elements. Providers interested in receipt of those additional data elements are to be directed to begin use of the 270/271.

D. Direct Data Entry (DDE) Eligibility Access

HIPAA uses the term "direct data entry" generically to refer to a type of functionality operated by many different payers under a variety of titles. Within this instruction, the acronym DDE is being used to refer to any type of direct data entry system maintained by Medicare carriers or standard system maintainers. DDE was specifically permitted to continue in the transactions regulation (45

CFR162.923), with the stipulation that direct data entry is subject to "…the applicable data content and data condition requirements of the standard when conducting the transaction. The health care provider is not required to use the format requirements of the standard."

Carriers are not required to make eligibility information available via DDE. Carriers that currently offer that data via DDE, however, must continue to offer eligibility data via DDE after January 1, 2003. For those carriers that do offer eligibility data via DDE, the DDE eligibility data supplied must be drawn directly from CWF effective January 1, 2003. The eligibility data issued by CWF will meet the data content requirements of the 271-version 4010 implementation guide. Maintainers of the carrier DDE screen(s) must modify the screen(s) by January 1, 2003 to correspond to the eligibility data elements to be issued by CWF. Screen maintainers will be able to obtain the CWF eligibility data flat file specifications from their data center after October 1, 2002. Effective January 1, 2003, carriers will be prohibited from furnishing eligibility data in a DDE screen that has not been supplied by CWF. accessed by providers upon implementation of the new screen(s).

The data elements that will be used by CWF to identify beneficiaries to determine eligibility status for DDE are:

HICN:
Surname (last 6digits);
First initial; and
Date of birth.

E. <u>Inquiry and Response Information (270/271)</u>

The following data elements will be used to process an eligibility query:

HICN;
Surname;
First name;
Date of birth;
Sex;
Carrier 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 in the 270 at a minimum to enable a 271 to be generated for error reporting. Otherwise, a 997 or TA1 will be issued, as applicable.

All physicians, suppliers, and pharmacies authorized to receive eligibility data will be issued the same data set. The following information will be returned in the 271 eligibility data response as applicable:

Carrier 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 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, state/zip

Lifetime reserve days
Part A Spell Data:
- Hospital days remaining
- Co-insurance hospital days remaining
- SNF days remaining
- Co-insurance 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
Mammography risk indicator:
- Mammography date
- Screening risk indicator
- Tech or prof
- Recent dates

Glaucoma risk indicator:
- Tech or prof
- Recent dates

Colorectal risk indicator
- Tech or prof
- Recent dates

Prostate risk indicator:
- Tech or prof
- Recent dates

Pelvic 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
- HHEH date of latest billing action

HHEB Data (current two episodes):
- HHBP start date

III. Restricting and Controlling Access to Eligibility Information

Carriers/data centers must allow both participating and non-participating providers, and their authorized agents to access beneficiary eligibility data via the 270/271 and DDE, if supported, if a provider has filed a valid provider EDI Enrollment Form (see MCM Part E section 3021.4) and has no history of abuse of eligibility inquiry privileges (see section IV.) Carriers/data centers must allow clearinghouses/vendors to access beneficiary eligibility data for a provider if: the clearinghouse/vendor has filed a valid EDI Network Service Agreement; there is an EDI Enrollment Form on file for the provider (see MCM Part 3 section 3021.8); there is a letter on file from the provider authorizing the clearinghouse/vendor to have access; and there is no history of abuse of eligibility inquiry privileges by the provider.

IV. Audit Trail Requirements

The CWF module will capture audit trail data (control information, sender/receiver information, etc.) to track the number of 270/271 and DDE inquiries and responses issued per provider. The standard system maintainers will develop a program that will allow carriers to calculate a per provider ratio of adjudicated claim volume to inquiry volume. The carriers will generate the ratio report within 15 calendar days of the end of each calendar quarter to detect unusual volumes of eligibility queries by individual providers. Carriers must complete evaluation of these ratio reports and contact aberrant providers as warranted by the end of the quarter in which the reports were generated. Neither the standard systems nor the carriers are responsible for matching a particular inquiry with a particular claim. The audit trail will contain:

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

The claims to inquiry ratio should be at least 80 percent. This means that for every 100 inquiries submitted for a provider, at least 80 claims should have been submitted for the provider. If the claim to inquiry count does not meet the 80 percent ratio for a given provider, the carrier must contact the provider to explain Medicare's inquiry volume expectations and restrictions. If there is a problem or the behavior continues, the carrier must suspend the provider's online access to eligibility data for one year from the date of determination that there has been abuse of the provider's eligibility inquiry privileges. The provider must be notified to reapply for online eligibility access at the end of that year if the provider wishes to restore online access.

V. CWF Data Flow Documents

The following CWF data flow documents may be downloaded at: www.hcfa.gov/medicare/edi3.htm by any interested entity:

1. Detail flows of the carrier process from end to end
2. HIPAFLOW - High level view of the new 270 and ELGB process
3. Map 270/271 elements - Breakdown of all 270/271 data elements
4. Map 270 997 & TA1 - Breakdown of all 270, 997, and TA1 data elements
5. Map 271 EB 2110C - Detailed mapping of all the EB fields (CWF data being sent back on a 271 response)

VI. Security Requirements

Carriers are responsible for enabling authentication of the user ID and password of a 270 submitter or DDE user at the time of connection through carrier maintenance of the provider control file and of the eligibility security module that reside at their data center. (See the CWF modules section of this

PM.) Security validation will be done at the following levels at a minimum prior to distribution of eligibility data to a provider/clearinghouse/vendor:

- MDCN connection;
- Data center connection; and
- CWF module connection.

The eligibility security module will use the following data elements to validate authority to access CWF eligibility data:

1. Carrier number;
2. Provider number;
3. Submitter number;
4. Submitter name;
5. Submitter contact name;
6. Date created;
7. Time created;
8. Date last updated;
9 UserID last update;
10. EDI Enrollment Form (Y or N); and
11. Network Service Agreement (Y or N).

CMS will issue additional security validation information in the eligibility PM to be issued by October 1, 2002. CMS will continue to hold the carrier/data center responsible for the privacy and security of eligibility transactions sent directly to them from providers, and require carriers/data centers to be able to associate each inquiry with a provider. However, carriers/data centers must not require providers to send user IDs and passwords within the eligibility transactions. Provider authentication must be established outside of the transaction. CMS will hold network service vendors responsible for the privacy and security of eligibility transactions sent directly to them from providers that contract their services for eligibility transactions, and vendors must also be able to associate all inquiries with their providers. Network service vendors must not require providers to send user IDs and passwords within the eligibility transaction.

VII. Implementation Schedule

The schedule is as follows:

- CWF production date - October 1, 2002;
- Standard systems production date - January 1, 2003;
- Carrier internal testing of the standard system and CWF modules – Complete by December 31, 2002;
- Carriers begin to test with those providers, clearinghouses, and vendors that request testing pre-production - January 1, 2003.

The current Part B eligibility transaction will run parallel with the 270/271 through January 1, 2003. Carriers are not required to conduct compatibility testing for each provider, clearinghouse or vendor who plans to use the version 4010 270/271, but carriers are required to test with each provider, clearinghouse, and vendor that requests such testing.

VIII. Provider and Clearinghouse Outreach -- What Carriers Must Tell Providers:

By November 1, 2002, carriers must provide information in a regularly scheduled bulletin, and/or other provider education medium (electronic bulletin board, website, etc.) if the paper publication moratorium is still in effect, regarding implementation of the ANSI X12 270/271 to their providers, third-party provider billing services, provider clearinghouses, and vendors. Carriers must inform providers, billing services, clearinghouses, and vendors:

- The 270/271 will be supported in real-time by Medicare and not in batch;
- The 270/271 implementation guide adopted for national use under HIPAA can be obtained at www.wpc-edi.com/HIPAA;
- A provider that prefers to obtain eligibility data in an EDI format but that does not want

to use the 270/271 version 4010 may contract with a clearinghouse to translate the information on its behalf; however, that provider would be liable for those clearinghouse costs;

- Provider, clearinghouse, and vendor testing is not required prior to production use, but will be conducted if requested, and there will not be a charge for such testing;
- When testing requests can be submitted and when testing is actually expected to begin; issued;
- The eligibility data elements that will become available as result of this change that were not previously available through ARU, DDE, or via 270/271 if locally supported in a pre-HIPAA version;
- The home health benefit period information is expected to be of particular interest to providers affected by home health consolidated billing, but they must use the 270/271 or DDE to obtain the HHA data elements;
- Where DDE is supported, what changes users can expect to see in the eligibility data presented on the DDE screen(s);
- If asynchronous and/or LU6.2 connectivity will continue to be supported for eligibility queries and responses, and if so, any changes users can expect to encounter as result of implementation of version 4010 of the 270/271;
- ARU eligibility queries will continue to be accepted, but the additional data elements that will first become available in the version 4010 271 will not be added to the ARU and must be accessed via the 270/271 or DDE (where supported);
- Electronic formats, other than DDE, that you my have supported for request and receipt of eligibility data will not be used after October 16, 2003; and
- How to contact their carrier to obtain further information or to initiate use of the 270/271.

Those providers that request further information must be informed:

- The submitter of a 270 must self-program or obtain software to generate and receive HIPAA-compliant 270/271 transactions, receive a TA1 to report transmission envelope errors, receive a 997 to report translation problems, and be able to accept the supplemental implementation guide error report that will be used to report any implementation guide errors that could not be reported in a 271;
- The format and general data content of the implementation guide error report to be used, when this report will be issued, and action to take if received;
- What steps must be followed to connect with the MDCN;
- Real-time queries must be submitted one a time and one immediate response at a time will be returned. Providers or their agents can program to enable their system to submit multiple eligibility inquiries in succession during a single session, but not simultaneously as in a batch submission
- The submitter of a 270 is responsible for all costs incurred to enable connection with the MDCN;
- The days and hours when real-time eligibility access will be supported and what can be expected if a query is submitted outside of those days or hours;
- Data elements that must match the Medicare data base to enable a positive response to be generated;
- Eligibility inquiries are supported to enable a provider to establish eligibility prior to claim submission Eligibility data may not be requested for a provider not involved in provision of health care services to a purported Medicare beneficiary, unless the provider has been approached by the purported Medicare beneficiary or other provider to provide health care services to that individual. Searches of eligibility data of possible beneficiaries who are not currently receiving services, or for whom a provider has not been approached to furnish services, is prohibited;
- The ratio of claims to eligibility inquiries per provider will be monitored. Providers will be contacted if their ratio suggests possible overuse of eligibility queries. Providers that determined to have abused their query privileges will lose eligibility query access either directly or though a clearinghouse or other vendor for 1 year after the date of determination of abuse;
- Although Medicare will furnish providers with basic information on the HIPAA standard transaction requirements to enable providers to make educated and timely decisions to plan for use of a HIPAA standard, Medicare will not furnish in-depth training on the use

and interpretation of the standards implementation guides. Providers who feel they have a need to obtain such in-depth training for their staff are expecting to obtain training of that nature from commercial vendors, their clearinghouse, or through standards development organizations; and
- Any other information a carrier would consider of value to a provider, clearinghouse, or vendor contemplating use of the 270/271 under HIPAA.

IX. Cost Issues

The Carrier HIPAA EDI Transactions Productivity Investments section of the FY Budget and Performance Requirements (BPRs) required carriers to "include an estimate in your BR [budget request] of the Productivity Investment funds that you will need to implement and operate [the 270/271] transaction in FY 2003 using Miscellaneous Code 17004/06. This Program Memorandum (PM) contains more detail than previously shared about the actual CMS requirements for this transaction. As result, carriers must submit a supplemental budget request (SBR) to CMS through normal channels by October 15, 2002. The SBR must include the following separately itemized incremental costs expected to be incurred related to implementation of this PM:

- Any necessary hardware costs;
- Any necessary software costs;
- Release testing costs;
- Submitter testing costs;
- Anticipated number of submitters;
- Share of data center costs;
- Staff training costs;
- Any subcontracting costs and identify the activity being subcontracted; and
- Other costs not previously included in one of the above estimates. Identify the costs and the associated amount of each reported as "other;" and
- Total funding requested.

Do not include provider outreach costs in these estimates. Limit these estimates to direct costs for implementation of the X12N 270/271 transaction as discussed in this PM. Provider costs included in these estimates must be limited to those incurred for testing with individual providers, vendors, and clearinghouses, if such testing is requested.

In preparation of any HIPAA-related funding requests, it must be noted that HIPAA established requirements binding on all health care payers, not only on Medicare. HIPAA did not provide funding for implementation of the administrative simplification transaction standards requirements by each health payers. As with other system and program changes that impact a Medicare contractor's parent company's private/commercial lines of business as well as their Medicare processing activities, direct and indirect costs related to such changes must be proportionately shared by the impacted lines and cost centers, and not charged to Medicare in total. Programming, transition, and operational costs related to a corporate clearinghouse operated by a Medicare contractor's parent company, or any other profit or non-profit line of business of the parent company not required to support Medicare processing under the terms of their Medicare contract, may not be charged in total or in part to the Medicare program.

The *effective date* for this PM is October 1, 2002.

The *implementation date* for this PM is January 1, 2003.

See the section titled "cost issues" for SBR submission information.

This PM may be discarded after January 1, 2005.

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 vendor with questions related to this PM must contact their servicing Medicare carrier.