North Carolina Department of Health and Human Services (NC DHHS)

Division of Medical Assistance (DMA)
Division of Mental Health (DMH)
Division of Public Health (DPH)

Standard Companion Guide Transaction Information Instructions related to Transactions based on ASC X12 Implementation Guides, version 005010X279A1 Health Care Eligibility Benefit Inquiry and Response (270/271), for the Replacement MMIS NCTracks starting July 1, 2013

North Carolina Department of Health and Human Services

OFFICE OF MMIS SERVICES

Preface

Companion Guides (CG) may contain two types of data, instructions for electronic communications with the publishing entity (Communications/Connectivity Instructions) and supplemental information for creating transactions for the publishing entity while ensuring compliance with the associated ASC X12 IG (Transaction Instructions). Either the Communications/Connectivity component or the Transaction Instruction component must be included in every CG. The components may be published as separate documents or as a single document.

The Communications/Connectivity component is included in the CG when the publishing entity wants to convey the information needed to commence and maintain communication exchange.

The Transaction Instruction component is included in the CG when the publishing entity wants to clarify the IG instructions for submission of specific electronic transactions. The Transaction Instruction component content is limited by ASCX12's copyrights and Fair Use statement.

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1. Transaction Instruction (TI) Introduction

1.1 BACKGROUND

1.1.1 Overview of HIPAA Legislation

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 carry provisions for administrative simplification. This requires 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 primarily between health care providers and plans. HIPAA directs the Secretary to adopt standards for transactions to enable health information to be exchanged electronically and to adopt specifications for implementing each standard HIPAA serves to:

- Create better access to health insurance
- Limit fraud and abuse
- Reduce administrative costs

1.1.2 Compliance According to HIPAA

The HIPAA regulations at 45 CFR 162.915 require that covered entities not enter into a trading partner agreement that would do any of the following:

- Change the definition, data condition, or use of a data element or segment in a standard.
- Add any data elements or segments to the maximum defined data set.
- 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).
- Change the meaning or intent of the standard’s implementation specification(s).

1.1.3 Compliance According to ASC X12

ASC X12 requirements include specific restrictions that prohibit trading partners from:

- Modifying any defining, explanatory, or clarifying content contained in the implementation guide.
- Modifying any requirement contained in the implementation guide

1.2 INTENDED USE

The Transaction Instruction component of this companion guide must be used in conjunction with an associated ASC X12 Implementation Guide. The instructions in this companion guide are not intended to be stand-alone requirements documents. This companion guide conforms to all the requirements of any associated ASC X12 Implementation Guides and is in conformance with ASC X12’s Fair Use and Copyright statements.

1.3 INTENDED AUDIENCE

This companion guide is intended for the business and technical users, within or on behalf of trading partners, responsible for the testing and setup of electronic claims submissions to NCTracks. In addition, this information should be communicated to, and coordinated with, the provider's billing office in order to ensure that the required billing information is provided to its billing agent/submitter.

1.4 PURPOSE OF COMPANION GUIDE

The Companion Guide is to be used with, and to supplement the requirements in the HIPAA ASC X12 Implementation Guides, without contradicting those requirements. Implementation Guides define the national data standards, electronic format, and values for each data element within an electronic transaction. The purpose of the Companion guide is to provide trading partners with a guide to communicate NCTracks specific information required to successfully exchange transactions.

The primary purpose of this document is to assist the trading partner with the appropriate use of the transactions and is not intended to be a billing or policy guide.

1.5 ACKNOWLEDGEMENTS

For all inbound transactions, a 999 Acknowledgement report will be sent to the trading partner's OUTBOX for retrieval. This report serves as the acknowledgement of the submission of a file. Typically, 999 Acknowledgement reports are available within moments of submission.

1.6 TRADING PARTNER AGREEMENT SETUP

This is a test version – more information will be provided with the final version of the Companion Guide

1.7 TESTING

NC DHHS (DMA, DMH, and DPH) requires testing, or third party certification, prior to approving a trading partner to submit claims in production. Once in production, NC DHHS (DMA, DMH, DPH) reserves the right to require re-testing if it is determined the trading partner is receiving/generating an unacceptable volume of errors.

This is a test version – more information will be provided with the final version of the Companion Guide

2. Included ASC X12 Implementation Guides

The table below identifies the X12N Implementation Guides for all of the transactions supported by NCTracks. Companion guides are available for each of the transactions.

Section 3 of this document provides information specific to the 270/271 transaction set, as defined in the 005010X279 270/271 Health Care Eligibility Benefit Inquiry and Response Technical Report 3 (TR3) dated April 2008, and updated by:

- Errata 005010X279E1 270/271 Health Care Eligibility Benefit Inquiry and Response dated January 2009
- Addenda 005010X279A1 270/271 Health Care Eligibility Benefit Inquiry and Response dated June 2010

Unique ID	Name
005010X222	Health Care Claim: Professional (837P)
005010X223	Health Care Claim: Institutional (837I)
005010X224	Health Care Claim: Dental (837D)
005010X228	Health Care Claim Pending Status Information (277P)
005010X279	Health Care Eligibility Benefit Inquiry and Response (270/271)
005010X221	Health Care Claim Payment/ Advice (835)
005010X212	Health Care Claim Status Request and Response (276/277)
005010X220	Benefit Enrollment and Maintenance (834)
005010X218	Payroll Deducted and Other Group Premium Payment for Insurance Products (820)
005010X231	Implementation Acknowledgment for Health Care Insurance (999)

3. Instruction Tables

These tables contain one or more rows for each segment for which a supplemental instruction is needed.

Legend
SHADED rows represent “segments” in the X12N implementation guide.
NON-SHADED rows represent “data elements” in the X12N implementation guide.

005010X279A1 Health Care Eligibility Benefit Inquiry and Response (270/271)

Loop ID	Reference	Name	Codes	Notes/Comments
270		**Health Care Eligibility Benefit Inquiry**		
Header	ISA	Interchange Control Header		
	ISA05	Interchange ID Qualifier		Must match Trading Partner Agreement
	ISA06	Interchange Sender ID		Must match Trading Partner Agreement
	ISA07	Interchange ID Qualifier		Must match Trading Partner Agreement
	ISA08	Interchange Receiver ID		Use “NCTRACKSREL” for real time submissions and “NCTRACKSBAT” for batch submissions
Header	BHT	Beginning of Hierarchical Transaction		
	BHT02	Transaction Set Purpose Code	13	Use ‘13’. NCTracks does not support Cancellation via 270 Inquiry.
2100A	NM1	Information Source Name		
	NM101	Entity Identifier Code	PR	Use “PR”
	NM102	Entity Type Qualifier	2	Use “2”
	NM103	Name Last or Organization Name		Use “NCTRACKS”
	NM108	Identification Code Qualifier	PI	Use “PI”
	NM109	Information Source Primary Identifier		Use “NCTRACKS”
2100B	NM1	Information Receiver Name		
	NM101	Entity Identifier Code	2B, GP	Use “2B” or “GP”
	NM108	Identification Code Qualifier	SV, XX	Use “SV” to sent provider Number in NM109 or “XX” to send NPI number in NM109

Loop ID	Reference	Name	Codes	Notes/Comments
270		**Health Care Eligibility Benefit Inquiry**		
2100B	PRV	Information Receiver Provider Information		
	PRV01	Provider Code	SB	Use “SB”
	PRV03	Reference Identification		Requesting provider's Taxonomy Code
2100C	REF	Subscriber Additional Identification		
	REF01	Reference Identification Qualifier	SY	Use “SY”
2100C	PRV	Provider Information		
	PRV01	Provider Code	OT, RF	Use “OT” or “RF”
	PRV02	Reference Identification Qualifier	9K, HPI	Use “9K” or “HPI”
2100C	DTP	Subscriber Date		
	DTP01	Date /Time Qualifier	291	Use “291”
	DTP02	Date Time Period Format Qualifier	RD8	Use “D8” or “RD8”
2110C	EQ	Subscriber Eligibility or Benefit Inquiry		
	EQ01	Service Type Code		Any value other than “30” will be treated as “30”
2000D	HL	Dependent Level		NCTracks does not support the Dependent Loop. Patients are identified at the Subscriber Level (Loop 2000).

Loop ID	Reference	Name	Codes	Notes/Comments
271		**Health Care Eligibility Benefit Response**		
Header	ISA	Interchange Control Header		
	ISA03	Security Information Qualifier	00	"00" is returned
	ISA05	Interchange ID Qualifier	ZZ	"ZZ" is returned
	ISA06	Interchange Sender ID		NCTRACKSREL = Real time transaction NCTRACKSBAT = Batch transaction
	ISA07	Interchange ID Qualifier	ZZ	"ZZ" is returned
	ISA08	Interchange Receiver ID		Return Provider's ETIN (Receiver's ETIN) is returned
	ISA11	Repetition Separator	^	
	ISA14	Acknowledgment Requested	0	"0" is returned
	ISA16	Component Element Separator	:	": " is returned
Header	GS	Functional Group Header		
	GS01	Functional Identifier Code	HB	"HB" is returned
	GS02	Application Sender's Code		NCTRACKSREL = Real time transaction NCTRACKSBAT = Batch transaction
	GS03	Application Receiver's Code		Return Provider's ETIN (Receiver's ETIN) is returned
2000A	AAA	Request Validation		
	AAA01	Valid Request Indicator	N	"N" when sent
	AAA03	Reject Reason Code	42	When 42 is returned, call 1-800 for explanation (system down or data error)
	AAA04	Follow-up Action Code	P	"P" when sent
2100A	NM1	Information Source Name		
	NM101	Entity Identifier Code	PR	"PR" is returned
	NM102	Entity Type Qualifier	2	"2" is returned
	NM103	Name Last or Organization Name	NCTRACKS	"NCTRACKS" is returned
	NM108	Identification Code Qualifier	PI	"PI" is returned
	NM109	Identification Code	NCTRACKS	"NCTRACKS" is returned

Loop ID	Reference	Name	Codes	Notes/Comments
271		**Health Care Eligibility Benefit Response**		
2100A	PER	Information Source Contact Information		This segment is used to provide NCTracks Call Center telephone number
	PER02	Name		“NCTRACKS CALL CENTER” is returned
	PER03	Communication Number Qualifier	TE	"TE” is returned
	PER04	Communication Number		“8668441113” is returned.
2100A	AAA	Request Validation		
	AAA01	Yes/No Condition or Response Code	N	“N” when sent
	AAA03	Reject Reason Code	42	When 42 is returned, call NCTRACKS Call Center for explanation (system down or data error)
	AAA04	Follow-up Action Code	P	“P” when sent
2100B	NM1	Information Receiver Name		
	NM108	Identification Code Qualifier	SV, XX	"SV” or “XX” is returned
	NM109	Identification Code		Contains the Provider Number as submitted on the 270 request
2100B	REF	Information Receiver Additional Identification		Contains what is received on the 270 request
	REF01	Reference Identification Qualifier	JD	"JD” is returned
	REF02	Reference Identification		431= Recipient and Provider are DMA and DPH eligible, however, inquired ‘to date of service’ is past the end of the current month 432= Combination of DMH and other payer(s)
2100B	AAA	Information Receiver Request Validation		
	AAA01	Yes/No Condition or Response Code	N	“N” when sent
	AAA03	Reject Reason Code	41,50, 51, T4	
	AAA04	Follow-up Action Code	C	“C” when sent
2100C	NM1	Subscriber Name		
	NM108	Identification Code Qualifier	MI	"MI” is returned
	NM109	Identification Code		Recipient ID is returned

Loop ID	Reference	Name	Codes	Notes/Comments
271		**Health Care Eligibility Benefit Response**		
2100C	AAA	Subscriber Request Validation		
	AAA01	Yes/No Condition or Response Code	N	“N” when sent
	AAA03	Reject Reason Code	57, 62, 72, 75, 76, 78	57” or “62” or “72” or “75”or, 76 or 78 is returned. When 76 is returned, call the CSC Provider Relations Call Center for more information When 78 is returned, the Provider/Recipient is not eligible to inquire
	AAA04	Follow-up action code	R	“R” when sent
2100C	DTP	Subscriber Date		Used when there is a single period of eligibility
	DTP01	Date Time Qualifier	291	"291” is returned
	DTP02	Date Time Period Format Qualifier	RD8	"RD8” is returned
	DTP03	Date Time Period		Eligibility period for Benefit Plan identified in EB segment
2110C	EB	Subscriber Eligibility or Benefit Information		
	EB01	Eligibility or Benefit Information Code	1, F, W, G	“1” when EB05 is: North Carolina Health Choice Department of Public Health ORHCC Division of Medical Assistance Hospice Opt-In Pharmacy Third Party Liability “F” when EB05 is: Service Limits Sickle Cell Infant Toddler ADAP “W” when EB05 is: Transfer of Assets “G” when EB05 is: Cost Sharing

Loop ID	Reference	Name	Codes	Notes/Comments
271		**Health Care Eligibility Benefit Response**		
	EB02	Coverage Level Code	IND	"IND" is returned
	EB03	Service Type Code		"30" when EB05 is: Third Party Liability "88" when EB05 is: Opt-In Pharmacy "45" when EB05 is: Hospice "1" when EB05 is: Service LimitsCost Sharing Otherwise, Service Type values are returned appropriate for the Benefit Plan. For more information, see section 4.2.3
	EB04	Insurance Type Code	MA, MB, HN, OT, MC, C1	"MA" = Medicare Part A "MB" = Medicare Part B "HM" = Medicare Part C Managed Care "MP" = Medicare Part D "OT" = North Carolina Health Choice Division of Public Health ORHCC Hospice Opt-In Pharmacy Service Limits Sickle Cell Infant Toddler ADAP Transfer of Assets Cost Sharing "MC" = Division of Medical Assistance

Loop ID	Reference	Name	Codes	Notes/Comments
271		**Health Care Eligibility Benefit Response**		
				"R" = Third Party Liability
	EB05	Plan Coverage Description		CAPAI = Community Alternatives Program (CAP) for Persons with AIDS CAPCH = CAP for Children CAPCO = CAP for Choice CAPDA = CAP for Disabled Adults CAPMR = CAP for Mental Retardation & Developmental Disability MAFDN = Medicaid Family Planning Waiver MQBQ = Medicaid for Qualified Beneficiaries Program Q MQBB = Medicaid for Qualified Beneficiaries Program B MQBE = Medicaid for Qualified Beneficiaries Program E MFP = Money Follows the Person PACE = Program of All-inclusive Care for the Elderly PHPB = Piedmont Health Program B PHPC = Piedmont Health Program C MCAID = Medicaid NCHC = North Carolina Health Choice

Loop ID	Reference	Name	Codes	Notes/Comments
271		**Health Care Eligibility Benefit Response**		
				ITP = Infant Toddler Program SICKL = Sickle Cell ADAP = AIDS HIV Drug Assistance Program EHDI = Early Hearing Detection & Intervention CCNC = Community Care of NC-UP HLTNT = HealthNet SVCLT = Service Limits Hospice = Hospice TPL Coverage Code is used for Third Party Liability Opt-In Primary or Opt-In Specialty is used for Opt-In Pharmacy “Yes” or “No” is used for Transfer of Assets “OOP” or “AA2OOP” is used when reporting Cost Sharing information
	EB06	Time Period Qualifier	25, 29,34	“25 or “29” is used to report Cost Sharing information regarding Service Limits, Sickle Cell, Infant Toddler, or ADAP
	EB07	Monetary Amount		Used to report Recipient out-of-pocket maximum limit and amount for Cost Sharing
	EB09	Quantity Qualifier	VS	“VS” is used to report information regarding Service Limits, Sickle Cell, Infant Toddler, or ADAP
	EB10	Quantity		Reports available count or total amount when EB05 =

Loop ID	Reference	Name	Codes	Notes/Comments
271		**Health Care Eligibility Benefit Response**		
				Service Limits, Sickle Cell, Infant Toddler or ADAP
2110C	REF	Subscriber Additional Identification		
	REF01	Reference Identification Qualifier	18, 1L, 6P, IG	"18" is used to report information regarding Medicare Part A & B "1L" is used to report information regarding Medicare Part C & "6P" is used to report Insurance Policy Group ID for applicable Third Party Liability "IG" is used to report Insurance Policy Number for applicable Third Party Liability
	REF02	Reference Identification		HIC Number is returned for Medicare Part A and B "999" is returned for Medicare Part C "998" is returned for Medicare Part D
	REF03	Description		"Medicare" is returned for Medicare Part A and Part "Medicare C Health Group Org" is returned for Medicare Part C "Medicare D Health Group Org" is returned for Medicare Part D
2110C	MSG	Message Text		
	MSG01	Free-form Message Text		Returned as follows: "Per X Months" for Service Limits, Sickle Cell, Infant Toddler and ADAP "Restriction Message" for Service Limits, Sickle Cell, Infant Toddler and ADAP

Loop ID	Reference	Name	Codes	Notes/Comments
271		**Health Care Eligibility Benefit Response**		
				"Yes" or "No" for Transfer of Assets
2120C	NM1	Subscriber Benefit Related Entity Name		
	NM101	Entity Identifier Code	2B, IL, 1P	Returned as follows: "2B" for North Carolina Health Choice Division of Public Health ORHCC Medicaid Managed Care "IL" for Third Party Liability Cost Sharing "1P" for Opt-In Pharmacy
	NM102	Entity Type Qualifier	1, 2	Returned as follows: "1" for North Carolina Health Choice Division of Public Health ORHCC Medicaid Managed Care Third Party Liability Opt-In Pharmacy "2" for Cost Sharing
2120C	PER	Subscriber Benefit Related Entity Contact Information		
	PER03	Communication Number Qualifier	TE	
	PER04	Communication Number		Used to report organizational or business phone number
	PER05	Communication Number Qualifier	TE	
	PER06	Communication Number		Used to report organizational or business after hours phone number

4. TI Additional Information

4.1 BUSINESS SCENARIOS

The 270/271 is to be used to verify eligibility prior to performing services.

Use of the 270/271 transaction set in batch mode allows trading partners to submit multiple eligibility requests for multiple recipients. Only single transactions are allowed to be submitted as real time transactions

4.2 PAYER SPECIFIC BUSINESS RULES AND LIMITATIONS

4.2.1 Search Criteria

The following search criteria are supported:

Scenario	Recipient ID	SSN	DOB	Last Name	First Name
1	X				
2		X	X		
3	X	X	X		
4	X		X	X	
5	X			X	X
6			X	X	X

4.2.2 Eligibility Returned

Eligibility information is returned based on the NCTracks payer and the benefit plan(s) for the payer.

CMS rules prevent sending dates > 365 days before the 1st day of the query month. Division of Public Health (DPH) allows up to 12 months into the future. DMA does not allow dates beyond the end of the current month.

Division of Mental Health (DMH) information is not returned. That information is available through the Local Managing Entity (LME).

4.2.3 Range of Dates Supported for Inquiries

An inquiry may not be for dates > 365 days before the 1st day of the query month.

DPH allows inquiries for up to 12 months beyond the end of the current month. DMA does not allow dates beyond the end of the current month.

4.2.4 Benefit Plans Returned

Eligibility information is only returned when the requesting provider and recipient are enrolled in the same benefit plan(s).

Eligibility information is not returned for benefit plans that are covered by the Division of Mental Health (DMH).

4.2.5 Reference Number Returned

A reference number is returned in 2100A REF02 when the payer is the Division of Medical Assistance (DMA). The reference number can be used to identify an eligibility request for tracking or research purposes.

4.2.6 999 Acknowledgement

A 999 acknowledgement is returned for all 270 batch submissions.

4.3 SCHEDULED MAINTENANCE

This is a test version – more information will be provided with the final version of the Companion Guide

4.4 FREQUENTLY ASKED QUESTIONS

This section will contain a compilation of questions and answers as they are identified. ***This is a test version – more information will be provided with the final version of the Companion Guide***

4.5 OTHER RESOURCES

- **Washington Publishing Company**

  The Implementation Guides for X12N and all other HIPAA standard transactions are available electronically at www.wpc-edi.com.

- **ASC X12 Organization**

  http://www.x12.org/

- **United States Department of Health and Human Services (HHS)**

  This site is a resource for the Notice of Proposed Rule Making, rules and other information about HIPAA:
  www.aspe.hhs.gov/admnsimp

- **Workgroup for Electronic Data Interchange (WEDI)**

  A workgroup dedicated to improving health-care through electronic commerce, which includes the Strategic National Implementation Process (SNIP) for complying with the administrative simplification provisions of HIPAA:
  www.wedi.org

- **North Carolina Department of Health and Human Services**

  www.ncdhhs.gov

- **North Carolina Division of Medical Assistance**

  http://www.ncdhhs.gov/dma/

- **North Carolina Division of Mental Health/Development Disabilities/Substances Abuse Services**

  http://www.ncdhhs.gov/mhddsas/

- **North Carolina Division of Public Health**
  http://publichealth.nc.gov/

5. Change Summary

Date	Change	Responsible Party
November 16, 2012	Initial trading partner test version	CSC under the direction of NC DHHS