Healthcare Eligibility Benefit Inquiry & Response (270/271)
A High-Level Comparison of v4010A1 to v5010
and
The CAQH CORE Operating Rules Help

National HIPAA Audio Conference
Analysis of Proposed Rules Regarding Transactions/Code Sets and the ICD-10
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High-Level Comparison: v4010A1 to v5010

v4010A1	v5010
Minimum required response when person is located in eligibility system	Minimum required response when person is located in eligibility system
Yes/No status of health plan coverage	*Status of health plan coverage*
	Plan begin date
	Benefit begin date when different than plan begin date
	Health plan name if one exists
	Additional patient demographic data needed to identify person on subsequent transactions, e.g., claim
	PCP if applicable
	Other payers if known
	Information about 10 other service types when 270 is a generic inquiry ONLY when status codes are 1-5; it not a covered benefit, do not return information about the code

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High-Level Comparison: v4010A1 to v5010

v4010A1	v5010
No requirement to return patient liability information	Recommends returning patient liability information but does not require it
No requirement to differentiate patient liability for in and out of network providers	No requirement to differentiate patient liability for in and out of network providers
No requirement to specify when a benefit is not covered for out of network providers	No requirement to specify when a benefit is not covered for out of network providers
No requirement for providers on submitting patient identification data elements: *all 4 maximum allowed identifying data elements assigned situational usage*	No requirements for providers on submitting patient identification data elements: *all 4 maximum identifying data elements assigned situational usage*
Identification of person who is the subject of the inquiry as either subscriber or dependent *Defined in §1.3.2 a subscriber is a person who can be uniquely identified to an information source.*	Identification of person who is the subject of the inquiry as either subscriber or dependent *Defined in §1.4.2 a subscriber is a person who can be uniquely identified to an information source* ***by a unique Member Identification Number.***
Limited Search Options and maximum data set that can be required by health plans to locate patient in eligibility system	Additional Alternate Search Options that must be supported by health plans to locate patient in eligibility system *Same maximum data set with different combinations of data elements*

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High-Level Comparison: v4010A1 to v5010

v4010A1	v5010
Insufficient set of service type codes	More service type codes added (38) but still insufficient for today's health plan product market; process to add codes lengthy and non responsive to rapidly changing market
No mechanism to identify when a service type is a preventive service – needed for high-deductible health plans	No mechanism to identify when a service type is a preventive service – needed for high-deductible health plans
Overly general and ambiguous definitions of some service type and date codes	Overly general and ambiguous definitions of some service type and date codes
EB segment can return information for only one service type codes, requiring multiple EB segments to convey comprehensive information about a benefit	EB segment re-designed to be able to return up to 99 service type codes when the benefit information is the same for all
Situational rules often not clearly and unambiguously stated – lots of room for interpretation	Updated situational rules language to remove ambiguousness and room for interpretation
No requirement for real-time processing mode	No requirement for real-time processing mode
No requirement for consistent use of standard acknowledgements (TA1/997)	Use of TA1 not required Use of 997 not required Use of 999 required for real time processing mode only when transaction is rejected and reason for rejection cannot be reported in AAA segment Use of 999 is required for batch processing mode for both compliant and non-compliant transactions

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CAQH/CORE Phase I and Phase II Operating Rules

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Phase I 270/271 Data Content Rule

- Specifies what must be included in the 271 response to a Generic 270 inquiry or a non-required CORE service type
- Response must include
  - The status of coverage (active, inactive)
  - The health plan coverage begin date
  - The name of the health plan covering the individual (if the name is available)
  - The status of nine required service types (benefits) in addition to the HIPAA-required Code 30
    - 1-Medical Care
    - 33 - Chiropractic
    - 35 - Dental Care
    - 47 - Hospital Inpatient
    - 50 - Hospital Outpatient
    - 86 - Emergency Services
    - 88 - Pharmacy
    - 98 - Professional Physician Office Visit
    - AL - Vision (optometry)

CORE Data Content Rule also Includes Patient Financial Responsibility

- Co-pay, co-insurance and base contract deductible amounts required for
  - 33 - Chiropractic
  - 47 - Hospital Inpatient
  - 50 - Hospital Outpatient
  - 86 - Emergency Services
  - 98 - Professional Physician Office Visit
- Co-pay, co-insurance and deductibles (discretionary) for
  - 1- Medical Care
  - 35 - Dental Care
  - 88 - Pharmacy
  - AL - Vision (optometry)
  - 30 - Health Benefit Plan Coverage
- If different for in-network vs. out-of-network, must return both amounts
- Health plans must also support an explicit 270 for any of the CORE-required service types

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Phase II 270/271 Data Content Rule

- Builds and expands on Phase I eligibility content
- Requires health plan to support explicit 270 eligibility inquiry for 39 service type codes
- Response must include all patient financial liability *(except for the 8 discretionary service types; a few codes from Phase I and mental health codes added in Phase II)*
    - Base contract deductible *AND* remaining deductible
    - Co-pay
    - Co-insurance
    - In/out of network amounts if different
    - Related dates
    - Whether or not benefit is covered for out-of-network
- Recommended use of 3 codes for coverage time period for health plan
    - 22 – Service Year (a 365-day contractual period)
    - 23 – Calendar year (January 1 through December 31 of same year
    - 25 – Contract (duration of patient's specific coverage

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Phase II: 270/271 Patient Identification Rules

- Normalizing Patient Last Name
  - **Goal**: Reduce errors related to patient name matching due to use of special characters and name prefixes/suffixes
    - Recommends approaches for submitters to capture and store name suffix and prefix so that it can be stored separately or parsed from the last name
    - Requires health plans to normalize submitted and stored last name before using the submitted and stored last names:
      - Remove specified suffix and prefix character strings
      - Remove special characters and punctuation
    - If normalized name validated, return 271 with CORE-required content
    - If normalized name validated but un-normalized names do not match, return last name as stored by health plan and specified INS segment
    - If normalized name not validated, return specified AAA code
    - Recommends that health plans use a no-more-restrictive name validation logic in downstream HIPAA transactions than what is used for the 270/271 transactions

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Phase II: 270/271 Patient Identification Rules

- Use of AAA Error Codes for Reporting Errors in Subscriber/Patient Identifiers & Names in 271 response
  - **Goal**: Provide consistent and specific patient identification error reporting on the 271 so that appropriate follow-up action can be taken to obtain and re-send correct information
    - Requires health plans to return a unique combination of one or more AAA segments along with one or more of the submitted patient identifying data elements in order to communicate the specific errors to the submitter
    - Designed to work with any search and match criteria or logic
    - The receiver of the 271 response is required to detect all error conditions reported and display to the end user text that uniquely describes the specific error conditions and data elements determined to be missing or invalid

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Overview of CORE Requirements by Phase

Transaction Type and Standard Data Content		Phase I*		Phase II*
Eligibility/ Benefits	Static *Patient Financial Responsibility,* e.g. co-pay, base deductible	X		X
	Remaining *Patient Financial Responsibility, e.g,* remaining deductible for benefit plan and 40+ service types			X
	Data to Support Financials, e.g. dates, in/out of network differences	X		X
	Use of transaction under "Basic Level" Infrastructure/Policy Requirements	X		X
	Use of transaction under "Enhanced 1" Infrastructure/Policy Requirements			X
Claims Status	Use of transaction under "Basic Level" Infrastructure/Policy Requirements			X
Infrastructure/Policy Requirements to Help Data Flow / Gain Provider Use				
Basic Level	• Policy requirements: Must offer CORE-certified capabilities to ALL trading partners • Infrastructure requirements: ❑ Real-time: 20-seconds AND batch turn around requirements ❑ System availability: 86% ❑ Connectivity: Internet connection with basic HTTP – certified entity uses own specifications, e.g. SOAP with WSDL ❑ Standard acknowledgements for batch and real-time, e.g. similar to fax machine acknowledgement ❑ Standard Companion Guide *Format and flow*	X		X
Enhanced 1	"Basic Level", plus, additional Infrastructure requirements: ❑ Patient identification rules ❑Standard error codes ❑Normalizing names ❑ Connectivity: Must offer two existing envelope standards using CORE-approved specifications, e.g. allows for direct connect, PHR transfers			X

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