HIPAA Transaction Companion Guide: Health Care Eligibility Benefit Inquiry and Response

Refers to the Implementation Guide Based on
ASC X12N Version 005010X279A1
Eligibility Inquiry and Response (270/271)

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Preface

This Companion Guide to the v5010 ASC X12N Standards for Electronic Data Interchange Technical Report Type 3 adopted under HIPAA clarifies and specifies the data content for exchanging transactions electronically with UnitedHealthcare for members with AARP Supplemental Plans. Transactions based on this companion guide, used in tandem with the v5010 ASC X12N Technical Report Type 3, are compliant with both ASC X12 syntax and the Technical Report Type 3 implementation guide. This companion guide is intended to convey information that is within the framework of the ASC X12N Technical Report Type 3 implementation guide adopted for use under HIPAA. This companion guide is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the implementation guide.

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EDITOR'S NOTE:

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1. INTRODUCTION

This is a Companion Guide to the Accredited Standards Committee (“ASC”) X12 Standards for Electronic Data Interchange Technical Report Type 3 Health Care Eligibility Benefit Inquiry and Response 270/271 (005010X279A1). This document provides information to explain and specify the data content used in electronic eligibility transactions for AARP Supplemental Plans insured by UnitedHealthcare Insurance Company (“UnitedHealthcare”). This guide is intended to supplement the ASC X12 Technical Report Type 3 (“TR3”).

Within this document, the Health Care Eligibility and Benefit Inquiry Response ASC X12N 271 may be detailed with the use of tables. When used, the tables contain a row for each segment for which UnitedHealthcare explains codes and usage specific to transactions for AARP Supplemental Plans, information over and above the information in the TR3. That information can do the following:
1. Limit the repeat of loops, or segments
2. Limit the length of a simple data element
3. Specify a sub-set of the TR3’s internal code listings
4. Clarify the use of loops, segments, composite and simple data elements
5. Provide any other information tied directly to a loop, segment, and composite or simple data element pertinent to trading electronically with UnitedHealthcare

The following table is an example of the use of a table to explain eligibility and benefit response information specific to AARP Supplemental Plans.

Page #	Loop ID	Reference	Name	Codes	Length	Notes/Comments
254	**2100C**	**NM1**	**Subscriber Name**			This type of row always exists to indicate that a new segment has begun. Notes or comment about the segment itself will be found here.
257	2100C	NM109	Subscriber Primary Identifier		**11**	This type of row exists to limit the length of the specified data element. For example, no more than 11 characters are used for the insured member’s member identification number in NM109.
294	**2110C**	**EB**	Subscriber Eligibility or Benefit Information			
303	2110C	EB04	Insurance Type Code	**SP, GP, IN**		This type of row calls attention to the segment identifier and the codes used. For example, SP, GP, and IN are the only codes transmitted EB04 of the 271 response for AARP Supplemental Plans insured by UnitedHealthcare Insurance Company.
				SP		This type of row exists when a note for a particular code value is used or required. For example, the value SP indicates that the plan is an AARP Medicare Supplement Plan.

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1.1 SCOPE

This document is intended to supplement the ASC X12 Standard for Electronic Data Interchange Technical Report Type 3 (“TR3”) Health Care Eligibility Benefit Inquiry and Response 270/271 (005010X279A1), in the electronic exchange of eligibility information for people who have AARP Supplemental Plan coverage insured by UnitedHealthcare Insurance Company. This guide is not intended to replace, or exceed the data requirements specified in, the TR3.

1.2 OVERVIEW

This companion guide will replace, in total, the previous version of the “**AARP Medicare Supplemental Insurance Plans Insured by United Healthcare Insurance Company Companion Guide**” for Health Care Eligibility and Benefit Inquiry and Response and must be used in conjunction with the TR3 instructions. This companion guide is intended to assist you in implementing electronic Eligibility and Benefit transactions that meet UnitedHealthcare processing standards, by identifying pertinent structural and data related requirements and recommendations.

Updates to this companion guide will be accessible at https://www.UHCprovider.com. On the home page, click the “Menu” at the top left, and select “Resource Library,” then “Electronic Data Interchange” in the menu on the left or midway down the page. In the menu on the left select “EDI Companion Guides,” and then “270/271: Eligibility and Benefit Inquiry and Response,” and “270/271: AARP Supplemental Plans (005010X279A1.

1.3 REFERENCE

For more information regarding the ASC X12 Standards for Electronic Data Interchange 270/271 Health Care Eligibility and Benefit Inquiry and Response (005010X279A1), and to purchase copies of the TR3 documents, consult the ASC X12 web site at http://store.x12.org.

1.4 ADDITIONAL INFORMATION

The American National Standards Institute (ANSI) is the coordinator for information on national and international standards. In 1979 ANSI chartered the Accredited Standards Committee (ASC) X12 to develop uniform standards for electronic interchange of business transactions and eliminate the problem of non-standard electronic data communication. The objective of the ASC X12 Committee is to develop standards to facilitate electronic interchange relating to all types of business transactions. The ANSI X12 standards are recognized by the United States as the standards for North America. Electronic Data Interchange (EDI) adoption has been proven to reduce the administrative burden on providers.

2. GETTING STARTED

2.1 WORKING WITH UNITEDHEALTHCARE

UnitedHealthcare currently uses Optum Clearinghouse Services (“Optum Clearinghouse”) as the exclusive clearinghouse for managing Eligibility and Benefit transaction connections for AARP Supplemental Plans. If your current clearinghouse is not a trading partner with UnitedHealthcare, please contact your clearinghouse vendor regarding their ability to work with Optum Clearinghouse for the 270/271 transactions.

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If you have an Optum Clearinghouse account, please contact your Optum Clearinghouse account manager. If you do not have an Optum Clearinghouse account manager and are interested in learning about Optum Clearinghouse services, please contact the Optum Clearinghouse Sales Team at 866-367-9778, option 3, for more information.

2.2 TRADING PARTNER REGISTRATION

Optum Clearinghouse currently manages the Eligibility Benefit Inquiry and Response transaction connectivity for AARP Supplemental Plans insured by UnitedHealthcare. Before exchanging benefit eligibility information for members with AARP Supplemental Plans insured by UnitedHealthcare, you must register with Optum Clearinghouse. For information regarding trading partner registration with Optum Clearinghouse, please contact the Optum Clearinghouse Sales Team at 866-367-9778, option 3.

2.3 CERTIFICATION AND TESTING OVERVIEW

UnitedHealthcare Insurance Company is CORE Phase I and Phase II certified.

For information regarding 270/271 transaction testing for AARP Supplemental Plans, please contact your current clearinghouse vendor or Optum Clearinghouse account manager.

3. TESTING WITH UNITEDHEALTHCARE

Physicians and Healthcare professionals should contact their current clearinghouse vendor regarding testing with Optum Clearinghouse of the 270/271 transactions for AARP Supplemental Plans.

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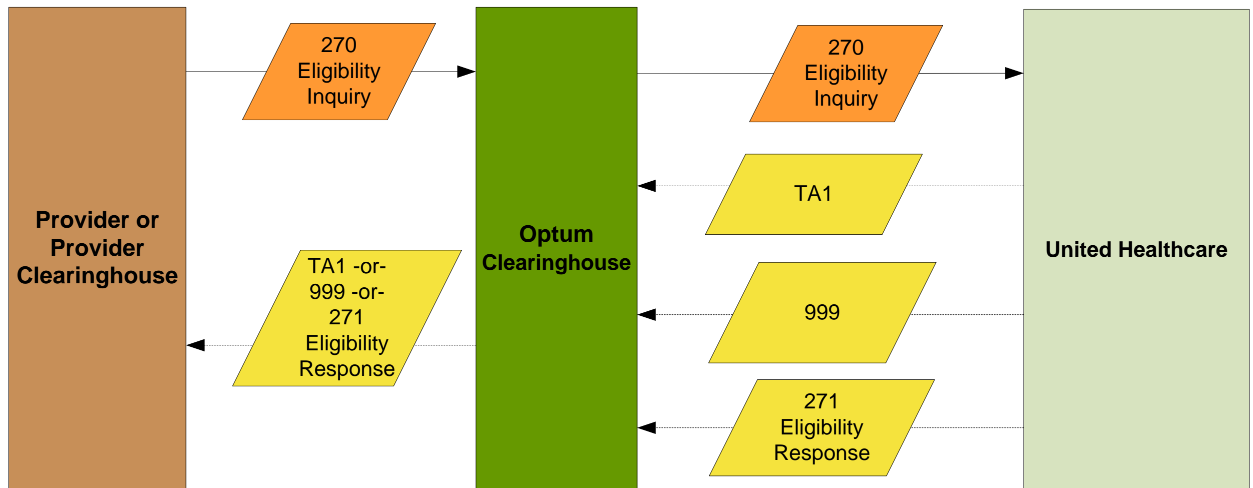
4. CONNECTIVITY WITH UNITEDHEALTHCARE

4.1 PROCESS FLOWS

Real-time Eligibility Benefit Inquiry and Response:

The response to a real-time benefit inquiry ad response transaction will consist of one of the following:

1. First level response – a TA1 will be generated if errors occur within the outer envelope.
2. Second level response – 270 transactions which fail compliance checks will generate a real-time 999 message back to the sender with an error message indicating the nature of the compliance error.
3. Third level response:
    - Transactions that pass compliance checks, but fail to process (e.g. due to member not being found) will generate a real-time 271 response transaction including an AAA error segment indicating the nature of the error and suggested follow-up action.
    - Transactions which pass compliance checks and do not have errors will return a 271 with requested eligibility and benefit information.



4.2 TRANSMISSION ADMINISTRATIVE PROCEDURES

Only real-time mode is supported for AARP Supplemental Plans insured by UnitedHealthcare Insurance Company.

4.3 RE-TRANSMISSION PROCEDURE

Please review the 271 AAA data segment for information regarding what data corrections need to be made in order to submit a successful request and receive the requested information in response.

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4.4 COMMUNICATION PROTOCOL SPECIFICATIONS

Physicians and healthcare providers are advised to contact their current clearinghouse vendor to discuss communication protocol specifications. The provider's clearinghouse may work with Optum Clearinghouse to address questions regarding communication protocols.

4.5 PASSWORDS

Physicians and healthcare providers are advised to contact their current clearinghouse vendor to discuss password policies.

Questions about Optum Clearinghouse passwords must be directed to Optum Clearinghouse.

4.6 SYSTEM AVAILABILITY

Optum Clearinghouse provides information regarding downtime for their regularly-scheduled maintenance on the Optum EDI Client Center page at https://iedi.optum.com. During these maintenance outages, Optum Clearinghouse will be unavailable for eligibility inquiry and response transactions.

Optum Clearinghouse also provides information to their EDI clients regarding UnitedHealthcare system availability when planned outages are scheduled to occur. During UnitedHealthcare system downtime, eligibility inquiry and response transactions may be impacted or unavailable.

4.7 COSTS TO CONNECT

Healthcare trading partners who use Optum Clearinghouse incur no transaction costs. Healthcare professionals who use other clearinghouses should contact their clearinghouse vendor to discuss costs.

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5. CONTACT INFORMATION

5.1 EDI CUSTOMER SERVICE

If you have questions related to transactions submitted through a clearinghouse, please contact your clearinghouse vendor.

If you have an Optum Clearinghouse account, please contact your Optum Clearinghouse account manager with questions related to eligibility benefit inquiry and response transactions.

5.2 EDI TECHNICAL ASSISTANCE

Clearinghouse

- When receiving the 271 from a clearinghouse, please contact the clearinghouse for EDI technical assistance.

UnitedHealthcare EDI Support

- Report EDI issues online by using the “EDI Transaction Support Form” at https://www.UHCprovider.com. Click “Resource Library,” “Electronic Data Interchange,” and “EDI Contacts” to access the “EDI Transaction Support Form.”

5.3 PROVIDER SERVICES NUMBER

If you have questions regarding the details of a member’s AARP Supplemental Plan coverage, please call 800-227-7789 to speak with a Provider Services specialist.

5.4 APPLICABLE WEBSITES

- **CAQH CORE** – http://www.caqh.org, provides access to the Council for Affordable Quality Healthcare (“CAQH”) Committee on Operating Rules for Information Exchange (“CORE”) website
- **AARP Supplemental Plans insured by UnitedHealthcare Insurance Company –** http://aarpprovideronlinetool.uhc.com, provides access to information regarding AARP members’ supplemental health plans insured by UnitedHealthcare Insurance Company and consideration of claims under those plans
- **Optum Clearinghouse Services** – https://iedi.optum.com provides information regarding Optum Clearinghouse services
- **ASCX12** – http://store.x12.org provides access to ASCX12 electronic data interchange products
- **UHCprovider.com -** Updates to this companion guide will be available at UHCprovider.com, and can be accessed at https://www.UHCprovider.com, by clicking “Resource Library” from the drop-down menu, then “Electronic Data Interchange,” “EDI Companion Guides,” “270/271: Eligibility and Benefit Inquiry and Response,” and “270/271: AARP Supplemental Plans (005010X279A1).”

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6. CONTROL SEGMENTS / ENVELOPES

6.1 ISA-IEA

Transactions transmitted during a session are identified by an interchange header segment (ISA) and by an interchange trailer segment (IEA) which form the envelope enclosing the transmission. Each ISA marks the beginning of the transmission and provides sender and receiver identification.

The ISA data segment is a fixed length record and all fields must be supplied. Fields that are not populated with actual data must be filled with spaces.

- The first element separator (byte 4) in the ISA segment defines the data element separator to be used through the entire interchange (*).
- ISA-11 defines the repetition separator used throughout the transaction (^).
- The ISA segment terminator (byte 106) defines the segment terminator used throughout the entire interchange (~).
- ISA16 defines the component-element separator to be used throughout the transaction (:).

The table below identifies the ISA field for which UnitedHealthcare requires a specific value to appropriately indicate that the inquiry is for a patient's AARP Supplemental Plan insured by UnitedHealthcare. The table does not describe all of the fields necessary for a successful transaction. Please refer to the TR3 for that information.

Page #	LOOP ID	Reference	NAME	Codes	Length	Notes/Comments
C.3	**None**	**ISA**	**ISA Interchange Control Header**			
C.5		ISA08	Interchange Receiver ID	**36273 or 362739571**		Electronic Payer ID for AARP Supplemental Plans insured by UnitedHealthcare -Right pad as needed with spaces to 15 characters.

Please refer to the Technical Report Type 3 ("TR3") for Health Care Eligibility Benefit Inquiry and Response (270/271) transactions for detailed information regarding the interchange control header (ISA) and interchange control trailer (IEA) segments.

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6.2 GS-GE

UnitedHealthcare conforms to the rules for element usage detailed in the ASC X12 Standards for Electronic Data Interchange Technical Report Type 3 (“TR3”) for Health Care Eligibility Benefit Inquiry and Response (270/271) transactions. Please refer to the TR3 for the appropriate functional group header (GS) and functional group trailer (GE) field values for the benefit eligibility inquiry and response transactions.

The table below references only those GS fields for which UnitedHealthcare requires a specific value for inquiries regarding AARP Supplemental Plans, or for which additional guidance is provided regarding what the value should be in the 270 request. The table does not describe all of the fields necessary for a successful transaction. Please refer to the TR3 for that information.

Page #	LOOP ID	Reference	NAME	Codes	Length	Notes/Comments
C.7	**None**	**GS**	**Functional Group Header**			
C.7		GS03	Application Receiver's Code	**36273 or 362739571**		Electronic Payer ID Code for AARP Supplemental Plans insured by UnitedHealthcare
C.8		GS08	Version/ Release/ Industry Identifier Code	**005010X279A1**		Version of the EDI standard expected for the transaction to be received by UnitedHealthcare.

6.3 ST-SE

UnitedHealthcare conforms to the rules for element usage detailed in the ASC X12 Standards for Electronic Data Interchange Technical Report Type 3 (“TR3”) for Health Care Eligibility Benefit Inquiry and Response (270/271) transactions. Please refer to the TR3 for the appropriate transaction set header (ST) and transaction set trailer (SE) field values for the benefit eligibility inquiry and response transactions.

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6.4 CONTROL SEGMENT HIERARCHY

Real time benefit eligibility and benefit requests (270 transactions) will contain only one inquiry using the following hierarchy:

ISA - Interchange Control Header segment
  GS - Functional Group Header segment
    ST - Transaction Set Header segment
      270 Transaction
    SE - Transaction Set Trailer segment
  GE - Functional Group Trailer segment
IEA - Interchange Control Trailer segment

7. PAYER SPECIFIC BUSINESS RULES AND LIMITATIONS

7.1 270 REQUEST

1. Identifying data elements for the patient should be submitted in the subscriber detail, “Subscriber Name” segments, Loop ID 2100C.

2. Individuals covered under AARP Supplemental Plans are considered “subscribers”; however, if the “Dependent Name” segment in Loop ID 2100D of the 270 request is used to identify the individual for whom eligibility information is being requested, this information will be used to search for a covered individual.

3. Be certain to enter the patient’s full member ID number, including any leading zeroes, shown on the ID card to improve the search efficiency. (Dashes are not required.)

4. Social Security Numbers are not used in the eligibility search.

5. Multiple Birth Sequence Number (2100C/D loop, data element INS17) is not used in the eligibility search.

6. At this time, eligibility requests containing multiple service type codes in 2110C/D EQ01 and using the repetition function of EQ01 (e.g., EQ*1^33^98~) will be processed as if an EQ01 value of “30” is submitted. Please submit individual explicit 270 requests for specific service types if the generic response will not provide the information needed.

7. Eligibility requests containing multiple 2110C/D EQ segments will result in 999 transaction responses.

8. Eligibility requests for a date range will return all of the member’s plans that are applicable for the requested date range. Any plans active during the date range will be returned.

9. Single dates, or date range start dates, must not be greater than 18 months in the past. A 271 AAA03 value of 62 will be returned if the date range fails validation.

10. Single dates, or the date range end date, must be no greater than the end of the current month. A 271 AAA03 value of 62 will be returned if the date range fails validation.

11. The search logic uses a combination of the following data elements: membership ID (when at least 9 digits of the 11-digit number are submitted), last name, first name and date of birth

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("DOB"). It is recommended that the maximum number of data elements be used in the 270 search in order to provide the best chance of finding a member; however, all data elements are not required. Cascading search logic will go through the criteria supplied and attempt to find a match. If a match is not found or multiple matches are found, a 271 response will be sent to the user indicating, if possible, what criteria needs to be supplied to find a match. It should be noted that while 9 or 10 digits of the member ID will be accepted in the request, submitting the full 11-digit ID optimizes the search process.

The following table describes the data for each search scenario that will be supported. If the necessary data elements are not sent to satisfy one of the below scenarios (e.g., if only the member ID is submitted), a 271 AAA03 error will be returned specifying the data that must be included in the request to enable the search, and a subsequent 270 request with the required additional data elements will need to be submitted.

SCENARIO	9, 10, or 11 digit Patient/Member ID	Last Name	First Name	Patient DOB
1	x	x	x	x
2	x	x		x
3	x		x	x
4	x			x
5	x	x	x	

7.2 271 RESPONSE

AARP Supplemental Plans insured by UnitedHealthcare are supplemental health insurance products.

- AARP Medicare Supplement Plans and Riders are identified as insurance type "SP" ("Supplemental Policy") in EB04. Payment determination under the Medicare Supplement Plans only occurs after the claim is processed by Medicare and considered under the Medicare Supplement Plan or Rider according to the plan benefits.
- Other AARP Supplemental plans are identified as insurance type "IN" ("Indemnity") in EB04, and these plans pay fixed benefits for various types of services irrespective of the costs for those services. These plans are not intended to, and do not, reimburse the cost of medical care.

The eligibility and benefit information provided in the 271 is not a guarantee or promise of payment.

The following items provide additional information regarding the eligibility response transaction process and response content for AARP Supplemental Plans.

7.2.1 The search for active coverage is specific to the date submitted in the inquiry, or the date of the inquiry if no date is specified.

7.2.2 When an insured member with coverage active during the inquired-upon date is located, the eligibility response will populate loop 2100C EB03 with "30" and DTP01 with '346' with the start date and end date, if applicable, of the coverage period pertinent to the inquiry, such as a calendar year. The start date referenced in the eligibility response is not necessarily the historical effective date of the member's plan.

a. When only one date is sent in the response, the date represents the member's eligibility start date, and DTP02 will be valued with 'D8'.

Example 1:

Response to request for service dates in 2019 reflects health plan coverage begin date with no termination date:

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DTP*346*D8*20190201~ = Member eligibility started on 02/01/2019

Example 2:
Response to request for service dates in 2019 reflects health plan coverage with no termination date and reference to current coverage period based on dates in inquiry:
DTP*346*D8*20190101~ = Member eligibility information for the 2019 calendar year

b. When the coverage, or the eligibility period, has an end date, the DTP02 value of 'RD8' will be returned in addition to both the coverage start date and the coverage end date.

Example 1:
Health plan coverage with termination date:
DTP*346*RD8*20180201-20180731~ = Member eligibility started on 02/01/2018 and ended on 07/31/2018

Example 2:
Eligibility period for a prior year:
DTP*346*RD8*20180101-20181231~ =Member eligibility for services in 2018

7.2.3 If the insured member has active Medicare Supplement Plan coverage for the date in question, the 271 response may include "benefit description" (EB*D) segments and message text (MSG) that provide general information regarding the benefits available under the plan.

Benefit description example:
EB*D**48~
MSG*Plan pays the Medicare Part A deductible~
(Plan pays the Medicare Part A deductible for in-patient hospital stays)

7.2.4 UnitedHealthcare supports explicit eligibility inquiries for the service types specified in the CORE Operating Rules (Phase I and Phase II). Explicit inquiries for other service types will result in a generic (service type 30) eligibility response.

8. ACKNOWLEDGEMENTS AND OR REPORTS

8.1 REPORT INVENTORY

Not applicable

9. TRADING PARTNER AGREEMENTS

9.1 TRADING PARTNERS

Trading partner agreements define and document the relationship between electronic data interchange trading partners, which, for the purpose of this document, are defined as any party (health care provider, billing service, software vendor, financial institution, etc.) that transmits EDI data directly to, and receives EDI data directly from, UnitedHealthcare.

UnitedHealthcare is not currently establishing direct connections with healthcare providers for the purpose of exchanging electronic data for members who have AARP Supplemental Plans. Rather, UnitedHealthcare exchanges electronic data with providers through Optum Clearinghouse. Therefore, providers and their clearinghouses will not have trading partner agreements with UnitedHealthcare specifically for electronic data exchange for their patients who have AARP Supplemental Plans. However, providers or their clearinghouses may need to establish trading

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partner agreements with Optum Clearinghouse. For information regarding trading partner registration with Optum Clearinghouse, please contact the Optum Clearinghouse Services Sales Team at at 866-367-9778, option 3.

10. TRANSACTION SPECIFIC INFORMATION

10.1 ELIGIBILITY BENEFIT REQUEST 270 (05010X279A1)

Please provide the following when submitting eligibility benefit inquiries for patients with AARP Supplemental Plans insured by UnitedHealthcare:

- Payer ID 36273 in element NM109 (Identification Code) of Loop 2100A (Information Source Name).
- At least 10 digits of the patient's membership identification number in element NM109 (Identification Code) of Loop 2100C (Subscriber Name). Use of the member ID increases the likelihood of a successful and accurate response. The patient's membership identification number can be found on the AARP Supplemental Health Plan Insurance ID card issued by UnitedHealthcare. Please use leading zeroes, if indicated on the ID card. Dashes are not required.
- Patient information should be submitted in the "Subscriber Name" loop, Loop ID 2100C, of the inquiry.

10.2 ELIGIBILITY BENEFIT RESPONSE 271 (005010X279A1)

Eligibility benefit responses for patients with AARP Supplemental Plans insured by UnitedHealthcare conform to the ASC X12 Standard for Electronic Data Interchange Technical Report Type 3 Health Care Eligibility Benefit Inquiry and Response 270/271 (005010X279A1).

11. APPENDICES

11.1 IMPLEMENTATION CHECKLIST

A basic checklist for establishing eligibility benefit inquiry and response transaction capability is as follows:

1. Register and complete any necessary contract with Trading Partner
2. Establish connectivity
3. Send test transactions
4. If testing succeeds, proceed to send production transactions

11.2 BUSINESS and TRANSMISSION SCENARIOS

Various business and transmission scenarios may be found in the ASC X12 Standard for Electronic Data Interchange Technical Report Type 3 Health Care Eligibility Benefit Inquiry and Response 270/271 (005010X279A1). A copy of the Technical Report Type 3 may be obtained from ASC X12 at http://store.x12.org.

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11.3 FREQUENTLY ASKED QUESTIONS

1. ***Does this Companion Guide apply to all UnitedHealthcare payers?***
   No. This Companion Guide applies only to business for AARP Supplemental Plans insured by UnitedHealthcare Insurance Company using electronic payer ID 36273.

2. ***If a 270 is successfully transmitted to UnitedHealthcare, are there any situations that would result in no response being sent back?***
   No. UnitedHealthcare will always send a response. Even if UnitedHealthcare's systems are down and the transaction cannot be processed at the time of receipt, a response detailing the situation will be returned.

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11.4 CHANGE SUMMARY

Version	***Release date***	***Changes***
1.0	December 2011	Initial External Release – Changes to comply with HIPAA 5010 (Eligibility Transaction Requirements) This functionality is planned for December, 2011.
2.0	October 2015	Updated to address enhancements to 271 functionality
3.0	July 2016	• Added information regarding the need to submit identifying information in the Subscriber Name loop • Updated transaction header information
4.0	October 2019	Updated to address enhancements to 270/271 functionality
4.1	November 2019	Updated telephone number in “Trading Partner” section of document
4.2	November 2019	Updated “UnitedHealthcareOnline.com” to reflect current webpage, “UHCprovider.com”

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