

# *Administrative Simplification*

A program of the Washington Healthcare Forum  
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## Best Practice Recommendation for

### *Requesting and Receiving Coverage Information for Eligibility and Benefits (270-271 5010 Transaction & Web Access)*

**For use with ANSI ASC X12N 270/271 (005010X279E1)  
Health Care Eligibility Benefits  
Inquiry and Response Implementation Guide**

Version	
Issue Date	Explanation
02-14-2011	Initial release
03-15-2011	Clarified the benefit information that will be provided for Mental Health (pg.7)
08-16-2011	Amended: Change Service Delivery Limits to Visit Limits
12-14-2011	Aligned Web-Based Information to be consistent with transaction (pg 9-10). Added Service Types (pg 44)
02-01-2012	Change “Lifetime Payment Maximum” to ‘Yearly or Lifetime Payment Maximum” (pg. 6)

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Best Practice Recommendation  
**Requesting and Receiving Coverage Information for Eligibility and Benefits**

- Topic:** Minimum standard set of eligibility and benefits coverage information
- Goals:**
- 1) Define an acceptable set of coverage information that will allow a provider to obtain a general idea about a patient's cost share for a service or treatment (e.g. they will know there is a 20% coinsurance but not \$43.29 in patient liability)
  - 2) Reduce the need for telephone calls to obtain eligibility and benefits related information about a patient
- Summary:** This document outlines the minimum standard set of eligibility and benefits information that should be available to providers whether they access health plan web sites directly or use the 5010v of the HIPAA 270-271 transaction set.
- Applicability:** All providers and health plans are encouraged to follow these recommended Best Practices. However, providers should be aware that information received from the following organizations may not be consistent with this best practice:
- Medicare
  - Self-funded plans
  - FEP
  - Blue Card
  - NASCO
  - And there may be others

## Overview

This Best Practice Recommendation BPR outlines a set of information that should be communicated by the health plans to provider organizations about a patient's eligibility and benefits coverage. This information will be communicated via two different methods:

- a) on the health plan's web site, and
- b) in a HIPAA 271 transaction

The information may be also available from a Customer Service type department. The information must be consistent across all available sources.

*All of the information outlined in the BPR must be communicated via a health plan's transaction and web site, though the formatting/presentation of the information may vary depending upon the method.* For a specific patient at a given point in time, the information presented in the transaction and on the web must match, though there doesn't need to be a specific field on the web site that corresponds exactly to every field in the transaction. As an example, the BPR calls for the health plan to communicate whether or not a patient has eligibility. In the transaction,

that information will be communicated by placing a value in a particular field. On the web site, that same information may be communicated simply by presenting eligibility and benefits information, i.e. the web site may not have a single, specific display field that states that coverage is in place.

*The web site content is not limited to the information that can be contained in the transaction. A health plan's web site and their transaction must convey the set of information outlined in this BPR. However, on their web sites, health plans may expand beyond the set of information that can fit in the transaction. All of a patient's eligibility and coverage information that is displayed on a health plan's web site should be clearly conveyed and easily accessible to a provider.*

Reminder: This BPR only discusses a subset of the information to be exchanged in the transactions and on the web site.

### **Transaction Compliance with the HIPAA Mandated TR3**

This BPR Document is intended to accompany the Technical Report Type 3 (TR3), previously referred to as the Implementation Guide, for the ASC X12N Health Care Eligibility Benefit Inquiry Response 270-271 Transactions. A complete version of the TR3s can be purchased at <http://www.wpc-edi.com>.

Health plans must be able to receive a compliant 270 transaction and produce and send a compliant 271 transaction to the provider or a clearinghouse. The HIPAA mandated 270-271 TR3 specifies the complete set of requirements that must be met in order to be compliant. One of the objectives of this BPR document is to recommend practices for how the 270-271 transaction should be used to accomplish specific business objectives related to the exchanging of eligibility and benefits information.

*The intent of this BPR document is to expand upon and NOT to repeat the requirements contained in the TR3. However, requirements from the TR3 will be included in this document when the requirement was in the 4010A1v but was typically not followed OR is new to the 5010v and, as such, may be overlooked in the implementation process, AND would significantly enhance administrative simplicity if it was followed. In these cases, the appropriate section of the TR3 will be referenced, but the details of the requirement will not be repeated*

### **Minimum Standard Set of Eligibility and Benefits Information**

The Best Practice Recommendation will call for health plans to make benefit information available by service type. As the demand for and usefulness of providing benefit information at the diagnosis and/or procedures level has not been established, it will not be included as a Best Practice Recommendation.

A patient's eligibility coverage and benefit information varies depending upon the specific plan in which they are enrolled. The capabilities and information listed in each of the following

sections represent the *minimum* set of information to be provided by a health plan, *to the extent that it is appropriate for the specific patient's plan and the information is available to the health plan*. If a listed information element, e.g. deductible, PCP, etc., is not appropriate for the patient's plan or is not electronically available to the health plan, the element may not be presented for that patient. Health plans may always provide more capabilities and information depending upon their policies and level of system sophistication.

Health plans will make this set of eligibility and benefits information available on their web site and via a 270-271 transaction set exchange.

This document outlines Best Practice Recommendations for Eligibility Coverage and Benefits information for each of the following categories:

- I. General Eligibility Coverage
- II. Contract Level Benefits Information
- III. Standard Set of Services - Benefit Information
- IV. Explicitly Requested Services - Benefits Information

### I. General Eligibility Coverage

The following information will be provided for every patient, given the availability caveat highlighted above. The information highlighted in **bold** should always be available.

<b>Information Elements</b>
<b>Subscriber Name</b>
<b>Patient Name</b>
<b>Patient's Relationship to Subscriber</b>
<b>Patient Date of Birth</b>
<b>Patient Gender</b>
<b>Patient Member Number</b>
Group Name
<b>Group Number</b>
Plan Type
<b>Coverage Date (aka Policy Effective Date)</b>
Other Coverage <sup>*1</sup>
Primary Care Physician (PCP) <sup>*1</sup>
<b>Eligibility Status</b>

<sup>\*1</sup> - This information should be sent if it is in the health plan's records and appropriate to the coverage. The health plans will send the information that they have. The accuracy of the information cannot be assured.

Note: As more fully described in the Overview section above, *all of the information outlined in the BPR must be communicated via a health plan's transaction and web site, though the formatting/presentation of the information may vary depending upon the method.*

**II. Contract Level Benefits Information**

The following table lists the Contract Level Limitations for which information will be available, given the availability caveat highlighted above.

Contract Level Limits	In-Network Provider				Out-of--Network Provider			
	Individual Coverage		Family Coverage		Individual Coverage		Family Coverage	
	Benefit Limit Amount	Benefit Amount Remain	Benefit Limit Amount	Benefit Amount Remain	Benefit Limit Amount	Benefit Amount Remain	Benefit Limit Amount	Benefit Amount Remain
Deductibles								
Out of Pocket (Stop Loss) Maximums								
Yearly or Lifetime Payment Maximum			N.A.	N.A.			N.A.	N.A.
Spend Down <sup>*1</sup>			N.A.	N.A.			N.A.	N.A.

N.A. - Not Applicable

<sup>\*1</sup> *Spend Down:* The client responsibility amount due from the patient before the health plan (typically Medicaid) begins to have any financial responsibility for their medical benefits and thus before any claims will be paid. (More detail can be found in section 1.4.9 of the TR3.)

For each of the Contract Level Limitations (as appropriate for the health plan), the Benefit Limit Amount and the Benefit Amount Remaining will be provided for Individual, In-Network coverage. These Amounts may be also available for the Family, In-Network coverage, depending upon the specific patient's plan. If and as appropriate to the patient's plan, these Amounts may also be separately described for Out of Network coverage.

**III. Standard Set of Services - Benefit Information**

The following is the baseline set of services for which benefit coverage information should be generally available from health plans as part of a standard request for benefits. For benefits related to other service types, individual requests for those service types should be made.

If the service level benefit is provided by the health plan as part of the member's coverage, the following benefit information will be made available.

Service Type	In-Network Provider					
	Co-Pay	Co-Ins	Service Specific Deductible	Benefit Limit	Visit Limits	Benefit Remain
Medical Care						
Professional (Physician) Visit Office <sup>*1</sup>						
Hospital <sup>*2</sup>						

Service Type	In-Network Provider					
	Co-Pay	Co-Ins	Service Specific Deductible	Benefit Limit	Visit Limits	Benefit Remain
Emergency Services						
Urgent Care						
Mental Health <sup>*3</sup>						
Vision (Optometry) <sup>*4</sup>						
Pharmacy - Prescription <sup>*4</sup>						
Chiropractic						
Dental Care <sup>*3</sup>						

Service Type	Out-of-Network Provider					
	Co-Pay	Co-Ins	Service Specific Deductible	Benefit Limit	Visit Limits	Benefit Remain
Medical Care						
Professional (Physician) Visit Office <sup>*1</sup>						
Hospital <sup>*2</sup>						
Emergency Services						
Urgent Care						
Mental Health <sup>*3</sup>						
Vision (Optometry) <sup>*4</sup>						
Pharmacy - Prescription <sup>*4</sup>						
Chiropractic						
Dental Care <sup>*4</sup>						

- <sup>\*1</sup> - Benefit information will be provided for the following - Physician Visit-Office: Sick and Physician Visit-Office: Well
- <sup>\*2</sup> - Benefit information will be provided for the following - Hospital - Inpatient and Hospital - Outpatient
- <sup>\*3</sup> - Benefit information will be provided for the following - Psychiatric - Inpatient, Psychiatric - Outpatient and Substance Abuse
- <sup>\*4</sup> - In these and other circumstances, the full range of benefits information may not be provided. These circumstances occur when:
  - The tiering of benefits is too complicated to exchange electronically. In this situation, applicability of the benefit and the dates of coverage must be provided.
  - An organization other than the health plan administers the service, i.e. ‘carve out’. In this situation, applicability of the benefit, the responsible organization name and dates of coverage must be provided.

The following describes the information that will be available for In-Network coverage, as appropriate, for each of the Service Types listed above. If and as appropriate to the patient's coverage, this information may also be separately described for Out of Network coverage.

- *Co-Pay*: The amount to be paid to the provider by the patient at the time of the visit.

- *Co-Insurance*: The percentage of the allowed amount to be paid to the provider by the patient after the health plan has paid their portion.
- *Service-Specific Deductible*: A specific deductible amount, only if it is not included as part of the Contract Level Medical Deductible Amount.
- *Benefit Limit*: Information about any limits that apply to this Service Level Benefit for a patient, e.g. number of visit, number of days, etc.
- *Benefit Remaining*: If there is a benefit limit, this is information about how much of that limit remains. For the Psychiatric and Substance Abuse benefits, health plans may indicate that the provider should call customer service for this information.
- *Visit Limitations*: For some benefit plans, there may be limitations pertaining to the dollar amount for each visit and/or the frequency and timeframe in which the services must be delivered, e.g. Benefit Limit is 12 visits, Visit Limits is no more than 2 visits per month

Note: *Pre-Authorization Requirement*:

This document acknowledges that informing providers about the need for a pre-authorization will help them to expedite their workflow. It also recognizes that a) the requisite clinical information that is necessary for the health plan to make that determination is not always available to health plans at the time that a provider requests eligibility/benefits information, and b) in those cases where a determination could be made, significant programming work is required of health plans and provider organizations -- to extract this information from the health plan system, exchange it in a 270-271 transaction set and incorporate it into the provider's production system. As such, no best practice is being recommended at this time. However, a future best practice recommendation is envisioned and is likely to take shape as outlined below.

For a service type (but not a procedure), information should be provided to indicate which or the following situations apply.

- A certification or pre-authorization is ***always required*** for all diagnoses and procedures related to that service type, OR
- A certification or pre-authorization is ***never required*** for any diagnoses or procedures related to that service type, OR
- The certification or pre-authorization requirements are ***not accessible or the rules are more complex*** than can be returned in the transaction

Health plans and provider organizations are encouraged to begin programming efforts in this direction.

#### IV. Explicitly Requested Services - Benefit Information

In addition to the baseline set of services listed in section III above, benefit information may be explicitly requested for specific services. Over time, health plans will increase the number of services for which they provide benefit information on their web sites and in the transaction. When a health plan provides a service level benefit as part of the member's coverage, the benefit information described above should be available.

## **Web-Based Access to the Information**

The Minimum Standard Set of Eligibility and Benefits Information outlined above will be available on each health plan's web site. The specific design of how this information is presented on their web site is left to each health plan. However, to enhance usability by the provider, a Best Practice Recommended design should consider the following factors:

- *Single sign-on:* The provider should be able to use their OHP credential to access the health plan's site.
- *Number of 'clicks':* The provider should be able to get to the eligibility & benefits information with as few 'clicks' as possible. Fewer clicks should be required to get to basic eligibility information than to detail benefits information.
- *Options for Patient Search:* The web site should offer providers multiple ways to "look-up" a patient. Each of the look-up options will be a different combination of data elements from the following list.
  - Firstname
  - Lastname
  - Member Date of Birth
  - Subscriber ID (Some health plans may refer to this as Member ID)

Each option should require the provider to enter only the minimum number of data elements (1-4) that is consistent with the health plan's patient privacy & security requirements per HIPAA regulations.

- *Time Period:* The health plan's system should respond to each query in no longer than 20 seconds from the point that their system receives the query. (A query is initiated when the provider enters "enter", "submit" or other similar command on their web browser.) Time periods may appear longer to the provider depending upon the type of computer they are using, type of browser, speed of the internet, etc.
- *Listing of the Standard Set of Services:* For the standard set of services for a selected member for In-Network and Out-of-Network, clearly identify those services for which benefits apply and those service for which benefits do not apply. When a benefit applies, display the benefit information. Examples of how this may be done include, but are limited to,
  - Listing all services in the standard set and displaying either the benefit or 'Does Not Apply
  - Displaying services, and related benefit information in two groups – one group for which benefits apply and one group for which benefit do not apply
  - Other method that is easily understood by providers.
- *Carved Out Services:* If an organization other than the health plan administers the service, the web site must, as a minimum, indicate whether or not the patient is eligible for the benefit and, if so, provide the responsible organization name and dates of

coverage. Ideally a contact phone number or link will be reported on the health plan's site that will point the provider to where the patient responsibility information can be found.

- *Service Specific Deductible:* The site will provide one or other of the following:

EITHER A.

1. Provide a tagline that indicates "Unless otherwise indicated for a specific service, any deductible amount for that service is included as part of the Contract Level Medical Deductible Amount", and
2. For a specific service, indicate any specific deductible amount that is not included as part of the Contract Level Medical Deductible Amount

OR B.

For every specific service, indicate whether or not there is any deductible amount that is not included as part of the Contract Level Medical Deductible Amount

- *Deductible and Patient Responsibility:* Indicate whether or not deductibles, both contract level and/or service-specific, apply to the patient's out of pocket responsibility
- *Printer-Friendly Report.* The provider should be able to easily print out a readable, paper version of the information that is on the web site.

## **270-271 Transaction Exchange of the Information**

The Best Practices outlined above will be operationalized in the Real Time and Batch Exchange of the HIPAA 270-271 Health Care Eligibility Benefits Inquiry and Response transaction between providers and health plans. More specific best practice requirements associated with the transaction include:

### **Transaction Turnaround**

The provider organization will send the 270 Inquiry transaction and health plans will reply with the 271 Response transaction.

When receiving a batch transmission of the 270 Inquiry transaction, health plans will respond with a 999 Acknowledgment transaction prior to processing the 271 Response.

### *Time Period*

For Real Time Exchange (i.e. for one inquiry at a time via an electronic connection that stays open until the response is provided):

Health plans will respond, with one 271 transaction for each eligibility request contained in a 270 transaction, as soon as possible and not later than 20 seconds after receiving the 270 transaction. Response errors, either via a 271 AAA segment or via a '999' as appropriate, will be returned in the same timeframe.

For Batch Exchange (i.e. for one or more inquiries and responses that are exchanged in batches where the electronic connection that does not stay open):

For each batch of 270 transactions received by 9 PM on a business day, health plans will respond, with one or more 271 transactions, for every eligibility request contained in the respective 270 transaction, as soon as possible and not later than 7 AM on the next business day. Response errors, either via a 271 AAA segment or via a '999' as appropriate, will be returned within one hour of receiving the batch.

For both types of exchanges, the time period starts when the health plan receives the 270 transaction and ends when all eligibility requests pertaining to that health plan's members contained in the 270 transaction are answered, i.e. via the sending of one or more 271 transactions. The time period does not include any processing/wait time by clearinghouses or intermediary organizations between the provider and the health plan.

### *Scope of Response*

The scope of response, within the time period, includes a reply to every request for information that is contained within the 270 transaction and that is not forwarded to another health plan. The scope includes, as appropriate, either a Member Not Found response or a response with

eligibility/benefits information. The scope does not include responding to a request for information that is forwarded to another health plan, e.g. Blue Card or FEP.

### **Returning Information Received**

Information submitted in the 270 request may or may not be used by the health plans in determining the 271 response. Any information submitted on the 270 that is used by the health plan in determining the response, must be returned in the 271.

Providers may include the Patient Account Number as their internal tracking number in the 270 request. If the Patient Account Number is contained in the 270 request (Loop 2100C/D, REF01= 'EJ', REF02 = patient account number), it must be returned in the 271 response.

### **Patient Identification & Search**

Providers should include the following patient identifying information on all 270 Request transactions

- Patient Firstname
- Patient Lastname
- Patient Date of Birth
- Patient Member ID

The health plan will check for that patient as both a subscriber and a dependent, regardless of whether the patient was indicated as a subscriber or dependent in the inquiry. More specifically, if a match on patient exists, the response will contain eligibility and benefits information for that patient even if the inquiry specifies the patient as a dependent and the health plan system has the patient as the subscriber, or visa versa.

### **Service Type Request & Response**

The Best Practice Recommendation will call for health plans to make benefit information available by service type. As the demand for and usefulness of providing benefit information at the diagnosis and/or procedures level has not been established, it will not be included as a Best Practice Recommendation. If a provider does send a request with EQ02 = valid composite medical procedure Id and the health plan does not provide eligibility/benefit information by diagnosis/procedure, the response returned by health plan will be the same as if the provider sent a request with EQ01 = 30.

Using the 270 transaction, providers can request benefit information for the standard set of services (EQ01=30) and/or can request information for one or more specific service (e.g. EQ01=64 for Acupuncture). Requests for benefit information are made by repeating the EQ01 data element for each desired service type (up to 99 times) as long as all of the information in the

2110C/D loop is the same for all of the requested services. If the information is different for each requested service type, separate EQ segments must be used.

In the 270 Request Transaction . . .

The following fields do not need to be populated in the transaction. In many cases, the health plans will not even look at the field. In all cases, the health plan will send the exact same response regardless of the values that are in the fields.

Data Element
Provider Information (PRV01-PRV06)
Date-Time Information (DTP01-DTP03)
Composite Medical Procedure Identifier (EQ02)
Coverage Level Code (EQ03)
AMT01-02, III01-02, REF01-02

In the 271 Response Transaction . . .

If one of the EQ01 codes = '30' OR IF one of the EQ01 codes is not supported by the health plan,

Participating health plans have agreed to respond with General Eligibility Coverage and Standard Services Benefits information for the member's policy. See the sections I, II and III below.

If one of the EQ01 codes contains something other than '30' . . .

*If the member's policy does have* a covered benefit for the service type(s) that is specified in EQ01, then the health plan will respond with detail benefit coverage data for that service type. See the section IV below.

*If the member's policy does not have* a covered benefit for the service type that is specified in EQ01, then the health plan will not respond with detail benefit coverage information but will include the following EB segment in Loop 2110C/D

	Non-Covered Benefit Values
EB01	'I'
EB02	Omit
EB03	HIPAA code that was in EQ01
EB04	Omit
EB05	Omit
EB06	Omit
EB07	Omit
EB08	Omit

<b>Non-Covered Benefit Values</b>	
EB09	Omit
EB10	Omit
EB11	Omit
EB12	Omit

Omit – No value is put between the field delimiters

**271 Response Transaction****I. General Eligibility Coverage**

Data Element	Location in 271 Transaction	
	For patient as subscriber	For patient as dependent
Subscriber Name	Loop 2100C, NM1 Segment	
Patient Name	Same as Subscriber Name above	Loop 2100D, NM1 Segment, NM101-NM105
Patient's Relationship to Subscriber	Loop 2100C, INS Segment, INS01-INS02, INS01='Y', INS02: See TR3 for full list of values	Loop 2100D INS Segment, INS01= N, INS02: See TR3 for full list of values
Patient Date of Birth	Loop 2100C, DMG Segment, DMG02	Loop 2100D, DMG Segment, DMG02
Patient Gender	Loop 2100C, DMG Segment, DMG03="F" – Female, "M" – Male, "U" - Unknown	Loop 2100D, DMG Segment, DMG03="F" – Female, "M" – Male, "U" - Unknown
Patient Member Number	Loop 2100C, NM1 Segment, NM109	Loop 2100D, NM1 Segment, NM109
Group Number	Loop 2100C, REF Segment, REF01-02, REF01 = '6P' - Group Number	Loop 2100D, REF Segment, REF01-02, REF01 = '6P' -Group Number
Coverage Date (aka Policy Effective Date) <sup>*2</sup>	Loop 2100C, DTP Segment, DTP01-DTP03	Loop 2100D, DTP Segment, DTP01-DTP03
Transaction Reference Number	TRN02 (that matches to the respective 270 transaction)	
Eligibility Status	EB Segment = EB*1**30*)	
Group Name	Loop 2100C, REF Segment, REF03	Loop 2100D, REF Segment, REF03
Plan Type	Loop 2110C, EB Segment, EB04-EB05	Loop 2110D, EB Segment, EB04-EB05
Other Coverage <sup>*1</sup>	Loop 2120C, Segments, NM101 = 'PRP' - Primary, 'SEP – Secondary Payer' or 'TTP – Tertiary Payer'. Other fields as appropriate to the payer. (See TR3 for full list of values)	Loop 2120D, Segments, NM101 = 'PRP' - Primary, 'SEP – Secondary Payer' or 'TTP – Tertiary Payer'. Other fields as appropriate to the payer. (See TR3 for full list of values)
Primary Care Physician (PCP) <sup>*1</sup>	Loop 2120C, NM101 = 'P3' -Primary Care Provider. (See TR3 for full list of values) PCP Name (NM1) and phone number (PER Segment).	Loop 2120D, NM101 = 'P3' -Primary Care Provider. (See TR3 for full list of values) PCP Name (NM1) and phone number (PER Segment).

<sup>\*1</sup> - This information should be sent if it is in the health plan's records and appropriate to the coverage. The health plans will send the information that they have. The accuracy of the information cannot be assured.

<sup>\*2</sup> - See section 1.4.7.1 of the TR3 for specific values to be used depending upon coverage conditions.

Note: Unfortunately, per HIPAA mandated specifications, valid data values may vary between transactions. Make sure that values valid for one transaction are also valid for the other transaction before using them in the other transaction.

## II. Contract Level Benefits Information

### A. Deductibles and Accumulators Information

#### 1. Individual

Deductible	Total Amount	Per Period	Amount Remaining
In Network	Y	As appropriate	Y
Out of Network	Y	As appropriate	Y

#### 2. Family

Deductible	Total Amount	Per Period	Amount Remaining
In Network	Y	As appropriate	Y
Out of Network	Y	As appropriate	Y

For each type of deductible, e.g. Individual-Medical-In Network, Family-Medical-Out of Network, etc., there will be 2 related EB segments. One EB segment will contain information about the total amount of the deductible for the specified period – either calendar year (EB06=23) or contract year (EB06=25). The other EB segment will contain information about how much of the deductible is remaining at the time the transaction was generated (EB06=29).

The values listed in EB02 and EB06 are typical for the basic deductible information. There may be slight variations between health plans.

Standard Deductible & Accumulator Values	
EB01	'C'
EB02	<ul style="list-style-type: none"> <li>• 'IND' – Individual</li> <li>• 'FAM' – Family</li> </ul>
EB03	'30' – Medical or Omit
EB04	Omit or a Standard Value
EB05	Plan Name if appropriate. Check with the health plan for values and meanings.
EB06	<ul style="list-style-type: none"> <li>➤ '22' – When EB07 contains the total deductible amount for the service year</li> <li>➤ '23' – When EB07 contains the total deductible amount for the calendar year</li> <li>➤ '25' - When EB07 contains the total deductible amount for the contract period</li> <li>➤ '29' – When EB07 contains the remaining deductible amount for the specified period</li> </ul>

<b>Standard Deductible &amp; Accumulator Values</b>	
EB07	Deductible Amount
EB08	Omit
EB09	Omit
EB10	Omit
EB11	Omit
EB12	<ul style="list-style-type: none"> <li>• 'Y' – if only for In-Network</li> <li>• 'N' – if only for Out of Network</li> <li>• 'U' - if requirements not accessible or rule too complex</li> <li>• 'W' – if for both In-Network and Out of Network</li> </ul>

Omit – No value is put between the field delimiters

## B. Out of Pocket Maximums and Accumulators Information

### 1. Individual

<b>Out of Pocket Maximum</b>	<b>Total Amount</b>	<b>Per Period</b>	<b>Amount Remaining</b>
In Network	Y	As appropriate	Y
Out of Network	Y	As appropriate	Y

### 2. Family

<b>Out of Pocket Maximum</b>	<b>Total Amount</b>	<b>Per Period</b>	<b>Amount Remaining</b>
In Network	Y	As appropriate	Y
Out of Network	Y	As appropriate	Y

For each type of out of pocket maximum, e.g. Individual In Network, Family Out of Network, etc, there will be 2 related EB segments. One EB segment will contain information about the total amount of the out of pocket maximum for the specified period, e.g. calendar year (EB06=23). The other EB segment will contain information about how much of the out of pocket maximum is remaining at the time the transaction was generated, i.e. annual period (EB06=29).

The value listed in EB02 and EB06 are typical for the basic out of pocket maximum information. There may be slight variations between health plans.

<b>Standard Out of Pocket Max &amp; Accumulator Values</b>	
EB01	'G'
EB02	<ul style="list-style-type: none"> <li>• <b>IND'</b> – Individual</li> </ul>

<b>Standard Out of Pocket Max &amp; Accumulator Values</b>	
	<ul style="list-style-type: none"> <li>• <b>'FAM'</b> – Family</li> </ul>
EB03	<b>'30'</b> – Medical or Omit
EB04	Omit or a Standard Value
EB05	Plan Name if appropriate. Check with the health plan for values and meanings.
EB06	<ul style="list-style-type: none"> <li>➤ <b>'22'</b> – When EB07 contains the total deductible amount for the service year</li> <li>➤ <b>'23'</b> – When EB07 contains the total out of pocket maximum amount for the calendar year</li> <li>➤ <b>'25'</b> – When EB07 contains the total deductible amount for the contract period</li> <li>➤ <b>'29'</b> – When EB07 contains the remaining out of pocket maximum amount for the specified period</li> </ul>
EB07	Out of Pocket Maximum Amount
EB08	Omit
EB09	Omit
EB10	Omit
EB11	Omit
EB12	<ul style="list-style-type: none"> <li>• <b>'Y'</b> – if only for In-Network</li> <li>• <b>'N'</b> – if only for Out of Network</li> <li>• <b>'U'</b> - if requirements not accessible or rule too complex</li> <li>• <b>'W'</b> – if for both In-Network and Out of Network</li> </ul>

Omit – No value is put between the field delimiters

C. Lifetime Payment Maximum and Accumulators Information

Individual

<b>Lifetime Payment Maximum</b>	Total Amount	Per Period	Amount Remaining
	Y	Lifetime	Y

For the Lifetime Payment Maximum, there will be 2 related EB segments. One EB segment will contain information about the total amount of the lifetime payment maximum for the specified period. The other EB segment will contain information about how much of lifetime payment maximum is remaining at the time the transaction was generated.

The value listed in EB02 and EB06 are typical for the basic lifetime payment maximum information. There may be slight variations between health plans.

Standard Lifetime Payment Max & Accumulator Values	
EB01	'F'
EB02	IND' – Individual
EB03	'30' – Medical or Omit
EB04	Omit or a Standard Value
EB05	Plan Name if appropriate. Check with the health plan for values and meanings.
EB06	<ul style="list-style-type: none"> <li>➤ '32' – When EB07 contains the total lifetime payment maximum amount for the patient</li> <li>➤ '29' or '33' – When EB07 contains the remaining lifetime payment maximum amount for the patient</li> </ul>
EB07	Lifetime Payment Maximum
EB08	Omit
EB09	Omit
EB10	Omit
EB11	Omit
EB12	<ul style="list-style-type: none"> <li>• 'Y' – if only for In-Network</li> <li>• 'N' – if only for Out of Network</li> <li>• 'U' - if requirements not accessible or rule too complex</li> <li>• 'W' – if for both In-Network and Out of Network</li> </ul>

Omit – No value is put between the field delimiters

E. Spend Down (primarily Medicaid)

Individual

**Spend Down**

Total Amount	Per Period	Amount Remaining
Y	Contract	Y

For Spend Down, there will be 2 related EB segments. One EB segment will contain information about the total amount of the patient's responsibility before their benefits begin. The other EB segment will contain information about how much of the patient's responsibility has yet to be met at the time the transaction was generated.

The value listed in EB02 and EB06 are typical for cost containment information.

Standard Lifetime Payment Max & Accumulator Values	
EB01	'Y'
EB02	IND' – Individual
EB03	'30' – Medical or Omit

<b>Standard Lifetime Payment Max &amp; Accumulator Values</b>	
EB04	Omit or a Standard Value
EB05	Plan Name if appropriate. Check with the health plan for values and meanings.
EB06	<b>25'</b> - When EB07 contains the total spend down amount for the contract period
EB07	Spend Down Amount
EB08	Omit
EB09	Omit
EB10	Omit
EB11	Omit
EB12	<ul style="list-style-type: none"> <li>• 'Y' – if only for In-Network</li> <li>• 'N' – if only for Out of Network</li> <li>• 'U' - if requirements not accessible or rule too complex</li> <li>• 'W' – if for both In-Network and Out of Network</li> </ul>

Omit – No value is put between the field delimiters

**III. Standard Set of Services - Benefit Information: CoPay, CoInsurance, Deductible & Limitations**

This section talks about obtaining information about the Standard Set of Services. The Standard Set of Services information will be provided in the 271 response when, in the 270 request, EITHER EQ01='30' OR the service type contained in EQ01 is not a separately coded, covered benefit for the member.

If a member does not have coverage for one of the standard service type(s) in the set, the health plan will not include any information about that service in the 271 response.

For each of the service types listed below, health plans will provide benefit information as long as the member has coverage for that service type. (Each service may have a number of EB segments to describe the related benefits.) Depending upon their policies and capabilities, health plans may supply more information about the services listed below, or about other services. (See table in Appendix.)

Benefits information for the each service within the set currently includes:

- A. CoPay, CoInsurance and Overriding Deductible Information
- B. Maximum Benefit Limit and Accumulator Information
  - Dollar Amount
  - Number of Days
  - Number of Visits
  - Limitation about the benefit period
- C. Service Delivery Limitations

*Note:* The EB03 column of each table indicates how each specified type of service will be coded in the transaction.

Information about the following Standard Set of Services must be provided in the 271 when EQ01=30 in the 270 transaction.

1.

<b>Medical Care</b>	EB03 =
Medical Care	'1'

2.

<b>Physician Office Visit</b>	In-Network	Out of Network	EB03 =
Professional (Physician) Visit Office	Y	Y	'98'
<i>As well as:</i>			
Professional (Physician) Visit Office - Sick	Y	Y	'BY'
Professional (Physician) Visit Office - Well	Y	Y	'BZ'

3.

<b>Hospital</b>	In- Network	Out of Network	EB03 =
Hospital	Y	Y	'47'
<i>As well as:</i>			
Hospital - Inpatient	Y	Y	'48'
Hospital - Outpatient	Y	Y	'50'

4.

<b>Emergency Service</b>	In- Network	Out of Network	EB03 =
Emergency Services	Y	Y	'86'

5.

<b>Urgent Care</b>	In- Network	Out of Network	EB03 =
Urgent Care	Y	Y	'UC'

6.

<b>Mental Health</b>	In- Network	Out of Network	EB03 =
Mental Health	Y	Y	'MH'
<i>As well as the below if consistent with health plan privacy policy</i>			
Psychiatric - Inpatient	Y	Y	'A7'
Psychiatric - Outpatient	Y	Y	'A8'
Substance Abuse <sup>*1</sup>	Y	Y	'AI'

<sup>1</sup>- There is typically no difference in copay amounts for the different type of chemical dependency, eg. alcohol, drugs, etc.

7.

<b>Vision</b>	In- Network	Out of Network	EB03 =
Vision (Optometry)	Y	Y	'AL'

8.

<b>Chiropractic</b>	In- Network	Out of Network	EB03 =
Chiropractic	Y	Y	'33'

9.

<b>Dental</b>	In- Network	Out of Network	EB03 =
Dental	Y	Y	'35'

10.

<b>Pharmacy</b>	EB03=
Pharmacy - Prescription	'88'

#### A. CoPay, CoInsurance and Overriding Deductible Information

The following table identifies how the EB segment of Loop 2110C (for Subscriber) and 2110D (for Dependent) will be coded.

Co-pay information will not be available in the 271 for the following situations:

- The complexity of benefits is not supported within the structure of the 271
- The health plan would like the provider to call customer service for benefit specific information. This is designated when EB01 = 'U' for the service type specified in EB03.
- The service type code is too general for an EB='B' segment to apply, e.g. for a '30' - Medical Service, there will be no EB='B' segment.

In most cases, there will be at least one EB='B' segment for co-pay. If there is no co-pay for that service, or if the co-pay is waived, the co-pay value will be '0'. Other EB segments will be included as appropriate to the benefit.

	Standard Co-Pay Values	Standard Co-Insurance Values	Standard Deductible Values
EB01	<b>'B'</b>	<b>'A'</b> <sup>*3</sup>	<b>'C'</b>
EB02	V <sup>*3</sup>	V <sup>*3</sup>	V <sup>*3</sup>
EB03	See each service above	See each service above	See each service above
EB04	V <sup>*1a</sup>	V <sup>*1a</sup>	V <sup>*1a</sup>
EB05	V <sup>*1b</sup>	V <sup>*1b</sup>	V <sup>*1b</sup>
EB06	V <sup>*2</sup>	V <sup>*2</sup>	V <sup>*2</sup>
EB07	CoPay Amount due from the patient or '0' if no co-pay or co-pay waived.	Omit	V <sup>*4</sup>
EB08	Omit	CoInsurance Percent -due from the patient – from .0-1	Omit
EB09	Omit	Omit	Omit
EB10	Omit	Omit	Omit
EB11	V <sup>*5</sup>	V <sup>*5</sup>	V <sup>*5</sup>

	<b>Standard Co-Pay Values</b>	<b>Standard Co-Insurance Values</b>	<b>Standard Deductible Values</b>
EB12	<ul style="list-style-type: none"> <li>• ‘Y’ – if only for In-Network</li> <li>• ‘N’ – if only for Out of Network</li> <li>• ‘U’ - if requirements not accessible or rule too complex</li> <li>• ‘W’ – if for both In-Network and Out of Network</li> </ul>	<ul style="list-style-type: none"> <li>• ‘Y’ – if only for In-Network</li> <li>• ‘N’ – if only for Out of Network</li> <li>• ‘U’ - if requirements not accessible or rule too complex</li> <li>• ‘W’ – if for both In-Network and Out of Network</li> </ul>	<ul style="list-style-type: none"> <li>• ‘Y’ – if only for In-Network</li> <li>• ‘N’ – if only for Out of Network</li> <li>• ‘U’ - if requirements not accessible or rule too complex</li> <li>• ‘W’ – if for both In-Network and Out of Network</li> </ul>

Omit – No value is put between the field delimiters

\*3 – WDS will use ‘D’ rather than ‘A’

V\*1a - Will contain Omit or a standard value

V\*1b - Plan Name if appropriate. Check with the health plan for values and meanings

V\*2 - Will contain Omit or the time period appropriate to the benefit

V\*3 - Will contain Omit or appropriate value from the TR3

V\*4 - Only put a deductible amount if it is different than the amount specified in the contract level deductible information. In other words,

- If a deductible amount does not need to be met for the specific benefit to apply, the deductible amount, EB07, will be ‘0’.
- If a deductible amount does need to be met and the deductible amount is different than the general information, then EB07 will contain a value greater than ‘0’.

V\*5 - This document acknowledges that informing providers about the need for a pre-authorization will help them to expedite their workflow. It also recognizes that a) the requisite clinical information that is necessary for the health plan to make that determination is not always available to health plans at the time that a provider requests eligibility/benefits information, and b) in those cases where a determination could be made, significant new programming work is required of health plans and provider organizations to extract this information from the health plan system, exchange it in a 270-271 transaction set and incorporate it into the provider's production system. As such, the best practice recommendation for exchanging pre-auth related information is as follows:

For exchanging the pre-authorization requirement for a requested procedure (EQ02 = valid composite medical procedure Id)

At the time of an eligibility/benefits request, the health plan is unlikely to have sufficient information to determine the need for a pre-authorization for a

specific procedure (e.g. medical notes will not have been provided.) As such, if the health plan cannot respond to an EQ02 = valid composite medical procedure Id, the response returned by health plan will be the same as if the provider sent a request with EQ01 = 30.

For exchanging the pre-authorization requirement for a requested service type (EQ01 = valid service type code)

At this time, no best practice will be recommended for the content of EB11.

However, a future best practice recommendation is envisioned and is likely to take shape as outlined below. Health plans and provider organizations are encouraged to begin programming efforts in this direction.

Likely future best practice recommendation for the content of EB11:

- 'Y' if a certification or pre-authorization is **always required** for all diagnoses and procedures related to that service type
- 'N' or Omit if a certification or pre-authorization is **never required** for any diagnoses or procedures related to that service type
- 'U' if the certification or pre-authorization requirements **are not accessible or the rules are more complex** than can be returned in the transaction

## B. Maximum Benefit Limit and Accumulator Information

For each service type,

### *If the service type has maximum benefit limitations*

NOTE: When a provider creates a 270 Request transaction with EQ01 = 30, some health plans interpret HIPAA Privacy regulations as preventing them from sending the level of benefit information described below for service types:

- MH - Mental Health
- A7 – Psychiatric-Inpatient
- A8 – Psychiatric-Outpatient
- AI – Substance Abuse

In these cases, the health plan will include an EB record with EB01 = 'U' in the transaction to indicate that customer service should be contacted for this information.

To get this level of benefit information, the provider can either contact customer service for the information or can send a 270 transaction with EQ01 = MH, A7, A8 and/or AI.

In the 271, an EB segment pair will identify the benefit maximum limitations (benefit \$ amount, # of visits, # of days) and the remaining benefit for each of those limitations. There will be at least two EB segments, with EB01 = 'F' (Limitation).

- *One of the EB segment of the pair* will identify the benefit maximum limitation for the service type. EB06 will indicate the benefit period -- a calendar year (EB06='23') or a contract year (EB06='25') or an episode of care (EB06 = '26'). The following fields will be used depending upon the type of benefit limitation for that period:
  - EB07 will contain any maximum benefit dollar amount. By convention this field will only be used for the benefit dollar amount, if one exists. It will not be used for any other limitation as EB06 doesn't qualify that limitation. (EB06 defines the benefit period.)
  - EB09 will identify whether there is a benefit maximum limitation related to number of days or number of visits.
  - EB10 will contain the benefit maximum limitation related to EB09

For example, if the benefit maximum limitations for a contract year are \$5000 and 12 visits then EB06 = 25, EB07 = 5000, EB09 = VS, EB10 = 12

- *The other EB segment of the pair* will identify the benefit remaining for the service type (EB06 will = '29'). The following fields will be used depending upon the type of benefit limit
  - EB07 will contain any remaining benefit dollar amount. By convention this field will only be used for the benefit dollar amount, if one exists. It will not be used for any other limitation as EB06 doesn't qualify that limitation. (EB06 defines the benefit period.)
  - EB09 will identify whether there is a benefit remaining related to number of days or number of visits.
  - EB10 will contain the benefit remaining related to EB09

For example, if the benefit maximum remaining for the contract year are \$2000 and 4 visits then EB06 = 29, EB07 = 2000, EB09 = VS, EB10 = 4

If a service type has more than two benefit limitations, e.g. benefit \$ amount and number of visits and number of days, then an additional pair(s) of EB segments will be required. The first EB segment of the second pair will specify the benefit maximum limitation(s) that can't fit in the first pair. The second EB segment of the second pair will specify benefit remaining that can't fit in the first pair.

Benefit Description Values	
EB01	'F'
EB02	Omit
EB03	See each service above
EB04	Omit
EB05	Omit

Benefit Description Values	
EB06	<ul style="list-style-type: none"> <li>➤ '23' – For benefit limitations for the calendar year</li> <li>➤ '25' - For benefit limitations for the contract year</li> <li>➤ '26' – For benefit limitations for an episode of care</li> <li>➤ '29' – For a benefit remaining</li> </ul>
EB07	Omit or Benefit \$ Amount
EB08	Omit
EB09	Omit or <ul style="list-style-type: none"> <li>• 'DY' – Days</li> <li>• 'VS' - Visits</li> </ul>
EB10	Omit or EB09-related quantity for benefit limitation or benefit remaining
EB11	See V <sup>5</sup> note above re pre-authorization
EB12	<ul style="list-style-type: none"> <li>• 'Y' – if only for In-Network</li> <li>• 'N' – if only for Out of Network</li> <li>• 'U' - if requirements not accessible or rule too complex</li> <li>• 'W' – if for both In-Network and Out of Network</li> </ul>

Omit – No value is put between the field delimiters

### C. Service Delivery Limitations

*If the service type has service delivery limitations,*

For some benefit plans, there may be limitations pertaining to the frequency and timeframe in which the services must be delivered, e.g. 12 visits, 3 visits per week for 1 month. In these cases, the HSD segment will be used to specify those limitations.

Service Delivery Values	
HSD01	<ul style="list-style-type: none"> <li>• 'DY' – Days</li> <li>• 'VS' - Visits</li> </ul>
HSD02	Quantity of HSD01 (same as EB09)
HSD03	<ul style="list-style-type: none"> <li>• 'DA' – Days</li> <li>• 'MO' – Months</li> <li>• 'VS' – Visits</li> <li>• 'WK' – Week</li> <li>• 'YR' – Years</li> </ul>
HSD04	Quantity of HSD01 within the time period of

Service Delivery Values	
	HSD03
HSD05	<ul style="list-style-type: none"> <li>• '21' – Years</li> <li>• '26' – Episode</li> <li>• '27' – Visit</li> <li>• '32' – Lifetime</li> <li>• '34' – Month</li> <li>• '35' – Week</li> </ul>
HSD06	HSD05 Duration in which benefits need to be delivered
HSD07	Omit
HSD08	Omit

Omit – No value is put between the field delimiters

For the example of 12 visits, 3 visits per week for 1 month

Service Delivery Values	
HSD01	'VS' - Visits
HSD02	12
HSD03	'WK' – Week
HSD04	3
HSD05	'34' – Month
HSD06	1
HSD07	Omit
HSD08	Omit

Omit – No value is put between the field delimiter

## IV. Explicitly Requested Services - Benefits Information

This section talks about obtaining information about explicitly requested service types specified in EQ01 in the 270 request.

*Note:* If the member's policy **does not have** a covered benefit for the service type that is specified in EQ01, then the health plan will respond with an EB01='1' (non-covered) response.

When the member's policy **does** provide coverage for the specified service, health plans will respond in the following ways, depending upon the service type that is explicitly requested:

1. *Request for a service type that is supported by the plan, and benefit detail is not too complex.* If a member has coverage for the requested service type, the health plan will provide benefit information as described below. (Each service may have a number of EB segments to describe the related benefits.) Depending upon their policies and capabilities, health plans may supply additional information. (See table in Appendix).
2. *Request for a service type that is not separately coded by the plan.* If the requested service is not separately coded by the plan, the response returned by health plan will be the same as if the provider sent a request with EQ01 = 30.
3. *Request for a service type that is supported by the plan, but benefit detail is too complex.* If a member has coverage for the requested service type and the health plan's system is not able to provide detail benefit information within the 271 transaction, they will respond with an EB segment with EB01 = 'U' for the service type specified in EB03

Benefits information for each supported service type currently includes:

- C. CoPay, CoInsurance and Overriding Deductible Information
- D. Maximum Benefit Limit and Accumulator Information
  - Dollar Amount
  - Number of Days
  - Number of Visits
  - Limitation about the benefit period
- C. Service Delivery Limitations

### A. CoPay, CoInsurance and Overriding Deductible Information

The following table identifies how the EB segment of Loop 2110C (for Subscriber) and 2110D (for Dependent) will be coded.

Co-pay information will not be available in the 271 for the following situations:

- The complexity of benefits is not supported within the structure of the 271

- The health plan would like the provider to call customer service for benefit specific information. This is designated when EB01 = 'U' for the service type specified in EB03.
- The service type code is too general for an EB='B' segment to apply, e.g. for a '30' - Medical Service, there will be no EB='B' segment.

In most cases, there will be at least one EB='B' segment for co-pay. If there is no co-pay for that service, or if the co-pay is waived, the co-pay value will be '0'. Other EB segments will be included as appropriate to the benefit.

	Standard Co-Pay Values	Standard Co-Insurance Values	Standard Deductible Values
EB01	'B'	'A' *3	'C'
EB02	V*3	V*3	V*3
EB03	V*6	V*6	V*6
EB04	V*1a	V*1a	V*1a
EB05	V*1b	V*1b	V*1b
EB06	V*2	V*2	V*2
EB07	CoPay Amount due from the patient or '0' if no co-pay or co-pay waived.	Omit	V*4
EB08	Omit	CoInsurance Percent -due from the patient – from .0-1	Omit
EB09	Omit	Omit	Omit
EB10	Omit	Omit	Omit
EB11	V*5	V*5	V*5
EB12	<ul style="list-style-type: none"> <li>• 'Y' – if only for In-Network</li> <li>• 'N' – if only for Out of Network</li> <li>• 'U' - if requirements not accessible or rule too complex</li> <li>• 'W' – if for both In-Network and Out of Network</li> </ul>	<ul style="list-style-type: none"> <li>• 'Y' – if only for In-Network</li> <li>• 'N' – if only for Out of Network</li> <li>• 'U' - if requirements not accessible or rule too complex</li> <li>• 'W' – if for both In-Network and Out of Network</li> </ul>	<ul style="list-style-type: none"> <li>• 'Y' – if only for In-Network</li> <li>• 'N' – if only for Out of Network</li> <li>• 'U' - if requirements not accessible or rule too complex</li> <li>• 'W' – if for both In-Network and Out of Network</li> </ul>

Omit – No value is put between the field delimiters

<sup>3</sup> – WDS will use ‘D’ rather than ‘A’

V\*1a - Will contain Omit or a standard value

V\*1b - Plan Name if appropriate. Check with the health plan for values and meanings

V\*2 - Will contain Omit or the time period appropriate to the benefit

V\*3 - Will contain Omit or appropriate value from the TR3

V\*4 - Only put a deductible amount if it is different than the amount specified in the contract level deductible information. In other words,

- If a deductible amount does not need to be met for the specific benefit to apply, the deductible amount, EB07, will be ‘0’.
- If a deductible amount does need to be met and the deductible amount is different than the general information, then EB07 will contain a value greater than ‘0’.

V\*5 - This document acknowledges that informing providers about the need for a pre-authorization will help them to expedite their workflow. It also recognizes that a) the requisite clinical information that is necessary for the health plan to make that determination is not always available to health plans at the time that a provider requests eligibility/benefits information, and b) in those cases where a determination could be made, significant new programming work is required of health plans and provider organizations to extract this information from the health plan system, exchange it in a 270-271 transaction set and incorporate it into the provider's production system. As such, the best practice recommendation for exchanging pre-auth related information is as follows:

For exchanging the pre-authorization requirement for a requested procedure (EQ02 = valid composite medical procedure Id)

At the time of an eligibility/benefits request, the health plan is unlikely to have sufficient information to determine the need for a pre-authorization for a specific procedure (e.g. medical notes will not have been provided.) As such, if the health plan cannot respond to an EQ02 = valid composite medical procedure Id, the response returned by health plan will be the same as if the provider sent a request with EQ01 = 30.

For exchanging the pre-authorization requirement for a requested service type (EQ01 = valid service type code)

At this time, no best practice will be recommended for the content of EB11.

However, a future best practice recommendation is envisioned and is likely to take shape as outlined below. Health plans and provider organizations are encouraged to begin programming efforts in this direction.

Likely future best practice recommendation for the content of EB11:

- 'Y' if a certification or pre-authorization is **always required** for all diagnoses and procedures related to that service type
  - 'N' or Omit if a certification or pre-authorization is **never required** for any diagnoses or procedures related to that service type
  - 'U' if the certification or pre-authorization requirements **are not accessible or the rules are more complex** than can be returned in the transaction
- V\*<sup>6</sup> - EB03 will contain the service type code supplied in EQ01 or may contain a service type that is related to but different than what was supplied in EQ01. For example – EQ01 in the 270 may contain a 33 (chiropractic). The health plan may respond in the 271 with an EB03=33 (chiropractic) and an EB03 = 4 (diagnostic xray)

## B. Maximum Benefit Limit and Accumulator Information

For each service type specified in EQ01 in the 270 request,

### *If the service type has maximum benefit limitations*

In the 271, an EB segment pair will identify the benefit maximum limitations (benefit \$ amount, # of visits, # of days) and the remaining benefit for each of those limitations. There will be at least two EB segments, with EB01 = 'F' (Limitation).

- *One of the EB segment of the pair* will identify the benefit maximum limitation for the service type. EB06 will indicate the benefit period -- a calendar year (EB06='23') or a contract year (EB06='25') or an episode of care (EB06 = '26'). The following fields will be used depending upon the type of benefit limitation for that period:
  - EB07 will contain any maximum benefit dollar amount. By convention this field will only be used for the benefit dollar amount, if one exists. It will not be used for any other limitation as EB06 doesn't qualify that limitation. (EB06 defines the benefit period.)
  - EB09 will identify whether there is a benefit maximum limitation related to number of days or number of visits.
  - EB10 will contain the benefit maximum limitation related to EB09

For example, if the benefit maximum limitations for a contract year are \$5000 and 12 visits then EB06 = 25, EB07 = 5000, EB09 = VS, EB10 = 12
- *The other EB segment of the pair* will identify the benefit remaining for the service type (EB06 will = '29'). The following fields will be used depending upon the type of benefit limit
  - EB07 will contain any remaining benefit dollar amount. By convention this field will only be used for the benefit dollar amount, if one exists. It will not be used for any other limitation as EB06 doesn't qualify that limitation. (EB06 defines the benefit period.)

- EB09 will identify whether there is a benefit remaining related to number of days or number of visits.
- EB10 will contain the benefit remaining related to EB09

For example, if the benefit maximum remaining for the contract year are \$2000 and 4 visits then EB06 = 29, EB07 = 2000, EB09 = VS, EB10 = 4

If a service type has more than two benefit limitations, e.g. benefit \$ amount and number of visits and number of days, then an additional pair(s) of EB segments will be required. The first EB segment of the second pair will specify the benefit maximum limitation(s) that can't fit in the first pair. The second EB segment of the second pair will specify benefit remaining that can't fit in the first pair.

Benefit Description Values	
EB01	'F'
EB02	Omit
EB03	See Note 1 above
EB04	Omit
EB05	Omit
EB06	<ul style="list-style-type: none"> <li>➤ '23' – For benefit limitations for the calendar year</li> <li>➤ '25' - For benefit limitations for the contract year</li> <li>➤ '26' – For benefit limitations for an episode of care</li> <li>➤ '29' – For a benefit remaining</li> </ul>
EB07	Omit or Benefit \$ Amount
EB08	Omit
EB09	Omit or <ul style="list-style-type: none"> <li>• 'DY' – Days</li> <li>• 'VS' - Visits</li> </ul>
EB10	Omit or EB09-related quantity for benefit limitation or benefit remaining
EB11	See V <sup>5</sup> note above re pre-authorization
EB12	<ul style="list-style-type: none"> <li>• 'Y' – if only for In-Network</li> <li>• 'N' – if only for Out of Network</li> <li>• 'U' - if requirements not accessible or rule too complex</li> <li>• 'W' – if for both In-Network and Out of Network</li> </ul>

Omit – No value is put between the field delimiters

### C. Service Delivery Limitations

For some benefit plans, there may be limitations pertaining to the frequency and timeframe in which the services must be delivered, e.g. 12 visits, 3 visits per week for 1 month. In these cases, the HSD segment will be used to specify those limitations.

Service Delivery Values	
HSD01	<ul style="list-style-type: none"> <li>• <b>'DY'</b> – Days</li> <li>• <b>'VS'</b> - Visits</li> </ul>
HSD02	Quantity of HSD01 (same as EB09)
HSD03	<ul style="list-style-type: none"> <li>• <b>'DA'</b> – Days</li> <li>• <b>'MO'</b> – Months</li> <li>• <b>'VS'</b> – Visits</li> <li>• <b>'WK'</b> – Week</li> <li>• <b>'YR'</b> – Years</li> </ul>
HSD04	Quantity of HSD01 within the time period of HSD03
HSD05	<ul style="list-style-type: none"> <li>• <b>'21'</b> – Years</li> <li>• <b>'26'</b> – Episode</li> <li>• <b>'27'</b> – Visit</li> <li>• <b>'32'</b> – Lifetime</li> <li>• <b>'34'</b> – Month</li> <li>• <b>'35'</b> – Week</li> </ul>
HSD06	HSD05 Duration in which benefits need to be delivered
HSD07	Omit
HSD08	Omit

For the example of 12 visits, 3 visits per week for 1 month

Service Delivery Values	
HSD01	<b>'VS'</b> - Visits
HSD02	12
HSD03	<b>'WK'</b> – Week
HSD04	3
HSD05	<b>'34'</b> – Month
HSD06	1
HSD07	Omit
HSD08	Omit

# Appendix

- 1. Use of EB12 - 'In Network' & 'Out of Network'**
- 2. Use of Messages**
- 3. Dual Coverage <<to be defined>>**
- 4. Use of AAA Segments for invalid patient search info.**
- 3. Service Types and associated information about Benefit Limitations**

## 1. Use of EB12 to indicate 'In Network' and 'Out of Network'.

In the 271 transaction, an EB Loop is used to present detail information about benefits. In that loop, EB12 is used to differentiate whether the benefit information relates to an 'In Network' provider or an 'Out of Network' provider. Whenever the loop is being used to convey deductible information, that loop should be used as follows;

- a. ***If the deductible amounts are different***, then they should always be reported separately. For example, if there is a \$500 deductible for in-network and a \$1000 deductible for - out of network then two different EB loops should be used; one where E07 = \$1000 & EB12 = N and a second EB loop where EB07=\$500 and EB12 = Y.
- b. ***If the deductible amounts are the same but they accumulate separately***, i.e. the patient's payment to one does not affect the other, then they should be reported separately. For example, there is a \$500 deductible for in-network and a \$500 deductible for - out of network and a \$100 payment to an out-of-network provider does not affect the deductible when an in-network provider is seen (and visa versa), then two different EB loops should be used, one where E07 = \$500 & EB12 = N and a second EB loop where EB07=\$500 and EB12 = Y.
- c. ***If the deductible amounts are the same and they DON'T accumulate separately***, i.e. the patient's payment to one also applies to the other, then they should NOT be reported separately. For example, there is a \$500 deductible for in-network and a \$500 deductible for - out of network and a \$100 deductible payment to one applies equally to the other, then only one EB loop should be used, where E07 = \$500 & EB12 = W.

## 2. Use of Messages

Use of Messages within the transaction should ONLY be used to convey information that is a) critical for the provider to know and b) cannot be conveyed using standard codes in EB01. For example, rather than include a MSG segment tell the provider to call Customer Service, an EB segment can be sent with EB01=U.

Disclaimers are examples of when messages should not be used. Informing a provider when limits are combined is an example of when messages should be used.

## 3. Dual Coverage

To be defined . . .

#### 4. Using AAA Segments in the 271 Response Transactions when patient search information is invalid

When a 270 Inquiry transaction contains invalid patient search information, AAA segments are used in the 271 Response transaction to inform the sender about what it wrong. To increase the likelihood that these AAA segments will be used in the same way by all health plans, the following business scenarios were created. The scenarios are intended to address the most common situations when an invalid search is likely to occur. Additional scenarios will be developed is/as required.

The scenarios depict what should happen depending upon which of the following data elements are provided:

- Subscriber ID
- Last Name
- First Name
- Patient Date of Birth (DOB)

Two scenarios are presented below, each with a number of possible options.

- Scenario A discusses the use of AAA segments when the invalid patient search information is contained in the Subscriber Loop 2100C (when the Patient is the Subscriber).
- Scenario B discusses the use of AAA segments when the invalid patient search information is contained in the Dependent Loop 2100C (when the Patient is a Dependent)

<b>Scenario A - Patient is Subscriber, Loop 2100C</b>
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Scenario Options are indicated /displayed in order as referenced in 270/271 TR3, References: 5010 TR3 Section 1.4.8. Scenario A-1 is the required primary search options. Scenarios A2-A3 is the required alternate search options. Support for Options A1-A3 is a best practice for all health plans.

Support for Options 4-6 is optional. However, when the option is supported, the best practice is outlined below.

Scenario A Options	Subscriber ID	Last Name	First Name	Patient DOB	TR3 References for Required Search Options for Maximum Data Elements to be used
<b>1</b>	X	X	X	X	Required <b>Primary</b> Search Options
<b>2</b>	X	X		X	Required <b>Alternate</b> Search Options
<b>3</b>	X	X	X		Required <b>Alternate</b> Search Options
<b>4</b>	X		X	X	Support is Optional
<b>5</b>	X			X	Support is Optional
<b>6</b>		X	X	X	Support is Optional

## Scenario A - Patient is Subscriber, Loop 2100C

### ➤ Required Primary Search Option:

If the patient is the subscriber, the maximum data elements that can be required by an information source to identify a patient in **Loop 2100C** are:

- Subscriber ID
- Last Name
- First Name
- Patient Date of Birth (DOC)

If all four of these elements are present, the information source must generate a response if the patient is in their database. All information sources are required to support the above search option.

When the patient is the subscriber, it is recommended that an Information Source use all four of these elements in locating the patient in their database; however Information Receivers should be aware that the Information Source might not have used all four of these elements.

Scenario	Subscriber ID	Last Name	First Name	Patient DOB
<b>A-1</b>	X	X	X	X

271 Response - AAA			
Possible Match Results	Resulting AAA03 Response	Description of AAA03 Response	AAA04 Response
Unique	None	None	None
Multiple	76	Duplicate subscriber/Insured ID Number	C
None-Not Found	75	Subscriber/Insured Not Found	C
No Name	73	Invalid/Missing Subscriber/Insured Name	C
No DOB	71	Patient Birth Date Does Not Match That for the Patient on the Database	C

AAA04 Description, C =Please Correct and Resubmit

### ➤ Required Alternate Search Options:

All four pieces of information from the Primary Search Option may not be available (such as in an emergency situation) or there are differences between the identifying information for the individual that the provider has and what the information source has (such as misspelled name). To accommodate these types of situations, and to provide a set of standardized alternate search options, alternate search options have been defined in addition to the Primary Search Option.

If the patient is the subscriber, the maximum data elements that can be required by an information source for a Required Alternate Search Option to identify a patient in loop 2100C are:

- Subscriber ID
- Last Name
- Either First Name or Patient DOB

## Scenario A - Patient is Subscriber, Loop 2100C

Scenario	Subscriber ID	Last Name	First Name	Patient DOB
A-2	X	X		X

271 Response - AAA			
Possible Match Results	Resulting AAA03 Response	Description of AAA03 Response	AAA04 Response
Unique	None	None	None
*Multiple	73	Invalid/Missing Subscriber/Insured Name	C
None-Not Found	72	Invalid/Missing Subscriber/Insured ID	C
No Last Name	73	Invalid/Missing Subscriber/Insured Name	C
No DOB	58	Invalid/Missing Date of Birth	C

**AAA04 Description, C** =Please Correct and Resubmit

\*Use 73 when there are no match errors on ID#, Last Name or Date of Birth

Note: Code 58 may not be returned if the information source has located an individual and the Birth Date does not match; use code 71 instead.

Scenario	Subscriber ID	Last Name	First Name	Patient DOB
A-3	X	X	X	

271 Response - AAA			
Possible Match Results	Resulting AAA03 Response	Description of AAA03 Response	AAA04 Response
Unique	None	None	None
*Multiple	58	Invalid/Missing Date of Birth	C
None-Not Found	72	Invalid/Missing Subscriber/Insured ID	C
No Name	73	Invalid/Missing Subscriber/Insured Name	C

\*Use 58 when there are no match errors on ID# or Name

### ➤ Optional Alternate Search Options:

If the patient is the subscriber, the maximum data elements that can be required by an information source for a Optional Alternate Search Option to identify a patient in loop 2100C are:

- Patient DOB
- Any 2 of 3 of (Subscriber ID, Last Name, First Name)

## Scenario A - Patient is Subscriber, Loop 2100C

Scenario	Subscriber ID	Last Name	First Name	Patient DOB
A-4	X		X	X

271 Response - AAA			
Possible Match Results	Resulting AAA03 Response	Description of AAA03 Response	AAA04 Response
Unique	None	None	None
Multiple	73	Invalid/Missing Subscriber/Insured Name	C
None-Not Found	72	Invalid/Missing Subscriber/Insured ID	C
No Name	73	Invalid/Missing Subscriber/Insured Name	C
No DOB	58	Invalid/Missing Date of Birth	C

\*Use 73 when there are no match errors on ID#, First Name or Date of Birth

**Note:** Code 58 may not be returned if the information source has located an individual and the Birth Date does not match; use code 71 instead.

Scenario	Subscriber ID	Last Name	First Name	Patient DOB
A-5	X			X

271 Response - AAA			
Possible Match Results	Resulting AAA03 Response	Description of AAA03 Response	AAA04 Response
Unique	None	None	None
Multiple	73	Invalid/Missing Subscriber/Insured Name	C
None-Not Found	72	Invalid/Missing Subscriber/Insured ID	C
No DOB	58	Invalid/Missing Date of Birth	C

**Note:** Code 58 may not be returned if the information source has located an individual and the Birth Date does not match; use code 71 instead.

Scenario	Subscriber ID	Last Name	First Name	Patient DOB
A-6		X	X	X

271 Response - AAA			
Possible Match Results	Resulting AAA03 Response	Description of AAA03 Response	AAA04 Response
Unique	None	None	None
*Multiple	72	Invalid/Missing Subscriber/Insured ID	C
None-Not Found	73	Invalid Missing Subscriber/Insured Name	C
No DOB	71	Patient DOB does not match that for the patient on the database	C

\*Use 72 when there are no match errors on Name or Date of Birth

## Scenario B - Patient is Dependent, Loop 2100D

### Scenario B - Patient is Dependent, Loop 2100D

Scenario Options are indicated /displayed in order as referenced in 270/271 TR3, References: 5010 TR3 Section 1.4.8. Scenario A-1 is the required primary search options. Scenarios A2-A3 are the required alternate search options. Support for Options A1-A3 is a best practice for all health plans.

Support for Options 4-6 is optional. However, when the option is supported, the best practice is outlined below.

Scenario B Options	2100C Subscriber ID	2100D Last Name	2100D First Name	2100D Patient DOB	TR3 Reference for Required Search Options for Maximum Data Elements to be used
1	X	X	X	X	Required <b>Primary</b> Search Options
2	X	X		X	Required <b>Alternate</b> Search Options
3	X	X	X		Required <b>Alternate</b> Search Options
4	X		X	X	Support is Optional
5	X			X	Support is Optional
6		X	X	X	Support is Optional

➤ **Required Primary Search Option** - If the **patient is a dependent** of a subscriber, the maximum data elements that can be required by an information source to identify a patient in loop **2100C and 2100D** are:

#### Loop 2100C

- Subscriber's Member ID Number

#### Loop 2100D

- Patient's Last Name
- Patient's First Name
- Date of Birth

If all four of these elements are present the information source must generate a response if the patient is in their database. All information sources are required to support the above search option if their system does not have unique Member Identifiers assigned to dependents.

When the **patient is the dependent**, it is recommended that an Information Source use all four of these elements in locating the patient in their database; however Information Receivers should be aware that the Information Source might not have used all four of these elements.

## Scenario B - Patient is Dependent, Loop 2100D

Scenario	Loop 2100C Subscriber ID	Loop 2100D Last Name	Loop 2100D First Name	Loop 2100D Patient DOB
B-1	X	X	X	X

271 Response - AAA			
Possible Match Results	Resulting AAA03 Response	Description of AAA03 Response	AAA04 Response
Unique	None	None	None
Multiple	68	Duplicate Patient ID	C
None-Not Found	64	Invalid Missing Patient ID	C
No Name	65	Invalid Missing Patient Name	C
No DOB	*58	Invalid/Missing Date-of-Birth	C

AAA04 Description, C =Please Correct and Resubmit

\*Code 71 must be returned when the transaction was rejected when the information source located an individual based on other information submitted, but the Birth Date does not match.

### ➤ Required Alternate Search Options - Patient is Dependent

If the patient is a dependent of a subscriber, the maximum data elements that can be required by an information source for a Required Alternate Search Option to identify a patient in Loop 2100C and 2100D are:

#### Loop 2100C

- Subscriber's Member ID Number

#### Loop 2100D

- Patient's Last Name
- Either Patient's First Name or Date of Birth

If all of the elements for one of the Required Alternate Search Options are present, the Information Source is required to search for the patient in their system and if a unique match for an individual can be made, the Information Source is required to return the appropriate eligibility response

Scenario	Loop 2100C Subscriber ID	Loop 2100D Last Name	Loop 2100D First Name	Loop 2100D Patient DOB
B-2	X	X		X

271 Response - AAA			
Possible Match Results	Resulting AAA03 Response	Description of AAA03 Response	AAA04 Response
Unique	None	None	None
*Multiple	65	Invalid/Missing Patient Name Required	C
None-Not Found	64	Invalid Missing Patient ID	C
No Name	65	Invalid Missing Patient Name	C
No DOB	58	Invalid/Missing Date of Birth	C

AAA04 Description, C =Please Correct and Resubmit

\*Use 65 when there are no match errors on ID#, Last Name or DOB

## Scenario B - Patient is Dependent, Loop 2100D

Note: When No Date of Birth match, Code 71 must be returned when the transaction was rejected when the information source located an individual based on other information submitted, but the Birth Date does not match.

Scenario	Loop 2100C Subscriber ID	Loop 2100D Last Name	Loop 2100D First Name	Loop 2100D Patient DOB
B-3	X	X	X	

271 Response - AAA			
Possible Match Results	Resulting AAA03 Response	Description of AAA03 Response	AAA04 Response
Unique	None	None	None
*Multiple	58	Invalid/Missing Date of Birth	C
None-Not Found	64	Invalid Missing Patient ID	C
No Name	65	Invalid Missing Patient Name	C

\*Use 58 when there are no match errors on ID# or Name

### ➤ Optional Alternate Search Options - Patient is Dependent

If the patient is the dependent, the maximum data elements that can be required by an information source for a Optional Alternate Search Option to identify a patient in Loop 2100C and 2100D are:

- Patient Date of Birth-Loop 2100D
- 2 of 3 of (Subscriber's Member ID Number-Loop 2100C, Patient's First Name-Loop 2100D, Patient's Last Name-Loop 2100D)

Scenario	Loop 2100C Subscriber ID	Loop 2100D Last Name	Loop 2100D First Name	Loop 2100D Patient DOB
B-4	X		X	X

271 Response - AAA			
Possible Match Results	Resulting AAA03 Response	Description of AAA03 Response	AAA04 Response
Unique	None	None	None
*Multiple	65	Invalid Missing Patient Name	C
None-Not Found	64	Invalid Missing Patient ID	C
No Name	65	Invalid Missing Patient Name	C
No DOB	*58	Invalid/Missing Date of Birth	C

\*Code 71 must be returned when the transaction was rejected when the information source located an individual based on other information submitted, but the Birth Date does not match.

## Scenario B - Patient is Dependent, Loop 2100D

Scenario	Loop 2100C Subscriber ID	Loop 2100D Last Name	Loop 2100D First Name	Loop 2100D Patient DOB
B-5	X			X

271 Response - AAA			
Possible Match Results	Resulting AAA03 Response	Description of AAA03 Response	AAA04 Response
Unique	None	None	None
*Multiple	65	Invalid/Missing Patient Name	C
None-Not Found	64	Invalid Missing Patient ID	C
Name	65	Invalid/Missing Patient Name	C
DOB	*71	Patient Date of Birth Does Not Match That for the Patient on the Database	C

\*Code 71 must be used when the Patient Date of Birth Does Not Match That for the Patient on the Database

**Note:** Code 58 may not be returned if the information source has located an individual and the Birth Date does not match; use code 71 instead.

Scenario	Loop 2100C Subscriber ID	Loop 2100D Last Name	Loop 2100D First Name	Loop 2100D Patient DOB
B-6		X	X	X

271 Response - AAA			
Possible Match Results	Resulting AAA03 Response	Description of AAA03 Response	AAA04 Response
Unique	None	None	None
*Multiple	*64	Invalid/Missing Patient ID	C
None-Not Found	65	Invalid Missing Patient Name	C
No Name	73	Invalid/Missing Subscriber/Insured Name	C
No DOB	71	Patient Date of Birth Does Not Match That for the Patient on the Database	C

\*Use code 64 when there are no errors on Name or Date of Birth

**Note:** Code 58 may not be returned if the information source has located an individual and the Birth Date does not match; use code 71 instead.

## 5. Service Types and associated information about Benefit Limitations

The table below identifies specific service types for which benefit information will be electronically provided by the health plan on their web site and in their 270-271 transaction set. Over time, additional service types are likely to be added to this list.

This table also identifies those service types for which benefit limitation information is *typically* associated. *Typically* means that a number of health plans, though not all, have benefit limitations around those service types (as designated by a 'Y' in the table).

If a health plan's member has a benefit for one of the listed service types, deductible, co-pay and co-insurance information will be provided, as discussed in Section IV above. Benefit limitation information, if appropriate for that health plan, will also be provided. Note, health plans may not always provide benefit limitation information. They will only provide the information that is relevant to their member's specific policy. For example, one patient's policy may have a maximum number of visits for acupuncture and another patient's policy would not. As another example, a patient's policy may have Date Limitations around the benefit period and those limitations are different than the patient's general eligibility period. In this case, the Date Limitations specific to the benefit will be included in the 271 transaction. If the benefit's Date Limitations are the same as the patient's general eligibility period, then Date Limitations specific to the benefit will not be included.

HIPAA Service Type Description	Operational Description of Benefit	HIPAA Service Type Code	Possible Set of Benefit Limitations Information				
			Need for Pre-Auth	Date Limitations Around Benefit Period	Benefit Maximums	Benefit Accumulators	Other
Acupuncture	Services provided by a licensed acupuncturist.	64		Y	Y	Y	
Allergy Testing	Testing to determine the substance to which a person is allergic.	79					
Ambulatory Service Center Facility	Facility fee for services provided in a free standing ambulatory surgery center.	13					
Anesthesia	Local or general insensibility to pain with or without the loss of consciousness induced by an anesthetic.	7	Y for Dental				

HIPAA Service Type Description	Operational Description of Benefit	HIPAA Service Type Code	Possible Set of Benefit Limitations Information				
			Need for Pre-Auth	Date Limitations Around Benefit Period	Benefit Maximums	Benefit Accumulators	Other
Audiology Exam	Hearing exams by a licensed provider to determine the need for corrective treatment.	71		Y	Y	Y	
(Baby) Newborn Care	Medical facility and related professional charges for an infant during the initial period of confinement following birth.	65		Y	Y	Y	May be required to notify health plan w/in 24 hrs of baby's birth
(Baby) Well Baby Care	Preventive office visits and immunizations during the first year of life.	68		Y	Y	Y	
Cardiac Rehabilitation	Rehabilitation therapy following an acute cardiac event.	BG			Y	Y	
Chemotherapy	The treatment of disease by chemical or biological antineoplastic agents.	78			Y	Y	May be required to notify health plan of drug type/dose
Chiropractic	Services provided by a licensed chiropractor.	33		Y	Y	Y	
Dental Care	The prevention and treatment of diseases of the teeth, gums, and related structures of the mouth.	35	Y	Y	Y	Y	
(Diagnostic) Diagnostic X-Ray	Radiology to diagnose specific symptoms or rule out medical conditions.	4			Y	Y	
(Diagnostic) Diagnostic Lab	Laboratory and pathology tests to diagnose specific symptoms or rule out medical conditions.	5			Y	Y	

HIPAA Service Type Description	Operational Description of Benefit	HIPAA Service Type Code	Possible Set of Benefit Limitations Information					
			Need for Pre-Auth	Date Limitations Around Benefit Period	Benefit Maximums	Benefit Accumulators	Other	
(Diagnostic) MRI/Cat Scan	Testing used to diagnose or evaluate a condition. <ul style="list-style-type: none"> <li>A non invasive procedure that causes magnets and radio waves to construct pictures of the body.</li> <li>Computerized tomography of body imaging in which a thin x-ray beam rotates around the patient.</li> </ul>	62	Y		Y	Y		
(Diagnostic) Diagnostic Medical	Tests/services used to diagnose specific symptoms or rule out medical conditions.	73			Y	Y		
Dialysis	Outpatient dialysis services furnished by a Hospital, Community Health Center, free-standing dialysis facility or physician. This coverage may also include dialysis services rendered on an inpatient basis or in the patient's home.	76						
DME - Purchase	The purchase of new medical equipment which can withstand repeated use, is not disposable, and is used to service a medically necessary therapeutic purpose.	12	Y	Y	Y	Y		
DME - Used	The purchase of previously used medical equipment which can withstand repeated use, is not disposable, and is used to service a medically necessary therapeutic purpose.	11	Y	Y	Y	Y		
DME – Rental	The rental of medical equipment which can withstand repeated use, is not disposable, and is used to service a medically necessary therapeutic purpose.	18	Y	Y	Y	Y		
Family Planning	Consultations, exams, procedures and medical services	82						

HIPAA Service Type Description	Operational Description of Benefit	HIPAA Service Type Code	Possible Set of Benefit Limitations Information				Other
			Need for Pre-Auth	Date Limitations Around Benefit Period	Benefit Maximums	Benefit Accumulators	
	related to the use of contraceptive methods that have been approved by the US Food and Drug Administration.						
Home Health Care	Home care for homebound patients who require skilled care services. May include nursing services, physical therapy, occupational therapy, speech therapy, home health aide, and medical social worker.	42	Y		Y	Y	
Hospice	Care when a provider has determined that life expectancy is 6 months or less and a palliative, supportive care treatment approach has been chosen.	45	Y		Y		
Hospital - Ambulatory Surgical	Hospital billed surgery performed on a person who is admitted to and discharged from a hospital on the same day.	53					
Hospital - Emergency Accident	Hospital services for the treatment of a sudden and unexpected medical injury caused by an external force or element that requires immediate medical attention.	51					
Hospital - Inpatient	Care and services provided in a hospital setting after admission	48	Y		Y	Y	
Hospital - Outpatient	Care and services provided in a hospital setting without admission	50	Y				
Hospital – Emergency Medical	Care and services provided in a hospital emergency department	52					
Immunizations	Vaccination to prevent disease.	80			Y	Y	
Massage Therapy	Services provided by a licensed massage therapist.	BE		Y	Y	Y	
Maternity	Prenatal and postnatal visits as well as the facility fee	69			Y	Y	

HIPAA Service Type Description	Operational Description of Benefit	HIPAA Service Type Code	Possible Set of Benefit Limitations Information					
			Need for Pre-Auth	Date Limitations Around Benefit Period	Benefit Maximums	Benefit Accumulators	Other	
	for the delivery.							
Medical Care	Medical services and supplies to diagnose and/or treat medical condition, illness or injury. Medical services and supplies provided by physicians and other healthcare professionals	1						
Mental Health	Services provided by a physician and/or other healthcare providers who are trained and educated to perform services related to mental health and may be licensed to practice within the scope of licensure or training.	MH			1	1		
Occupational Therapy	Constructive activities designed and adapted to promote the functional restoration of the person's daily living abilities that are lost or impaired by disease or accidental injury.	AD	Y	Y	Y	Y		
Oral Surgery	Surgery to the jaw, sound natural teeth, mouth, or face.	40	Y		Y	Y		
Orthodontics	Treatment to correct and align irregularities of the teeth.	38	Y	Y	Y	Y		
Pediatric	Routine medical exams and related routine services, including immunizations, rendered to an infant, child or adolescent. Restrictions may apply due to age schedule and/or visit limits	BH						
Periodontics	Treatment of periodontal disease.	24			Y	Y		
Pharmacy	Coverage for prescription drugs and related supplies.	88						
Physical Medicine	Services provided by a licensed Physical Therapist.	AE	Y	Y	Y	Y		
Podiatry	Diagnosis, treatment, and prevention of diseases of the human foot.	93			Y	Y		
Professional (Physician) Visit	Medical services provided by physicians and/or other healthcare professionals to a patient admitted into the	99						

HIPAA Service Type Description	Operational Description of Benefit	HIPAA Service Type Code	Possible Set of Benefit Limitations Information				
			Need for Pre-Auth	Date Limitations Around Benefit Period	Benefit Maximums	Benefit Accumulators	Other
- Inpatient	hospital staying overnight as inpatient (not for observation)						
Professional (Physician) Visit - Outpatient	Medical services provided by physicians and/or other healthcare professionals to a patient in the outpatient department of a hospital or other covered facility. (may be for observation)	A0					
Professional (Physician) Visit - Home	Medical services provided by physicians and/or other healthcare professionals to a patient at their home	A3					
Professional (Physician) Visit Office - Sick	An outpatient visit with a licensed care provider for treatment of an illness or condition when the patient is sick	BY					
Professional (Physician) Visit Office - Well	An outpatient visit with a licensed care provider for preventative care	BZ					
Professional (Physician) Visit-Office	An outpatient visit with a licensed care provider for treatment of an illness or condition	98					
Prosthetic Device	Artificial substitutes which replace parts of the human body.	75	Y		Y	Y	
Psychiatric - Inpatient	Inpatient facility treatment for psychiatric/mental conditions.	A7	Y	Y	Y	Y	
Psychiatric - Outpatient	Outpatient treatment for psychiatric/mental conditions.	A8	Y	Y	Y	Y	
Psychotherapy	Inpatient or outpatient professional services, including individual or group therapy by providers such as psychiatrists, psychologists, clinical social workers, or	A6			1	1	

HIPAA Service Type Description	Operational Description of Benefit	HIPAA Service Type Code	Possible Set of Benefit Limitations Information				
			Need for Pre-Auth	Date Limitations Around Benefit Period	Benefit Maximums	Benefit Accumulators	Other
	psychiatric nurses.						
Radiation Therapy	Advanced imaging services, sometimes called radiotherapy, x-ray therapy radiation treatment, cobalt therapy, electron beam therapy, or irradiation uses high energy, penetrating waves or particles such as x rays, gamma rays, proton rays, or neutron rays, provided by or ordered and billed by a physician or other healthcare provider to destroy malignant cells and or tumors or keep them from reproducing	6			1	1	
Rehabilitation - Inpatient	Inpatient rehabilitative treatment for patients recovering from injuries or illnesses that severely impair their physical functioning or understanding.	AB	Y	Y	Y	Y	
Rehabilitation - Outpatient	Outpatient therapy services to restore and significantly improve function that was previously present but lost due to acute injury or illness.	AC	Y	Y	Y	Y	
Respite Care	Temporary residential care for patients that provides relief for the permanent caregivers.	46	Y	Y	Y	Y	
Routine Physical	Exam to screen for diseases, assess risk of future medical problems, and update vaccinations.	81		Y	Y	Y	
Second Surgical Opinion	An additional professional opinion sought to verify or confirm the necessity of a surgical procedure.	20					
Skilled Nursing Care	Services provided in a licensed skilled nursing facility.	AG	Y	Y	Y	Y	
Smoking Cessation	Treatment to aid in quitting smoking.	67		Y	Y	Y	
Speech Therapy	Treatment of speech defects and disorders.	AF	Y	Y	Y	Y	
Substance Abuse	Treatment for the dependence of an addictive substance,	AI	Y	Y	Y	Y	

HIPAA Service Type Description	Operational Description of Benefit	HIPAA Service Type Code	Possible Set of Benefit Limitations Information				
			Need for Pre-Auth	Date Limitations Around Benefit Period	Benefit Maximums	Benefit Accumulators	Other
	including alcohol or a narcotic drug.						
Surgical	Invasive procedure for diagnosis and treatment of injury, deformity, and disease.	2	Y				
Surgical Assistance	Assistant Surgeon/surgical assistance provided by a physician if required because of the complexity of the surgical procedures.	8					
Transplants	The grafting of a tissue/organ.	70	Y	Y	Y	Y	
(Transportation) Cabulance	Transportation by a licensed cabulance service.	58			Y	Y	
(Transportation) Licensed Ambulance	Transportation by a licensed ambulance service.	59			Y	Y	
(Transportation) Medically Related Transportation	Other medically related transportation.	56			Y	Y	
(Transportation) Air Transportation	Transportation via helicopter or plane in order to transport a sick or injured patient to the nearest appropriate hospital/facility.	57			Y	Y	
Urgent Care	Non-emergent episodic care that cannot be delayed until an appointment at a physician office is available. Care is provided by a physician and/or other healthcare providers on an outpatient basis in a fixed location or designated mobile unit that is not designated as an emergency department.	UC					
Vision (Optometry)	Eye examination, determination of visual abilities, diagnosis of eye diseases and conditions, and the	AL		Y	Y	Y	

HIPAA Service Type Description	Operational Description of Benefit	HIPAA Service Type Code	Possible Set of Benefit Limitations Information				Other
			Need for Pre-Auth	Date Limitations Around Benefit Period	Benefit Maximums	Benefit Accumulators	
	prescription of lenses and other corrective measures.						

Legend:

- **HIPAA Service Type Description:** Description used in the HIPAA TR3. Organizational Categories (which are not included in the TR3) are denoted in *(italics)*.
- **Operational Description of Benefit:** Best Practice Recommended description of the benefit to be used in common practice by health plans and providers.
- **HIPAA Service Type Code:** From the EQ01 field in the 270 or the EB03 field in the 271
- **Need for Pre-Auth:** If ‘Y’ then services may need to be pre-authorized
- **Date Limitations Around Benefit Period:** If ‘Y’ then limitations around the benefit period may be different than the general eligibility period. For example, for a specific service, a member’s policy may only allow a maximum of 4 visits for an episode of care.
- **Benefit Maximums:** If ‘Y’ then there may be specific benefit maximums for the service type. Benefit maximum information may include:
  - Maximum Dollar Amount
  - Maximum Number of Treatments/Visits
  - Maximum Number of Days
- **Benefit Accumulators:** If ‘Y’ then the benefit remaining may be tracked
- **Other:** Other types of benefit related information needed by providers. (There is currently not a place for this information in the 271 transaction.)