270 / 271 – Assessment of Changes (8010v)

The changes are primarily focused in the following areas:

- Service Type Codes
- Benefit Information
- Cascading Search Logic
- Reporting Changes between 271 & 270
- Error Reason Codes

A. <u>Using Service Type Codes</u>

Service Type Codes (STC) are groupings of health care benefit or service information that are used to request and describe the coverage provided in a member's policy, at various levels of detail.

Example:

1	Medical Care
30	Plan Coverage and General Benefits
47	Hospitalization
86	Emergency Services
98	Prescription Drug
A6	Psychotherapy
AL	Optometry
BY	Physician Visit-Sick
F1	Medical Coverage

In the 8010, the list of STCs has changed along with their location and usage. Changes include:

1) Location & General Usage

   a) The STCs will no longer be listed in the TR3. They will be listed and maintained in the TR2

   b) Variation in Service Type Codes

      - Service Type Codes that do not begin with an "F" are to be used to describe a benefit or service.

1	Medical Care
30	Plan Coverage and General Benefits
47	Hospitalization
86	Emergency Services
98	Prescription Drug
A6	Psychotherapy
AL	Optometry
BY	Physician Visit-Sick
F1	Medical Coverage

- Service Type codes that begin with the letter "F" are considered Health Plan Coverage Type codes (hereinafter referred to as Coverage Type Code), and are not used to indicate types of coverage and not benefits or services.

Plan Coverage Type Code	Plan Coverage Type Code Description
F1	Medical Coverage
F2	Social Work Coverage
F3	Dental Coverage
F4	Hearing Coverage
F5	Prescription Drug Coverage
F6	Vision Coverage
F7	Orthodontia Coverage
F8	Mental Health Coverage

Coverage Type Codes, STC "F" codes, cannot be submitted on a 270. They can only be used by the payer on the 271 response to indicate the type of coverage(s) that are active and inactive.

- Non-F and F type codes are not to be used interchangeably; meaning, a Coverage Type cannot be a service or benefit, and a service or benefit cannot be a Coverage Type.

c) Payers need to be able to respond to all valid STCs that are submitted (1.4.8.2) Up to 10 STCs in a single 270 request.

d) If 10 or less STCs are submitted on a single 270 (EQ01-01), the payer must be able to receive and respond to all of them. The payer can respond to more than 10 if the providers and payers agree to a higher number.

Q*: How does the payer respond if more than 10 STCs are submitted and there is no agreement in place between provider and payer? Can the payer choose to which 10 of the submitted STCs do they respond?*

e) STC descriptor can be sent as a composite to STC. (EQ01-02, EB03-02)

f) A ‘Baseline Response Group’ has been defined that contains the set of Service Type Codes that must be returned when Service Type Code 30 is requested.

Service Type Code	Service Type Code Description
1	Medical Care
4	Diagnostic X-Ray
5	Diagnostic Lab
33	Chiropractic
35	Dental Care
47	Hospitalization
86	Emergency Services
98	Prescription Drug
AL	Optometry
BY	Physician Visit-Sick
BZ	Physician Visit-Well
MH	Mental Health
UC	Urgent Care

Based upon legal issues with MH – what about accumulators

2) STC30 and STC60

a) General Usage

- Use of the STC30 on the 270 is to request general coverage information and specific plan benefits of a member’s policy. STC30 can no longer be used to respond to a STC30 request. If an STC of 30 is received, the Health Plan will return coverage information using the new “F” codes along with the appropriate benefit and service STC codes.
- Use of the STC60 on the 270 is to request general coverage information of a member’s policy.

b) Submission on a 270

- STC30 - Plan Coverage and General Benefits request should be submitted by itself, i.e. with no other STC codes or procedure codes. A non-severe AAA will be returned for all other codes submitted.
- STC60 - Plan Coverage request should be submitted by itself, i.e. with no other STC codes or procedure codes. A non-severe AAA will be returned for all other codes submitted.

c) Response on a 271

- STC30 or STC60 cannot be returned by the Health Care Plans on EB03 (1.4.8.2.2))

- In response to an STC30, the following must be returned:
    - The Plan Coverage Type Codes, i.e. 'F' STCs, that are active or inactive on a member's policy
    - The defined set of Baseline Response STCs

      Some of the STCs in the Baseline Response Group can be separated into more granular Service Type Codes. When a STC30 is submitted, the payer can choose to use these more granular STCs to provide more detailed, relevant information

STC in Baseline Response	More Granular STC
1 - Medical Care	1 - Medical Care 2 - Surgical 3 - Consultation 42 - Home Health Care 45 - Hospice 54 - Long Term Care 69 - Maternity 76 - Dialysis 83 - Infertility AG - Skilled Nursing Care BT - Gynecological BU - Obstetrical BY - Physician Visit - Sick BZ - Physician Visit - Well

- In response to an STC60, the Plan Coverage Type Codes, i.e. 'F' STCs, that are active or inactive on a member's policy must be returned

3) STCs other than 30, 60, "F" codes

   When one or more other these codes are submitted on the 270, the 271 must return:

   - All Plan Coverage Types applicable to the requested service type(s) that are active or inactive during the date(s) requested.
   - Health Care Service Type Codes that are applicable to each of the reported Plan Coverage Types

B. <u>Benefit Information</u>

1. Selectively Requesting and Reporting Benefit Information

   a. Coverage and Benefit Information can be requested for a specific time period.

i. The provider can ***specify a date or date range*** for which they would like to receive eligibility, plan, and benefit information. If no date is included, then the current processing date of the transaction is to be used. (1.4.8.1.4, 2100CA/DA – DTP)

   The payer must support a single date or date range request that extends:

   - Up to the end of the current month
     AND
   - Up to 12 months in the past or up to the applicable Payer's Timely Filing Requirements, whichever is greater

   The 271 response must return the 270 inquiry request date or date range to serve as a frame of reference for the plan enrollment, accumulators (both financial and non-financial) – see B.3 below), and benefit coverage information. This request date or date range from the 270 inquiry must be accompanied by the 2100CA/DA DTP01 = "881". (1.4.8.2.1.4)

ii. The payer is required to ***return all active, inactive, or suspended plan coverage periods*** that intersect the date(s) requested, ensuring that every date included in the date or date range requested is represented in a coverage period. Plan coverage periods that do not fall within or intersect the date(s) requested on the 270 must not be returned on the 271 response. (1.4.8.2.1.2)

iii. ***If benefit dates are different from the plan coverage date(s),*** then the benefit related date(s) must be returned in the 2105CA/DA DTM or 2110CA/DA DTP (with the associated EB03 and/or EB13). (1.4.8.2.1.3)

b. Benefit Information can be requested for only In-Network Providers, only Out-of-Network Providers or Both (EQ06). Note: this can be requested but the Plan is not required to respond. Too often insufficient information is provided to determine servicing provider's network status.

c. The reporting of Benefits can be grouped together into meaningful categories (271 - 2105CA)

   To reduce confusion, benefits with similar characteristics can be reported in the same hierarchical loop and benefits with different characteristics can be reported in a different hierarchical loop. For example, different hierarchical loops can be created for each Coverage Type and the corresponding benefit level Service Type Codes can be grouped within the respective Coverage Type loop. For example: a coverage type loop of vision may be returned separately from a coverage type loop of medical. This is particularly useful when an STC of 30 is submitted

d. Benefit information cannot be repeated

Coverage and benefit details for a given Service Type Code must not be duplicated within a single patient 271 eligibility response when using any combination of multiple EBs and/or the repeating feature of EB03, except when used with different plan coverage types. This may be a point of discussion. For example, I may return an office visit 98 and return it a 2nd time with the qualifier of III 99 indicating place of service is telehealth.

2. New Benefit Information Requirements

   a. First Dollar Coverage Information (2110CA/DA SBI)

      First Dollar Coverage is a benefit that reflects an employer's arrangement with the insured that a certain dollar amount will be covered, for the overall plan or at service levels, prior to the patient being responsible for financial liability.

      The First Dollar Coverage Segment is associated with a corresponding EB segment. (value SBI01 = value EB01).

      For example: A member may have a plan that covers the first six office visits (plan or calendar year) with zero copay for an in-network provider. All additional office visits will have a copay

   b. Tiered Benefits Information (2110CA/DA SBI)

      Some plans have categories of providers, called tiers. These tiers identify which providers have a lower cost to their members. Tier 1 means the member will pay a lower copayment or coinsurance when they are treated by that provider. Tier 2 means higher copayments or coinsurance. Tiered Benefit Information reports information such as copay, coinsurance, deductible, etc. by tier.

      The Tiered Benefit Information Segment is associated with a corresponding EB segment. (value of EB01 = TB).

      An example may be helpful here, but might be sensitive. A member who's employer group is MultiCare will have a lower member cost share if the servicing provider is a MultiCare provider. All other in-network providers will have a higher member cost share.

   c. Grace Periods with Premium Paid-To Date. (2105CA/DA DTM01 or 2110CA/DA DTP01)

      If the individual is known to be in a grace period for non-receipt of the premium payment, the 2105CA/DA DTM01 or 2110CA/DA DTP01 may be used to indicate the Beginning of Grace Period ("BGP") and End of Grace Period ("756") dates. The information source is encouraged to return the premium paid to dates with the applicable 2105CA/DA DTM01 or 2110CA/DA DTP01 code values "342" and "343". The 2110CA/DA EB01 code values "10", "11", or "12" may be used to indicate the individual's eligibility status. (1.4.8.2.1.5)

3. Using the EB to report information about specific benefits
    a. The same EB segment can contain information about Service Type Codes (EO03) and related Procedure Codes (EB13).
    b. Accumulators (1.4.8.2.12): The remaining amounts (EB06 Value = '29-Remaining') must be returned for deductible, out of pocket (stop loss) and spend down, along with the original base values. ***Note: Not new but now required.***

       Q: If STC30 is submitted, must accumulators be returned for STC MH? This question is driven by concerns about the sensitivity of mental health information. Per our current BPR, that information will be provided "if consistent with health plan privacy policy".
    c. The EB (EB15) can report whether the benefit, e.g. copay, deductible must be satisfied separately for each service type code (EB03) and procedure code (EB13) reported in the EB or whether the benefit is shared and all services reported in EB03 satisfy the same deductible
    d. The EB (EB16) can report whether the service type code (EB03) or procedure code (EB13) requires some type of review, e.g. Authorization, Notification, Referral, etc. This is an existing optional requirement, but 8010 now differentiates between prior-auth and referrals, which is new and should be very helpful.

C. <u>Cascading Search Logic 1.4.9.8</u>

Payers are required to support cascading search logic. They may use any search options they choose to support upon receipt of the 270 transaction, however, if the search results in an error based on the patient's information or if the patient is not found, the payer must then use cascading search logic as outlined TR3 section 1.4.9.8. ***Note: Kate suggests that health plans may already be doing this.***

There are two possible outcomes from using the cascading search logic. The first (and desired) outcome is to locate a unique individual in the information source's system. Once a unique individual is located, then the response is created complying with the requirements of Section 1.4.8.2 - 271 Minimum Requirements. The second outcome is an individual is not located in the information source's system and all appropriate AAA error reason code(s) are returned.

D. <u>Reporting changes between the 271 response and the 270 request</u>

Two elements have been added to the INS segment (INS 18 and 19) to report identifying information changes between 270 & 271:

1. **INS18 - Changed Identifying Information Code** – A code specifying the identification information that changed from a request to a response

b. when any identifying element for the subscriber is different from those submitted in the 270, OR

c. when the Loop ID for the patient information in the 271 is different from that submitted in the 270 (i.e. when 270 contained subscriber loop, but determined to be a dependent on the 271 and vice versa)

2. I**NS19** - **Provider Network Status Information Code –** A code specifying that the Provider Network Information changed from a request to a response.

E. Error Reason Codes

1. The Error Reason codes are now maintained separately as an external code list associated with Date Element 1787 Error Reason Code (AAA05). Data Element 901 is unused in 007030X332 and Data Element 1787 Code has been added

2. The AAA segment has been updated with a new element – AAA05 - to report Error Reason Codes

   Per 1.4.11

   There are three elements that are used in the AAA segment.

   - AAA01 is a Yes/No indicator that identifies if the data content sent on the 270 was valid.
   - ~~AAA03 is no longer used~~
   - AAA04 is the Follow-up Action Code and identifies what, if any, further action should be taken.
   - AAA05 is the Error Reason Code. AAA05 is a repeating data element that can occur up to 99 times

   If the AAA segment contains both AAA04 and AAA05, the information receiver should recognize the error as severe.

   If the AAA segment does not contain AAA04, the information receiver should recognize the error as non-severe and may want to address the error prior to any subsequent EDI transaction submission.