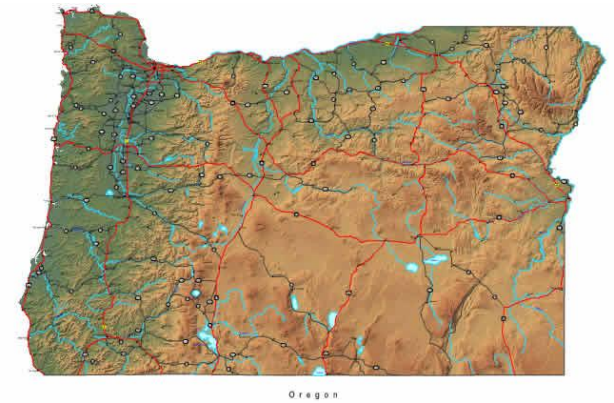

Oregon Companion Guide

For the Implementation of the

ASC X12N/005010X279

HEALTH CARE ELIGIBILITY BENEFIT INQUIRY AND RESPONSE (270/271)

And the published errata:

- ***ASC X12N/005010X279E1 (JANUARY 2009)***
- ***ASC X12N/005010X279A1 (JUNE 2010)***

JANUARY, 2011
VERSION 1.0

Disclaimer

The following Oregon Companion Guide is intended to serve as a companion document to the corresponding *ASC X12N/005010X279 Health Care Eligibility Benefit Inquiry and Response (270/271) and the errata documents subsequently published by ASC X12 (005010X279E1 and 005010X279A1).* Throughout the rest of the document, the ASC X12 technical report and attendant errata are referred to as 005010X279. The document further specifies the requirements to be used when preparing, submitting, receiving and processing electronic health care administrative data. The document supplements, but does not contradict, disagree, oppose, or otherwise modify the *005010X279* in a manner that will make its implementation by users to be out of compliance. Further this guide is not a replacement for using the TR3: the TR3 is required for the compliant implementation of this transaction. Using this companion guide does not mean that a claim will be paid. It does not imply payment policies of payers or the benefits that have been purchased by the employer or subscriber.

Statutory Authority

It is intended that this companion guide will be adopted and its use will be mandated for all HIPAA covered entities (payers, providers, and clearinghouses) conducting business or licensed in the state of Oregon.

Document Changes

The content of this companion guide is subject to change. The version, release and effective date of the document are included in the document, as well as a description of the process for handling future updates or changes.

About the Oregon Department of Health

The Oregon Department of Health is responsible for protecting, maintaining and improving the health of Oregonians. The department operates programs in the areas of disease prevention and control, health promotion, community public health, environmental health, health care policy, and registration of Health Care Providers.
http://www.health.state.or.us

About the Oregon Health Authority

The Oregon Health Authority (OHA) was created by the 2009 Oregon legislature to bring most health-related programs in the state into a single agency to maximize its purchasing power. Although the state is in the planning stages for organizing the new agency, work to change the health care system has already begun. The OHA works with a nine-member, citizen-led board called the Oregon Health Policy Board. Members are appointed by the Governor and confirmed by the Senate. The Health Authority will transform the health care system in Oregon by; improving the lifelong health of Oregonians; Increasing the quality, reliability, and availability of care for all Oregonians; Lowering or containing the cost of care so it's affordable to everyone in the state.
http://www.oregon.gov/OHA/

About the Oregon Health Leadership Council

The Oregon Health Leadership Council is a collaborative organization working to develop practical solutions that reduce the rate of increase in health care costs and premiums so health care and insurance is more affordable to people and employers in the state. Formed in 2008 at the request of the Oregon business community, the council brings together health plans, hospitals and physicians to identify and act on cost-saving solutions that maximize efficiencies while delivering high quality patient care.
http://www.orhealthleadershipcouncil.org

About the Administrative Simplification Group

The Administrative Simplification group was first formed in the spring of 2008 by the Oregon Medical Association, Oregon Association of Hospitals & Health Systems and Regence BlueCross BlueShield of Oregon. After the formation of the Oregon Health Leadership Council, the workgroup became one of the four Leadership Council's workgroups.

This group identifies effective ways to simplify the administrative challenges faced by physicians and other healthcare professionals in order to streamline the business side of health care and provide cost-savings to the entire system. Three sub-groups were formed to explore increasing use of web sites for eligibility and claims information, investigate a common credentialing solution, and work toward standardization and automation of key processes.
http://www.orhealthleadershipcouncil.org/administrative-simplification

Contact for Further Information on this Oregon Companion Guide

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Oregon Companion Guide Revision History

Ver.	Revision Date	Summary Changes
1.0	January 12th , 2011	Complete initial draft of Oregon Companion Guide (270/271)

1 EXCERPT FROM STATEMENT: OREGON HEALTH AUTHORITY

The 2009 Oregon Legislative Assembly directed the Office for Oregon Health Policy and Research (OHPR) to bring together a work group to recommend uniform standards for insurers for, at a minimum, eligibility verification, claims processes, payment remittance advice, and claims payment. The Oregon Health Policy Board asked the work group to expand the legislative direction and include a broad strategy for administrative simplification, including specifying the appropriate role for the state, and to estimate the potential for cost savings that can be achieved through administrative simplification.

The goal of administrative simplification is to reduce total system costs and reduce the amount of provider resources that must be devoted to administrative transactions between providers of care and payers by simplifying and streamlining these activities.

(Please refer to Section 7, Appendix C : Statement from the Oregon Health Authority for a complete extract of this statement)

2 INTRODUCTION AND OVERVIEW

2.1 Overview

On January 16, 2009, the U.S. Department of Health and Human Services (HHS) published rules (CMS–0009–F) announcing the adoption of new versions of the federal transaction standards, known as ASC X12/005010 ("Version 5010"). The compliance deadline to implement the 5010 version of the transaction standards, on a nationwide basis, is January 1, 2012.

One of the major transactions included in this version upgrade is the Health Care Eligibility Benefit Inquiry and Response (270/271). The standard was originally published on in April 2008 and two errata were published on January 2009 and June 2010.

The 'Eligibility' transaction is the transmission of either of the following:

(a) An inquiry from a Health Care Provider to a Health Plan, or from one Health Plan to another Health Plan, to obtain any of the following information about a benefit plan for an enrollee:
(1) Eligibility to receive health care under the Health Plan.
(2) Coverage of health care under the Health Plan.
(3) Benefits associated with the benefit plan.

(b) A response from a Health Plan to a Health Care Provider's (or another Health Plan's) inquiry described in paragraph (a).

Beginning January 1, 2012, Providers and Health Plans executing the Health Care Eligibility Benefit Inquiry and Response (270/271) transactions may only use the 5010 version of the Eligibility/Benefits Request/Response (005010X279).

2.1.1 PURPOSE OF THE OREGON COMPANION GUIDE

The purpose of the Oregon Companion Guide is to clarify, supplement, and further define specific data content requirements to be used in conjunction with the 005010X279 (270/271) Technical Report Type 3 (TR3)* created for the electronic transaction standard, mandated by the HIPAA regulations. Its purpose is to provide a common standard that can be easily and consistently applied by all Health Plans and Health Care Providers (refer definitions in Section 2.1.3) and yet, would continue to be fully compliant with federal regulations.

* Formerly known as an Implementation Guide (IG)

The term "Oregon Companion Guide" or its abbreviation "**OCG**" will be used consistently throughout this document to refer to the OCG being created at the request of the Oregon Health Authority.

2.1.2 KEY ABBREVIATIONS

The following abbreviations are used extensively throughout this document

005010X279	Collective reference for the Health Care Eligibility Inquiry and Response transaction and published errata – inclusive of the following 3 documents: ASC X12N/005010X279 (April 2008) ASC X12N/005010X279E1 (January 2009) ASC X12N/005010X279A1 (June 2010)
TR3	Technical Report Type 3 – formerly known as the Implementation Guide (IG)
OCG	Oregon Companion Guide – this guide

2.1.3 APPLICABILITY

Effective July 1, 2012, all Health Plans licensed or doing business in Oregon and Health Care Providers providing services for a fee or as an encounter in Oregon, must exchange eligibility inquiry and response information electronically using the transactions, this OCG, and implement fully operational transactions within the timelines that will be required under proposed Oregon Statutes (see Section 2.1.5.1). The only exceptions to the statutory requirements are as follows:

- The requirements do not apply to the exchange of electronic eligibility inquiry and response transactions with:
  - Medicare
  - Federally Administered programs
  - Workers' Compensation programs
  - Property and Casualty insurance plans

The following definitions apply to the HIPAA covered entities that will establish trading relationships using this OCG.

2.1.3.1 Health Plan

Health Plan *is defined as follows:*

***Note*:** *This definition reproduced from Subtitle D—Privacy, Section 13400. Definitions, that appear in the Conference Report on page H1345 of Congressional Record—House, February 12, 2009.*

An individual or group plan that provides, or pays the cost of, medical care (as defined in section 2791(a)(2) of the Public Health Service Act, 42 U.S.C. 300gg-91(a)(2)).
(1) Health plan includes the following, singly or in combination:

- A group health plan
- A health insurance issuer
- An HMO

- Part A or Part B of the Medicare program under title XVIII of the Act.
- The Medicaid program under title XIX of the Act, 42 U.S.C. 1396, et seq.
- An issuer of a Medicare supplemental policy (as defined in section 1882(g) (1) of the Act, 42 U.S.C. 1395ss (g) (1)).
- An issuer of a long-term care policy, excluding a nursing home fixed- indemnity policy.
- An employee welfare benefit plan or any other arrangement that is established or maintained for the purpose of offering or providing health benefits to the employees of two or more employers.
- The health care program for active military personnel under title 10 of the United States Code.
- The veterans' health care program under 38 U.S.C. chapter 17.
- The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) (as defined in 10 U.S.C. 1072(4)).
- The Indian Health Service program under the Indian Health Care Improvement Act, 25 U.S.C. 1601, et seq.
- The Federal Employees Health Benefits Program under 5 U.S.C. 8902, et seq.
- An approved State child health plan under title XXI of the Act, providing benefits for child health assistance that meet the requirements of section 2103 of the Act, 42 U.S.C. 1397, et seq.
- The Medicare + Choice program under Part C of title XVIII of the Act, 42 U.S.C. 1395w-21 through 1395w-28.
- A high risk pool that is a mechanism established under State law to provide health insurance coverage or comparable coverage to eligible individuals.
- Any other individual or group plan, or combination of individual or group plans, that provides or pays for the cost of medical care (as defined in section 2791(a)(2) of the PHS Act, 42 U.S.C. 300gg-91(a)(2)).

- "Health Plan" includes an employee welfare benefit plan (as defined in section 3(1) of the Employee Retirement Income Security Act of 1974(ERISA)(29 U.S.C. 1002(1)), including insured and self-insured plans, to the extent that the plan provides medical care, as defined in section 2791(a)(2) of the Public Health Service (PHS) Act, 42U.S.C. 300gg–91(a)(2), including items and services paid for as medical care, to employees or their dependents directly or through insurance, reimbursement, or otherwise, that (1) Has 50 or more participants (as defined in section 3(7) of ERISA, 29 U.S.C. 1002(7)); or (2) Is administered by an entity other than the employer that established and maintains the plan. (*Note: This item included from HIPAA regulations*)

(2) Health plan excludes:

- Any policy, plan, or program to the extent that it provides, or pays for the cost of, excepted benefits that are listed in section 2791(c)(1) of the PHS Act, 42 U.S.C. 300gg-91(c)(1); and
- A government-funded program (other than one listed in section 1 of this definition):
  (A) Whose principal purpose is other than providing, or paying the cost of, health care; OR
  (B) Whose principal activity is?
  a. The direct provision of health care to persons; or

b. The making of grants to fund the direct provision of health care to persons.

Health Plans may also be referred by the industry colloquial - **payers.**

2.1.3.2 Health Care Provider

Health Care Provider *is defined as follows:*
A person or organization that provides health care or medical care services within Oregon for a fee and is eligible for reimbursement for these services. For purposes of this subdivision, "for a fee" includes traditional fee-for-service arrangements, capitation arrangements, and any other arrangement in which a provider receives compensation for providing health care services or has the authority to directly bill a Health Plan, health carrier, or individual for providing health care services. This definition includes licensed nursing homes, licensed boarding care homes, and licensed home care providers.

Health Care Providers may also be referred by the industry colloquial - **providers.**

2.1.3.3 Clearinghouse

Clearinghouse *is defined as follows:*
Entity contracted by Health Plans and Health Care Providers to create, send, receive, process, manage, or administrate standard electronic transactions are also subject to comply with the OCG. This would include entities that process the health care eligibility benefit inquiry and response (270/271) and other HIPAA standard X.12 transactions as or on behalf of a HIPAA covered entity.

2.1.3.4 Trading Partner

The term Trading Partner is used in the most general sense of its meaning, in EDI terms, within this document. It essentially means any entity that exchanges EDI transactions with another entity, addressed by the scope of the OCG. The entity could be a direct submitter (such as a **Health Plan** or **Health Care Provider**) or an entity that provides EDI and billing agents (such as a **Clearinghouse**).

As described in the beginning of this section, this OCG applies to all eligibility inquiries and responses submitted electronically on or after July, 2012 (depending on actions of the Oregon legislature) that use the transaction standard and corresponding *005010X279 (270/271).* The Code of Federal Regulations , title 45, part 162, subpart L specifies that the standard for dental, professional, and institutional health care eligibility benefit inquiry and response is this transaction standard.

2.1.4 USAGE OF OREGON COMPANION GUIDE – CONSISTENCY OF APPLICATION

The 270/271 Health Care Eligibility Benefit transactions have the capacity for very specific requests (at the procedure code level) and very detailed responses. This document provides the agreed upon 'foundation' for a request/response. This document does not prevent trading partners from agreeing to

make more specific/detailed requests and receiving more detailed responses. However, the trading partners must all have at least the basic inquiry/response requirements provide in this document.

This OCG contains the maximum required set of data values to be submitted or received by Health Care Providers and Health Plans when executing an electronic eligibility inquiry (270) and response transaction (271). This OCG specifies how it will be used in order to accomplish the goal of consistent, efficient, and error free execution of the transactions, among trading partners conducting business in the state of Oregon. The maximum requirements may be extended as per the conditions identified as follows:

1. No trading partner may unilaterally or collectively require any other trading partner(s) to conform to standards that are not included in this OCG.

2. Once adopted through Oregon State mandates, no additions or modifications may be made to this OCG by Health Plans or Health Care Providers through their own companion guides or by establishing other requirements.

3. All transactions must fully comply with the current version of the HIPAA 270/271 transaction TR3 (current version - 005010X279- published in April 2008 and updated through errata published in June 2010) in force at the time of executing the transactions.

4. Additional data elements and values may be included in the transaction based on the **mutual agreement** of trading partners.

2.1.5 UPDATING THE OREGON COMPANION GUIDE

This OCG will have to be updated periodically to conform to prevailing rules and standards that change and evolve over time. The current set of rules and guidelines are described in the TR3 for the 270/271 transaction and two follow up errata that are incorporated in this version of the OCG.

2.1.5.1 Current Schedule

The current schedule for the release of this OCG for the 270/271 transaction, based on the Oregon Health Authority direction, is as follows:

January 1, 2011	Period of industry review for this OCG ends
April 1, 2011	Department of Consumer & Business Services (DCBS) rule-making to adopt uniform OCG complete
January 1, 2012	All trading partners using 270/271 transactions conform to OCG
July 1, 2012	All OR entities must conduct such transactions electronically conforming to the OCG

2.1.5.2 Future Updates to Oregon Companion Guide

The 270/271 EDI Workgroup undertook responsibility to develop this OCG and it is intended that the group will continue to track industry changes and best practices in the implementation of this, and other Oregon Companion Guides (for the 837, 835, and 276/277 transactions).

In order to track these changes and incorporate relevant updates to the OCGs (including the 270/271 OCG), it is recommended that the workgroup retain its membership and organizational structure even after the first version of the OCGs is completed.

It is recommended that the workgroup schedule to meet once every quarter to review industry news during the quarter, and make any recommendations to the Administration Simplification Executive Committee that may result in a change to the guide or operational aspects of executing transactions.

The Administration Simplification EDI Workgroup co-Chairs will retain the option of not calling the meeting if there are no newsworthy or pressing items that need discussion. Interest in scheduling a quarterly meeting may also be confirmed by polling the group sometime before the meeting.

When issues or changes come to light that must be addressed by the workgroup, the team can collectively make a recommendation to the Executive Committee with a new schedule and resource requests necessary to complete the work or resolve the issue(s) or incorporate valid changes to the OCG(s). The Executive Committee will then approve the recommendations on a case by case basis.

The specific process for updating OCG documents, including submitting and collecting change requests, reviewing and evaluating requests and making recommendations, adopting and publishing a new version of the guide will be available from the Oregon Health Authority's website at http://www.oregon.gov/OHA/.

2.1.6 SCOPE OF THE OREGON COMPANION GUIDE

This OCG references the required and situational Loops, Segments and certain Data Elements contained in the *005010X279 (270/271)*.

This OCG does not include any of the Loops, Segments or Data Elements defined as NOT USED in the *005010X279*. Consistent with the HIPAA requirements and *005010X279* instructions, the NOT USED Loops, Segments and Data Elements are not permitted to be submitted or received when conducting this transaction.

This OCG excludes any of the EDI transmission instructions, generally defined in trading partner agreement documents. The Interchange Control Header (ISA) and the Functional Group Header (GS) are not covered by this OCG. The specifications of these Loops, Segments and Data Elements are generally defined in trading partner agreement documents and are specifically defined in the *005010X279* TR3.

2.1.7 OPERATING RULES AND CORE

Operating rules can be generally defined as the content that must be returned in a response, and also may include items such as methods of communication, response times, system availability times etc. The task assigned to this workgroup was the development of an Oregon Companion Guide based off of the federally required 005010X279, which has limited requirements for operating rules. Because of the interest in CORE (*Committee on Operating Rules for Information Exchange* of the Council for Affordable Quality Healthcare) especially by those participants certified in CORE---the workgroup did review a comparison of the CORE Phase 1, Phase 2 and Phase 3 service types along with the service types required (and supported) by the 5010 version.

At the time of this writing, the CORE rules developed by CAQH are associated with the 4010 version of the guides and are being redeveloped for the 5010 version of this transaction. It was agreed that the workgroup would work with the content requirements laid out in the TR3 and continue to monitor the development of additional content relevant to the 5010 TR3. The workgroup will also continue to monitor and adopt (once defined) the required operating rules as set forth in the Patient Protection Act (PPACA), as appropriate. The development of a 'Best Practice' related to the 5010 supported service types would be the next step in the adoption of content. The workgroup should continue to adopt industry best practices as they are made available and in support of this version of the transaction.

2.1.8 005010X279 HEALTH CARE ELIGIBILITY BENEFIT INQUIRY AND RESPONSE (270/271)

The reference for this OCG is the *005010X279 Health Care Eligibility Benefit Inquiry and Response (270/271)* (Copyright © 2008, Data Interchange Standards Association on behalf of ASC X12 Format © 2008, Washington Publishing Company. All Rights Reserved). A copy of the full *005010X279* can be obtained from the Washington Publishing Company at http://www.wpc-edi.com.

2.1.9 KEY TERMINOLOGY USED IN THIS OREGON COMPANION GUIDE

This OCG treats the required and situational Loops, Segments and Data Elements included in the *005010X279* as described in the following sections.

2.1.9.1 Required Loops, Segments and Data Elements

In some instances, the values and conditions defined in the *005010X279* for required Loops, Segments and Data Elements are further clarified by the OCG. Such further clarifications are appropriately noted in the OCG Tables included in Sections 3 and 4.

Under no circumstance does this OCG add new or different values to those defined in the Reference *005010X279*.

2.1.9.2 Situational Loops, Segments and Data Elements

The OCG further defines or refines the conditions and values of Situational Loops, Segments and Data Elements to one of the following three possibilities:

- Required, with further definition of condition and/or values: This means that in Oregon, Health Plans and Health Care Providers do consider and need this data for proper processing of the transaction, and that the Loop, Segment and Data Element will be REQUIRED for all values further defined in the OCG.

- Situational, with or without further definition of condition: This means that the Loop, Segment or Data Element will retain in the OCG the original Situational classification given in the *005010X279*, and that the OCG will follow either:

  - The exact same conditions and values defined in the *005010X279* (because the conditions and values are close-ended, unambiguous, and straight forward)

  - A set of further refined conditions and values applicable to that Situational Loop, Segment or Data Element

- Not Considered for Processing – see next section.

2.1.9.3 Segments and Data Elements Classified as Not Considered for Processing (NCFP)

Required and Situational Segments and Data Elements may also be classified in the OCG as "Not Considered for Processing." This means that receivers of this transaction in Oregon do not consider these Segments and Data Elements necessary for processing of the transaction for services covered under this OCG.

With respect to these NCFP Segments and Data Elements, the interpretation of this classification will be as follows:

- If the Segment or Data Element is REQUIRED by the *005010X279* and the Oregon Usage in the tables included in Sections 3 and 4 of this OCG is "NCFP," then the Segment or Data Element must be sent by the sender and received by the receiver (to meet HIPAA requirements) but the receiver may ignore it for processing.

- If the Segment or Data Element is SITUATIONAL in the *005010X279* and the Oregon usage in the tables included in Sections 3 and 4 of this OCG is "NCFP," then the Segment or Data Element:

  - Will not be required by a Source*

  - May be submitted by a Receiver*

  - Will be accepted by a Source*

  - May be ignored by the Source* for processing

  - May be omitted by the Source* in the response as permitted in the TR3

  - The Source* will not reject transaction if source submits this element, provided the transaction is compliant.

Source *refers to the entity providing the information – typically the Health Plan*
Receiver *refers to the entity receiving the response – typically the Health Care Provider*

It is important to note that the parameters of Situational Elements in the *005010X279* are generally written in a manner that creates a "requirement" for the element to be used (if such conditions are met). Please refer to the disclaimer in the front matter of this guide.

2.1.10 ADDRESSING CODE SET ISSUES IN THE OREGON COMPANION GUIDE

Code sets utilized in HIPAA electronic transactions are classified as:

- Internal Transaction Codes (included and defined inside the *005010X279*).
- External Code Sets (referenced by *005010X279* defined and maintained by external bodies) including:

  1. Non-Medical External Code Sets (such as Taxonomy Codes, Claims Adjustment Reason Codes, Remark Codes, etc) These values are effective based upon transaction date;

  2. Medical External Code Sets (such as ICD-9, ICD-10, HCPCS). These values are effective based upon service date.

  The OCG does not redefine existing external code sets used in the transaction. Rather, the OCG may identify a subset of external codes to be used in specific Loops, Segments and Data Elements of the transaction.

2.2 Health Care Eligibility Benefit Inquiry and Response (270/271) Transaction

2.2.1 BASIC CONCEPTS/BUSINESS TERMINOLOGY

2.2.1.1 Patient Request (2110C or 2110D)

The 270/271 IG defines a patient request as follows:

"The patient request is defined as the occurrence of one or more 2110 (EQ) Loops for an individual. If the patient is the subscriber, the patient request is the existence of at least one 2110C Loop. If the patient is a dependent, the patient request is the existence of at least one 2110D Loop. In the event the patient has more than one occurrence of a 2110 (EQ) Loop, that still constitutes one patient request." (005010X279[1])

2.2.1.2 Subscriber and Dependent Information

With the implementation of the *005010X279* it is necessary to pay special attention to the definitions of Subscriber, Dependent, and Patient as they relate to the actual ASC X12 005010 transactions. While the business definition seems to be similar across the industry, the *005010X279* defines a subscriber as

"A person who can be uniquely identified to an information source by a unique Member Identification Number (which may include a unique suffix to the primary policy holder's identification number). The subscriber may or may not be the patient." (005010X279[2])

A dependent conversely is

"a person who cannot be uniquely identified to an information source by a unique Member Identification number…" (005010X279[3])

Information Sources must have the ability to receive data in the Subscriber Loop, or the Subscriber and Dependent Loops. They must assess the validity of the data using the OCG Search Option requirements (see Section 2.2.4) and return the accurate data (or AAA rejection code) in the appropriate loop(s).

As referenced in the TR3, subsequent transactions, including but not limited to the ASC X12/005010X222, ASC X12N005010X223A1, and ASC X12n005010X224A1 Health Care Claim transactions, must be submitted with the correct Subscriber and Dependent data. Neither the *005010X279 Health Care Eligibility Benefit Response (271)* nor the Health Care Claim transactions listed above have an identification number (NM109) Data Element at the Dependent level. Therefore, if there is a unique identification number assigned to an individual, that person is defined as a Subscriber in the context of the ASC X12 005010 transaction. (005010X279[4])

Information Sources and Information Receivers should review processes, procedures and system data repository requirements to ensure the appropriate data is reflected, sent and processed within the ASC X12 005010 transactions. It may be necessary to reflect the "business definitions" for communications with policy holders and the "transaction definitions" to complete the actual eligibility, claim and remittance process.

Information Sources and Information Receivers should pay special attention to Section 1.4.2 in the *005010X279.* (005010X279[5])

2.2.2 OREGON REQUIREMENTS FOR COMPLIANCE

2.2.2.1 *005010X279* (270) Transaction

Information Receivers can submit code "30" ("Health Benefit Plan Coverage"), or any of the Service Type codes in EQ01. Information Sources are permitted to return the entire benefit data set (005010X279[6]).

If an Information Receiver submits an explicit Service Type inquiry, it is recommended that Information Sources respond with only the explicit benefit information. However, Information Sources are permitted to respond with the entire benefit data set (005010X279[7]).

Specific procedure/diagnosis code capability is not supported by Information Sources in this release of the *Oregon Companion Guide for the Implementation of the 005010X279 Health Care Eligibility Benefit Inquiry and Response (270/271).* Should willing trading partners agree to exchange transactions using the more robust capabilities of the TR3, they may do so—however, no trading partners will be coerced to exchange transactions at a more sophisticated level than is set out in this guide (Section 2.1.4).

2.2.2.2 *005010X279* (271) Transaction

Patient Financial Responsibility and Related Benefit Information

Related benefit information must be returned if the Subscriber/Dependent is found (positive response). Related benefit information includes any known patient financial responsibility (co-pay, co-insurance, deductible, out-of-pocket or cost containment). If patient financial responsibility for a mandated Service Type Code is being reported at a component level (see Section 1.4.7.2 of the *005010X279*), do not report any patient financial responsibility for the mandated Service Type Code. For example: If reporting different co-pays for Hospital Inpatient and Hospital Outpatient (Service Type Code Components 48 and 50), do not report any co-pay amount for the mandated Service Type Code 47 – Hospital. (005010X279[9])

Reporting Remaining Deductibles and Out of Pocket Expenses

Deductible expenses remaining must be returned if Subscriber/Dependent is found (positive response) and active in the Information Source's system. Either the Remaining Deductible (e.g. EB01 = C, EB06=29, EB07=$?), or the Subscriber/Dependent Deductible, and the Subscriber/Dependent Deductible met for the year must be included in the response.

Out of Pocket expenses remaining must be returned if Subscriber/Dependent is found (positive response) and active in the Information Source's system. Either the Remaining Out of Pocket amount (e.g. EB01=G, EB06=22, EB07=$?); or the Out of Pocket for the year, and the Out of Pocket met for the year must be included in the response.

2.2.3 OREGON BEST PRACTICES: IMPLEMENTATION OF ELECTRONIC HEALTH CARE TRANSACTIONS

The Oregon Administrative Simplification Work Group is continuously working on the identification of 'Best Practices' for the implementation of administrative transactions and processes. 'Best Practices' are consensus recommendations of the EDI Workgroup to further standardize and harmonize health care administrative transactions for the entities to whom the OCG applies. An example of a best practice would include but are not limited to the benefit content to be returned in response to an inquiry.

There has been considerable discussion in the workgroup around requiring the use of best practices. A consensus recommendation for a given best practice will be made along with a date of required implementation. If an organization(s) cannot meet the required implementation date or believes that the required practice cannot or does not apply to them, an application for waiver may be made to the Oregon Department of Consumer and Business Services (DCBS).

The following are two Best Practices that have been included in this guide. Both cases are extensions of the TR3 which identify these as situational or optional.

1. Reporting Remaining Deductibles and Out of Pocket Expenses - Included in the guide as a 'requirement' in Section 2.2.2.2.
2. Additional Search Options 5 and 6 – Included in the guide as 'highly recommended' for implementation in Section 2.2.4.1. These options will be considered for inclusion as full requirements in the next update of this guide.

2.2.4 SEARCH OPTIONS AND REJECTED TRANSACTIONS

In order to ensure consistency as well as the highest probability of a successful inquiry and accurate response, search options are discussed in this section. Three of the search options are required as part of the 270/271 TR3 and must be implemented. The Workgroup has also adopted a 4th required search option based on the needs of the provider community. The Workgroup has not been prescriptive in the requirements of 'how to search' for eligibility and benefits when a valid search option is used. We have provided in Section 6 (Appendix B : Search & Filter Criteria – Prescriptive Example), examples of suggested search methodologies for each of the search options. We recognize that some application systems are already programmed to search with highly developed options. For those creating their own search methodologies, the appendix serves as a reference to the type of detail that will lead to a better result.

2.2.4.1 Search Options

Information Sources must use the following Search Options (See Table 1) when responding to *005010X279* Health Care Eligibility Benefit Inquiry (270) transactions sent by Information Receivers. The goal of these search options is to increase the number of matches found by an Information Source. By maximizing the number of automated matches, both Information Receivers and Information Sources will experience fewer follow-up phone calls, which will reduce administrative costs. The Information Receiver should submit every available search option data element in each *005010X279* Health Care Eligibility Benefit Inquiry (270) transaction.

The options are designed so that an Information Source continues to look for the Subscriber/Dependent even if some of the data elements submitted do not match the Information Source's system. The options are not intended to require Information Receivers to continually resend the *005010X279* Health Care Eligibility Benefit Inquiry (270) transaction to fit the different options.

Table 1
Search Options

Option	Subscriber Id	Last Name	First Name	Patient Dob
1	X	X	X	X
2	X	X		X
3	X	X	X	
4		X	X	X
5	X		X	X
6	X			X

Shaded rows are highly recommended for support but optional for this version of the OCG

Note: In every case the use of the term '**positive response'**, confirms the *identification of a Subscriber* that matches the inquiry criteria.
This note is relevant to Sections 2.2.2, 2.2.4, and 6 in this document.

The following search options should be supported by all trading partners included in the scope of this OCG.

- Options 1, 2, 3, and 4 - required to be supported by this OCG.
- Options 5 and 6 – highly recommended they be supported by all trading partners. These searches are likely to be required in future version of this OCG.

2.2.4.2 Rejected Transaction Reporting (AAA Segment Usage)

The Search Options define a standard way to determine and report when an Information Source is able to find a subscriber or dependent and respond with eligibility information to the Information Receiver. If Information Source is unable to find the subscriber/dependent and, therefore, is unable to respond with eligibility information for the subscriber/dependent, the goal is to use a unique error code for a given error condition.

It is important to return as detailed information as possible so the Information Receiver can understand the intent of the response particularly in the case where the match of 270 inquiry information results in multiple subscriber records to be identified, as differentiated from not being able to be identified at all.

Refer to the *005010X279* for further information about rejecting a transaction for reasons other than subscriber/dependent not found.

For a recommended step by step approach to searching and filtering Information Source records, in order to respond to the eligibility inquiry, is included in Section 6.

2.2.4.3 Option #1: (Subscriber ID, Last Name, First Name, DOB)

- Result with unique hit, **positive response**
- Result with no hits

  Subscriber ID
  If Subscriber ("Invalid Missing Subscriber/Insured ID"–72)
  If Dependent ("Invalid Missing Patient ID"–64)

  Subscriber Last Name and/or First Name
  If Subscriber ("Invalid Missing Subscriber/Insured Name"–73)
  If Dependent ("Invalid Missing Patient Name"–65)

- Result with multiple hits

  Subscriber ID
  If Subscriber ("Duplicate Subscriber/Insured ID"–76)
  If Dependent ("Duplicate Patient ID"–68)

  Patient DOB does not match that for the patient on the database
  If Subscriber ("Patient DOB does not match that for the patient on the database"– 71)
  If Dependent ("Patient DOB does not match that for the patient on the database"– 71)

2.2.4.4 Option #2: (Subscriber ID, Last Name, DOB)

- Result with unique hit, **positive response**
- Result with no hits

  Subscriber ID

  If Subscriber ("Invalid Missing Subscriber/Insured ID"–72)
  If Dependent ("Invalid Missing Patient ID"–64)

Subscriber Last Name
If Subscriber ("Invalid Missing Subscriber/Insured Name"–73)
If Dependent ("Invalid Missing Patient Name"–65)

- Result with multiple hits

Subscriber ID
If Subscriber ("Duplicate Subscriber/Insured ID"–76)
If Dependent ("Duplicate Patient ID"–68)

Patient DOB does not match that for the patient on the database
If Subscriber ("Patient DOB does not match that for the patient on the database"– 71)
If Dependent ("Patient DOB does not match that for the patient on the database"– 71)

2.2.4.5 Option #3: (Subscriber ID, Last Name, First Name)

- Result with unique hit, **positive response**
- Result with no hits

Subscriber ID
If Subscriber ("Invalid Missing Subscriber/Insured ID"–72)
If Dependent ("Invalid Missing Patient ID"–64)

Subscriber Last Name and/or First Name
If Subscriber ("Invalid Missing Subscriber/Insured Name"–73)
If Dependent ("Invalid Missing Patient Name"–65)

- Result with multiple hits

Subscriber ID
If Subscriber ("Duplicate Subscriber/Insured ID"–76)
If Dependent ("Duplicate Patient ID"–68)

2.2.4.6 Option #4: (Last Name, First Name, DOB)

- Result with unique hit, **positive response**
- Result with no hits

Subscriber Last Name and/or First Name
If Subscriber ("Invalid Missing Subscriber/Insured Name"–73)
If Dependent ("Invalid Missing Patient Name"–65)

- Result with multiple hits

Subscriber ID
If Subscriber ("Duplicate Subscriber/Insured ID"–76)
If Dependent ("Duplicate Patient ID"–68)

Patient DOB does not match that for the patient on the database
If Subscriber ("Patient DOB does not match that for the patient on the database"– 71)
If Dependent ("Patient DOB does not match that for the patient on the database"– 71)

2.2.4.7 Option #5: (Subscriber ID, First Name, DOB)

- Result with unique hit, **positive response**
- Result with no hits

Subscriber ID
If Subscriber ("Invalid Missing Subscriber/Insured ID"–72)
If Dependent ("Invalid Missing Patient ID"–64)

Subscriber First Name
If Subscriber ("Invalid Missing Subscriber/Insured Name"–73)
If Dependent ("Invalid Missing Patient Name"–65)

- Result with multiple hits

Subscriber ID
If Subscriber ("Duplicate Subscriber/Insured ID"–76)
If Dependent ("Duplicate Patient ID"–68)

Patient DOB does not match that for the patient on the database
If Subscriber ("Patient DOB does not match that for the patient on the database"– 71)
If Dependent ("Patient DOB does not match that for the patient on the database"– 71)

2.2.4.8 Option #6: (Subscriber ID, DOB)

- Result with unique hit, **positive response**
- Result with no hits

Subscriber ID
If Subscriber ("Invalid Missing Subscriber/Insured ID"–72)
If Dependent ("Invalid Missing Patient ID"–64)

- Result with multiple hits

Subscriber ID

If Subscriber ("Duplicate Subscriber/Insured ID"–76)
If Dependent ("Duplicate Patient ID"–68)

Patient DOB does not match that for the patient on the database
If Subscriber ("Patient DOB does not match that for the patient on the database"– 71)
If Dependent ("Patient DOB does not match that for the patient on the database"– 71)

2.3 General Introduction to the OCG Tables

All the information related to the way this OCG classifies and defines required and situational Data Elements is presented in a table format in the next sections.

Given that this is a "paired" transaction, a first set of tables is presented for the *005010X279* Health Care Eligibility Benefit Inquiry (270) transaction, followed by a separate set of tables for the *005010X279* Health Care Eligibility Benefit Response (271) transaction.

Tables are organized by Loops and Segments, to make it easier to review and locate.

The following Sections 3 and 4 contain the 270 and 271 Oregon Administrative Simplification Work Group OCG tables to be used when conducting the *005010X279* Eligibility Benefit Inquiry and Response (270/271) transaction.

The tables include the following:

- ALL of the Loops, Segments and Data Elements that are classified as required by the *005010X279* (except as noted in Section "Compressing Data Element Rows into Segment Rows" below)
- ALL of the Loops, Segments and Data Elements that are classified as Situational by the *005010X279* (except as noted in Section "Compressing Data Element Rows into Segment Rows" below)

The tables do not include any of the Loops, Segments or Data Elements classified as Not Used by the *005010X279*.

The tables are organized into the following columns:

- Loop ID: The LOOP ID from the IG
- Segment Information: The NAME and USAGE given to the Segment in the *005010X279*
- Data Element Information: The ID and USAGE given to each Data Element in the *005010X279*
- Oregon Information:
  - Oregon Usage - The only permitted values are:
    - "R" for Required
    - "S" for Situational
    - "NCFP" for Not Considered for Processing
  - Value Definition and Notes: The specific values and other notes applicable to the Segment or Data Element required to be followed in Oregon
  - Oregon Usage Same as the *005010X279*: If checked, it means that the OCG conditions, values and notes for the Segment or Data Element are identical to the conditions, values and notes from the *005010X279*

NCFP – does not mean that the data cannot be sent in the transaction. If sent, the data must be compliant. If sent, the receiver is not required to act on the data for use in returning a 271 response. Should trading partners agree to exchange information using some of the more sophisticated methodologies available in the 005010X279, they may do so. However, a trading partner may not be forced to trade and cannot refuse to trade when the basics of this guide are in place.

2.3.1 COMPRESSING DATA ELEMENT ROWS INTO SEGMENT ROWS

In preparing the OCGs, some "compression" or "collapsing" of Data Element rows into Segment rows has been done to simplify the size and content of the document. This compression or collapsing was done as follows: If the "Oregon Usage" classification of a Segment and its Data Elements are ALL IDENTICAL with the *005010X279*, then the Data Element rows for that Segment are not included in these tables and only the Segment-level row is presented.

2.3.2 SUMMARY SCENARIOS OF OREGON USAGE CLASSIFICATION

A summary of the seven (7) specific and mutually exclusive scenarios that could occur in the OCG when relating the following three elements are presented in the table below:

1. The condition that a Loop, Segment or Data Element has in the original *005010X279* (Required or Situational)
2. The "Oregon Usage" as defined by the OCG development teams (Required; Situational; Not Considered for Processing)
3. Whether the Oregon Usage/Notes are identical to the *005010X279*

Table 2
Seven Specific OCG Scenarios for
Oregon-defined Usage of Loops, Segments and Data Elements

Condition of Loop/ Segment/Data Element from *005010X279*	Oregon Usage Classification OCG	Oregon Notes about Usage
1. Required	Required	Same as *005010X279*
2. Required	Required	Further clarifies the *005010X279*
3. Required	NCFP (Not Considered for Processing)	Same as *005010X279*
4. Situational	Required	Further defines the requirement from the *005010X279*
5. Situational	Situational	Same as *005010X279*
6. Situational	Situational	Further refines the requirements from the *005010X279*
7. Situational	NCFP (Not Considered for Processing)	Same as *005010X279*

3 HEALTH CARE ELIGIBILITY BENEFIT INQUIRY (270) TRANSACTION

Oregon Companion Guide Table

3.1 Introduction to Table

The following table contains the OCG information needed to implement the *005010X279* Health Care Eligibility Benefit Inquiry (270) transactions. A description of this table is provided in Section 2.3 of this Oregon Companion Guide.

The 270 request, as presented below, is set up to provide the basis for making an eligibility/benefits response based on the service types. All parties must participate in the sending and receiving of this transaction set at the service type level. They may also trade at a more sophisticated level in addition to this more basic level. For additional information please refer to the TR3 - EQ - Eligibility or Benefit Inquiry Loop: 2110C (At least one of EQ01 or EQ02 is required).

3.2 Oregon Companion Guide Table (270)

Transaction: Health Care Eligibility Benefit Inquiry (270)						
Loop ID	Segment		Data Element	Oregon Information		
	Name	*005010X279* Usage	ID	OR Usage	Value Definition and Notes	OR Usage Same as *005010X279*
	ST - Transaction Set Header	R		R		X
	BHT - Beginning of Hierarchical Transaction	R		R		X
	BHT	R	BHT01	R		X
	BHT	R	BHT02	R		X
	BHT	S	BHT03	S		X
	BHT	R	BHT04	R		X
	BHT	R	BHT05	R		X
	BHT	S	BHT06	NCFP		X
2000A	HL - Information Source Level	R		R		X
2100A	NM1 - Information	R		R		X

Transaction: Health Care Eligibility Benefit Inquiry (270)						
Loop ID	Segment		Data Element	Oregon Information		
	Name	*005010X279* Usage	ID	OR Usage	Value Definition and Notes	OR Usage Same as *005010X279*
	Source Name					
2100A	NM1	R	NM101	R		X
2100A	NM1	R	NM102	R		X
2100A	NM1	R	NM103	NCFP		X
2100A	NM1	S	NM104	NCFP		X
2100A	NM1	S	NM105	NCFP		X
2100A	NM1	S	NM107	NCFP		X
2100A	NM1	R	NM108	R		X
2100A	NM1	R	NM109	R		X
2000B	HL - Information Receiver Level	R		R		X
2100B	NM1 - Information Receiver Name	R		R		X
2100B	NM1	R	NM101	R		X
2100B	NM1	R	NM102	R		X
2100B	NM1	R	NM103	NCFP		X
2100B	NM1	S	NM104	NCFP		X
2100B	NM1	S	NM105	NCFP		X
2100B	NM1	S	NM107	NCFP		X
2100B	NM1	R	NM108	R		X
2100B	NM1	R	NM109	R		X
2100B	REF - Information Receiver Additional Information	S		NCFP		X
2100B	N3 - Information Receiver Address	S		S		X
2100B	N4 - Information Receiver	S		S		X
2100B	PRV - Information Receiver Provider Information	S		S		X

Transaction: Health Care Eligibility Benefit Inquiry (270)						
Loop ID	Segment		Data Element	Oregon Information		
	Name	*005010X279* Usage	ID	OR Usage	Value Definition and Notes	OR Usage Same as *005010X279*
2000C	HL – Subscriber Level	R		R		X
2000C	TRN – Subscriber Trace Number	S		S		X
2100C	NM1 – Subscriber Name	R		R		X
2100C	REF – Subscriber Additional Identification	S		S		X
2100C	N3 – Subscriber Address	S		NCFP		X
2100C	N4 – Subscriber City/State/ ZIP Code	S		NCFP		X
2100C	PRV – Provider Information	S		S		X
2100C	DMG – Subscriber Demographic Information	S		S		X
2100C	INS – – Multiple Birth Sequence Number	S		S		X
2100C	HI – Subscriber Health Care Diagnosis Code	S		NCFP		X
2100C	DTP – Subscriber Date	S		S		
2110C	EQ – Subscriber Eligibility or Benefit Inquiry	S		S		X

Transaction: Health Care Eligibility Benefit Inquiry (270)						
Loop ID	Segment		Data Element	Oregon Information		
	Name	*005010X279* Usage	ID	OR Usage	Value Definition and Notes	OR Usage Same as *005010X279*
2110C	EQ	S	EQ01	S	Information Receivers can submit code "30" ("Health Benefit Plan Coverage"), or any of the other Service Type codes. EQ01 can handle multiple requests. Information Sources are permitted to return the entire benefit data set. If an Information Receiver submits an explicit Service Type inquiry, it is recommended that Information Source responds with only the explicit benefit information. However, Information Sources are permitted to respond with the entire benefit data set. See Section 2.2.2 for more information.	X
2110C	EQ	S	EQ02	NCFP		X
2110C	EQ	S	EQ03	NCFP		X
2110C	EQ	S	EQ05	NCFP		X
2110C	AMT – Subscriber Spent Down Amount	S		NCFP		X
2110C	AMT – Subscriber Spent Down Total Billed Amount	S		NCFP		X
2110C	III – Subscriber Eligibility or Benefit Additional Inquiry Information	S		NCFP		X
2110C	REF – Subscriber Additional Information	S		NCFP		X
2110C	DTP – Subscriber Eligibility/ Benefit Date	S		NCFP		X
2000D	HL – Dependent Level	S		S		X

Transaction: Health Care Eligibility Benefit Inquiry (270)						
Loop ID	Segment		Data Element	Oregon Information		
	Name	*005010X279* Usage	ID	OR Usage	Value Definition and Notes	OR Usage Same as *005010X279*
2000D	TRN – Dependent Trace Number	S		NCFP		X
2100D	NM1 – Dependent Name	R		R		X
2100D	REF – Dependent Additional Information	S		S		X
2100D	N3 – Dependent Address	S		NCFP		X
2100D	N4 – Dependent City/State/ ZIP Code	S		NCFP		X
2100D	PRV – Provider Information	S		S		X
2100D	DMG – Dependent Demographic Information	S		S		X
2100D	INS – Dependent Relationship	S		S		X
2100D	HI – Dependent Health Care Diagnosis Code	S		NCFP		X
2100D	DTP – Dependent Date	S		S		X
2110D	EQ – Dependent Eligibility or Benefit Inquiry Information	R		R		X
2110D	EQ	S	EQ01	S	Information Receivers can submit code "30" ("Health Benefit Plan Coverage"), or any of the other Service Type codes. Information Sources are permitted to return the entire benefit data set. If an Information Receiver submits an explicit Service Type inquiry, it is recommended that Information	X

Transaction: Health Care Eligibility Benefit Inquiry (270)						
Loop ID	Segment		Data Element	Oregon Information		
	Name	*005010X279* Usage	ID	OR Usage	Value Definition and Notes	OR Usage Same as *005010X279*
					Sources respond with only the explicit benefit information. However, Information Sources are permitted to respond with the entire benefit data set. See Section 2.2.2 for more information.	
2110D	EQ	S	EQ02	NCFP		X
2110D	EQ	S	EQ05	NCFP		X
2110D	III – Dependent Eligibility or Benefit Additional Inquiry Information	S		NCFP		X
2110D	REF – Dependent Additional Information	S		NCFP		X
2110D	DTP – Dependent Eligibility/ Benefit Date	S		NCFP		X
	SE – Transaction Set Trailer	R		R		X

4 HEALTH CARE ELIGIBILITY BENEFIT RESPONSE (271) TRANSACTION

Oregon Companion Guide Table

4.1 Introduction to Table

The following table contains the OCG information needed to implement the *005010X279* Health Care Eligibility Benefit Response (271) transaction. A description of this table is provided in Section 4.5 of this Oregon Companion Guide.

The 271 response as presented below supports a basic response as well as a more detailed answer, whether the response is 'positive' or has errors requiring resubmission.

Please note: Table 4.2 below references several standard health care transactions as follows:

- The *Eligibility Benefit Inquiry (270) portion of the 005010X279 transaction* is referred to in Table 4.2 as "270."
- The *ASC X12/005010X222 Health Care Claim: Professional (837), ASC X12/005010X223A1 Health Care Claim: Institutional (837), and ASC X12/005010X224A1 Health Care Claim: Dental (837)*, are all referred to generally in Table 4.2 as "837."

4.2 Oregon Companion Guide Table (271)

Transaction: Health Care Eligibility Benefit Response (271)						
Loop ID	Segment		Data Element	Oregon Information		
	Name	*005010X279* Usage	ID	OR Usage	Value Definition and Notes	OR Usage Same as *005010X279*
	ST – Transaction Set Header	R		R		X
	BHT – Beginning Hierarchical Transaction	R		R		X
2000A	HL – Information Source Level	R		R		X
2000A	AAA – Request Validation	S		S		X
2100A	NM1 – Information Source	R		R		X

Transaction: Health Care Eligibility Benefit Response (271)						
Loop ID	Segment		Data Element	Oregon Information		
	Name	*005010X279* Usage	ID	OR Usage	Value Definition and Notes	OR Usage Same as *005010X279*
2100A	NM1	R	NM101	R	Information Source will return the data submitted in the 270 element	
2100A	NM1	R	NM102	R	Information Source will return the data submitted in the 270 element	
2100A	NM1	R	NM103	R	Information Source will return the data submitted in the 270 element	
2100A	NM1	S	NM104	S	Information Source will return the data submitted in the 270 element	
2100A	NM1	S	NM105	S	Information Source will return the data submitted in the 270 element	
2100A	NM1	S	NM107	S	Information Source will return the data submitted in the 270 element	
2100A	NM1	R	NM108	R	Information Source will return the data submitted in the 270 element	
2100A	NM1	R	NM109	R	Information Source will return the data submitted in the 270 element	
2100A	PER – Information Source Contact Information	S		S		X
2100A	AAA – Request Validation	S		S		X
2000B	HL – Information Receiver Level	S		S		X
2100B	NM1 – Information Receiver Name	R		R		X
2100B	NM1	R	NM101	R	Information Source will return the data submitted in the 270 element	
2100B	NM1	R	NM102	R	Information Source will return the data submitted in the 270 element	
2100B	NM1	S	NM103	S	Information Source will return the data submitted in the 270 element	
2100B	NM1	S	NM104	S	Information Source will return the data submitted in the 270 element	
2100B	NM1	S	NM105	S	Information Source will return the data submitted in the 270 element	
2100B	NM1	S	NM107	S	Information Source will return the data submitted in the 270 element	
2100B	NM1	R	NM108	R	Information Source will return the data submitted in the 270 element	
2100B	NM1	R	NM109	R	Information Source will return the data submitted in the 270 element	
2100B	REF – Information Receiver Additional	S		S		X

Transaction: Health Care Eligibility Benefit Response (271)						
Loop ID	Segment		Data Element	Oregon Information		
	Name	*005010X279* Usage	ID	OR Usage	Value Definition and Notes	OR Usage Same as *005010X279*
	Information					
2100B	AAA – Information Receiver Request Validation	S		S		X
2100B	PRV – Information Receiver Provider Information	S		S		X
2000C	HL – Subscriber Level	S		S		X
2000C	TRN – Subscriber Trace Number	S		S		X
2100C	NM1 – Subscriber Name	R		R	The Subscriber NM1 must be returned. For a positive response, the Information Source will return Subscriber values from the Information Source's database. For a negative response, the data will be from the submitted 270 element.	
2100C	NM1	R	NM101	R		X
2100C	NM1	R	NM102	R		X
2100C	NM1	S	NM103	S	For a positive response, the Information Source will return Subscriber values from the Information Source's database.	
2100C	NM1	S	NM104	S	For a positive response, the Information Source will return Subscriber values from the Information Source's database.	
2100C	NM1	S	NM105	S	For a positive response, the Information Source will return Subscriber values from the Information Source's database.	
2100C	NM1	S	NM107	S		X
2100C	NM1	S	NM108	S		X
2100C	NM1	S	NM109	S	This should be the Subscriber identifier the Information Source expects to receive in subsequent transactions (837, etc.).	
2100C	REF – Subscriber Additional Information	S		S		X
2100C	N3 – Subscriber Address	S		S		X
2100C	N4 – Subscriber City/State/ZIP Code	S		S		X
2100C	AAA – Subscriber	S		S	Refer to 2.2.4.2 - Rejected Transaction Reporting for more information	

Transaction: Health Care Eligibility Benefit Response (271)						
Loop ID	Segment		Data Element	Oregon Information		
	Name	*005010X279* Usage	ID	OR Usage	Value Definition and Notes	OR Usage Same as *005010X279*
	Request Validation					
2100C	PRV – Provider Information	S		S		X
2100C	DMG – Subscriber Demographic Information	S		S	For a positive response, the Information Source will return Subscriber values from the Information Source's database. For a negative response the data will be from the submitted 270 element.	
2100C	INS – Subscriber Relationship	S		S		X
2100C	HI – Subscriber Health Care Diagnosis Code	S		NCFP		X
2100C	DTP – Subscriber Date	S		S	Refer to Section 2.2.2.2 for more information	X
2100C	MPI – Subscriber Military Personnel Information	S		NCFP		X
2110C	EB – Subscriber Eligibility or Benefit Information	S		S		X
2110C	HSD – Health Care Services Delivery	S		S		X
2110C	REF – Subscriber Additional Identification	S		S		X
2110C	DTP – Subscriber Eligibility/ Benefit Date	S		S		X
2110C	AAA – Subscriber Request Validation	S		S		X
2110C	MSG – Message Text	S		S		X
2115C	III – Subscriber Eligibility or Benefit Additional Information	S		NCFP		X
2115C	LS – Loop Header	S		S		X
2120C	NM1 –	S		S		X

Transaction: Health Care Eligibility Benefit Response (271)						
Loop ID	Segment		Data Element	Oregon Information		
	Name	*005010X279* Usage	ID	OR Usage	Value Definition and Notes	OR Usage Same as *005010X279*
	Subscriber Benefit Related Entity Name					
2120C	N3 – Subscriber Benefit Related Entity Address	S		S		X
2120C	N4 – Subscriber Benefit Related City/ State/ZIP Code	S		S		X
2120C	PER – Subscriber Benefit Related Entity Contact Information	S		S	.	X
2120C	PRV – Subscriber Benefit Related Provider Information	S		S		X
2120C	LE - Loop Trailer	S		S		X
2000D	HL – Dependent Level	S		S		X
2000D	TRN – Dependent Trace Number	S		S		X
2100D	NM1 – Dependent Name	S		S		X
2100D	REF – Dependent Additional Information	S		S		X
2100D	N3 – Dependent Address	S		S		X
2100D	N4 – Dependent City/State/ZIP Code	S		S		X
2100D	AAA – Dependent Request Validation	S		S	Refer to 2.2.4.2 - Rejected Transactions Reporting for more information	
2100D	PRV – Provider Information	S		S		X
2100D	DMG – Dependent Demographic Information	S		S		X
2100D	INS – Dependent Relationship	S		S		X

Transaction: Health Care Eligibility Benefit Response (271)						
Loop ID	Segment		Data Element	Oregon Information		
	Name	*005010X279* Usage	ID	OR Usage	Value Definition and Notes	OR Usage Same as *005010X279*
2100D	HI – Dependent Health Care Diagnosis Code	S		NCFP		X
2100D	DTP – Dependent Date	S		S	Refer to Section 2.2.2.2 for more information	X
2100D	MPI – Dependent Military Personnel Information	S		NCFP		X
2110D	EB – Dependent Eligibility or Benefit Information	S		S		X
2110D	HSD – Health Care Services Delivery	S		S		X
2110D	REF – Dependent Additional Information	S		S		X
2110D	DTP – Dependent Eligibility/ Benefit Date	S		S		X
2110D	AAA – Dependent Request Validation	S		S		X
2110D	MSG – Message Text	S		S		X
2115D	III – Dependent Eligibility or Benefit Additional Information	S		NCFP		X
2115D	LS – Dependent Eligibility or Benefit Information	S		S		X
2120D	NM1 – Dependent Benefit Related Entity Name	S		S		X
2120D	N3 – Dependent Benefit Related Entity Address	S		S		X
2120D	N4 – Dependent Benefit Related Entity	S		S		X

Transaction: Health Care Eligibility Benefit Response (271)						
Loop ID	Segment		Data Element	Oregon Information		
	Name	*005010X279* Usage	ID	OR Usage	Value Definition and Notes	OR Usage Same as *005010X279*
	City/State/ZIP Code					
2120D	PER – Dependent Benefit Related Entity Contact Information	S		S	.	X
2120D	PRV – Dependent Benefit Related Provider Information	S		S		X
2110D	LE – Loop Trailer	S		S		X
2110D	SE – Transaction Set Trailer	R		R		X

5 APPENDIX A : EXAMPLE 005010X279 TRANSACTIONS

Health Care Eligibility Benefit Inquiry (270) and Response (271)

Note: The examples shown are for illustration only. The examples are not to be used as an exhaustive guide to code *005010X279* or Oregon-specific requirements. These examples are not to be interpreted as the only scenarios associated with a particular requirement, and are not intended to be all-inclusive. Information Sources must look within their own particular benefit structure and refer to the TR3 to see if any other scenarios may fit the requirements.

The following Section contains three examples of a *005010X279* Health Care Eligibility Benefit Inquiry (270) transaction and the corresponding *005010X279* Health Care Eligibility Benefit Response (271) transaction.

5.1 Example A

5.1.1 *005010X279* 270 INQUIRY

This example is an inquiry by a provider (Information Receiver) for a Patient's eligibility and benefits. The Patient has their own unique ID; therefore they are being submitted as a "Subscriber" in the Subscriber Loop. The Information Receiver has submitted the maximum data elements for the inquiry (Patient Last Name, First Name, Subscriber ID and DOB).

ST*270*10011*005010X279	
BHT*0022*13**20091018*1222	
HL*1**20*1	
NM1*PR*2*XYZPAYER*****XV*999999	Information Source Name
HL*2*1*21*1	
NM1*1P*2*ABCPROVIDER*****XX*0123456789	Information Receiver Name
N3*123 MAIN ST	
N4*ANYTOWN*OR*12345	
HL*3*2*22*0	
TRN*1*XYZ123*9111222333	Trace Number
NM1*IL*1*CLAUS*FRED****MI*88888888	Patient Last Name, First Name and ID

DMG*D8*19881112	Patient DOB
DTP*291*D8*20091018	Eligibility Request Date
EQ*30	Generic Request using Service Type "30"
SE*15*10011	

5.1.2 *005010X279* 271 RESPONSE

The Information Source used Search Option #1 and has identified the Patient as a member with their own unique ID, therefore the eligibility information is returned in the Subscriber Loop. The response is a benefit set for in-network and out-of-network benefits.

ST*271*0001*005010X279	
BHT*0022*11**20091018*1223	
HL*1**20*1	
NM1*PR*2*XYZPAYER*****PI*999999	Information Source Name
PER*IC*MEMBER SERVICES*TE*8001234567	
HL*2*1*21*1	
NM1*1P*2*ABCPROVIDER*****XX*0123456789	Information Receiver Name
HL*3*2*22*0	
TRN*2*XYZ123*9111222333	Trace Number from the 270
NM1*IL*1*CLAUS*FRED*A***MI*88888888	Subscriber Name and ID
REF*6P*3386	Group Number
N3*456 MAIN ST	
N4*ANYTOWN*OR*123456789	
DMG*D8*19881113*M	Subscriber DOB and Gender
INS*Y*18*001*25	Change in identifying information for Subscriber (middle initial and DOB)
DTP*346*D8*20090101	Benefit Coverage begin date
EB*1*FAM*30**OPEN ACCESS CHOICE	Active Coverage for family
EB*R**30	Other Payer Loop
LS*2120	
NM1*PRP*2*ANY INSURANCE*****PI*123	Other Payer Name and ID
LE*2120	
EB*L	Primary Care Provider Loop
LS*2120	
NM1*P3*2*PCP CLINIC*****XX*1112223333	Primary Care Provider Name/ID

LE*2120	
EB*1**1^33^47^86^88^98^MH^UC********Y	Active coverage for mandated Service Types. Note: Vision (Service Type = AL) and Dental (Service Type = 35) are non-covered and are not included.
EB*B**48***27*50*****Y	Hospital Inpatient In-Network Co-Pay = $50
EB*B**50^98***27*10*****Y	Hospital Outpatient and Prof. Office Visit Co-pay = $10. Note the repeating data element (EB03).
EB*A**33*****30****N	Chiropractic Out-of Network Co-Insurance = 30%
EB*C*IND*30***23*300*****Y	Calendar Year Deductible = $300
EB*C*IND*30***24*225*****Y	Year to Date Deductible = $225
EB*C*IND*30***29*75*****Y	Remaining Deductible = $75
EB*G*IND*30***22*1000*****Y	Out-of-Pocket (Service Year) =$1000
EB*F**MH***22***HS*40**Y	Limitations (Mental Health) = 40 hours/year
III*ZZ*11	Limitations – additional information = visits restricted to office
EB*V**12********Y	Cannot Process DME benefits
MSG*CANNOT RETURN BENEFITS FOR THIS SERVICE, PLEASE CALL FOR DETAILS	Cannot Process – additional information
SE*38*0001	

5.2 Example B

5.2.1 *005010X279* 270 INQUIRY

This example is an inquiry by an Information Receiver for a Patient's (Subscriber) specific eligibility and benefits. The Information Receiver wants to know if the Patient has Pharmacy coverage. The Patient has a unique ID and is therefore being submitted as a Subscriber in the Subscriber Loop. The Information Receiver has submitted the Patient Last Name, First Name, and DOB elements for the inquiry.

ST*270*10011*005010X279	
BHT*0022*13**20091018*1222	
HL*1**20*1	
NM1*PR*2*XYZPAYER*****PI*999999	Information Source Name

HL*2*1*21*1	
NM1*1P*2*ABCPROVIDER*****XX*0123456789	Information Receiver Name
N3*123 MAIN ST	
N4*ANYTOWN*OR*12345	
HL*3*2*22*0	
TRN*1*XYZ123*9111222333	Trace Number
NM1*IL*1*CLAUS*FRED	Subscriber Last Name and First Name
DMG*D8*19881112	Subscriber DOB
DTP*291*D8*20091018	Eligibility Request Date
EQ*88	Explicit Request Service Type "88"
SE*15*10011	

5.2.2 *005010X279* 271 RESPONSE

The Information Source used Search Option #4 and has identified the Patient as the Subscriber, therefore the Patient information is returned in the Subscriber Loop. The Information Source could return the entire benefit set, but is only returning the specific benefits for Pharmacy in this response.

ST*271*0001*005010X279	
BHT*0022*11**20091018*1223	
HL*1**20*1	
NM1*PR*2*XYZPAYER*****PI*999999	Information Source Name
PER*IC*MEMBER SERVICES*TE*8001234567	
HL*2*1*21*1	
NM1*1P*2*ABCPROVIDER*****XX*0123456789	Information Receiver Name
HL*3*2*22*1	
TRN*2*XYZ123*9111222333	Trace Number from the 270
NM1*IL*1*CLAUS*FRED*G***MI*98989899	Subscriber Name and ID
REF*6P*3386	Group Number
N3*456 MAIN ST	Subscriber Address
N4*ANYTOWN*OR*123456789	Subscriber Address
PER*IC**HP*9521234567	Subscriber Phone Number
DMG*D8*19450420*M	Subscriber DOB and Gender
INS*Y*18*001*25	Change in identifying information – note the Subscriber's middle initial and ID.

DTP*346*D8*20070101	Plan begin date
EB*1*IND*88	Active Coverage Pharmacy
DTP*348*D8*20070201	Benefit begin date
EB*B**88***27*10*****Y	Pharmacy In-Network Co-Pay
EB*N**88	Services Restricted Loop
LS*2120	
NM1*13*2*THIS PHARMACY*****XX*999999123	Services Restricted to this Provider
LE*2120	
SE*25*0001	

5.3 Example C

5.3.1 *005010X279* 270 INQUIRY

This example is a request by an Information Receiver for a Dependent's eligibility and benefits. The Dependent information is sent in the Dependent Loop. The provider has submitted the Dependent Last Name, First Name, and DOB. In this example, the Subscriber's ID is unknown.

ST*270*10011*005010X279	
BHT*0022*13**20091018*1222	
HL*1**20*1	
NM1*PR*2*XYZPAYER*****PI*999999	Information Source Name
HL*2*1*21*1	
NM1*1P*2*ABCPROVIDER*****XX*0123456789	Information Receiver Name
N3*123 MAIN ST	
N4*ANYTOWN*OR*12345	
HL*3*2*22*1	
NM1*IL*1*CLAUS*BOB*G	Subscriber Name
DMG*D8*19450420*M	Subscriber DOB and Gender
HL*4*3*23*0	
TRN*1*XYZ123*9111222333	Trace Number
NM1*03*1*CLAUS*FRED	Dependent Name
DMG*D8*19881112	Dependent DOB
DTP*291*D8*20091018	Eligibility Request Date

EQ*30	Generic Request using Service Type "30"
SE*18*10011	

5.3.2 *005010X279* 271 RESPONSE

The Information Source used Search Option #4, but cannot uniquely identify the Patient; therefore the transaction is being rejected. The Information Source returns the submitted information with the rejected transaction information reported in the AAA Segment.

ST*271*10011*005010X279	
BHT*0022*13**20091018*1222	
HL*1**20*1	
NM1*PR*2*XYZPAYER*****PI*999999	Information Source Name
HL*2*1*21*1	
NM1*1P*2*ABCPROVIDER*****XX*0123456789	Information Receiver Name
N3*123 MAIN ST	
N4*ANYTOWN*OR*12345	
HL*3*2*22*1	
NM1*IL*1*CLAUS*BOB*G	Subscriber Name
DMG*D8*19450420*M	Subscriber DOB and Gender
HL*4*3*23*0	
TRN*2*XYZ123*9111222333	Trace Number from the 270
NM1*03*1*CLAUS*FRED	Dependent Name
AAA*Y**64*C	Reject Information – Invalid, Missing Patient ID
DMG*D8*19881112	Dépendant DOB
SE*17*10011	

6 APPENDIX B : SEARCH & FILTER CRITERIA – PRESCRIPTIVE EXAMPLE

This section includes one approach to filtering and matching transactions with Information Source records to ensure an accurate match, or failing which, the appropriate error message to be returned in response to the inquiry transaction.

The key requirement is that an accurate and appropriate result be returned on the 271 in response to a 270 eligibility inquiry. Information Sources may use any filtering or search algorithm when matching the inquiry with their internal systems as long as the results returned on the response 271 transaction are accurate and appropriate.

The Search Options define a standard way to determine and report when an Information Source is unable to find the subscriber/dependent and, therefore, is unable to respond with eligibility information for the subscriber/dependent. The goal is to use a unique error code for a given error condition. It is important to return as detailed information as possible so the Information Receiver can understand the …

Refer to the *005010X279* for further information about rejecting a transaction for reasons other than subscriber/dependent not found.

Table 1
Search Options

Option	Subscriber Id	Last Name	First Name	Patient Dob
1	X	X	X	X
2	X	X		X
3	X	X	X	
4		X	X	X
5	X		X	X
6	X			X

Shaded rows are highly recommended for support but optional for this version of the OCG

6.1.1.1 Option #1: (Subscriber ID, Last Name, First Name, DOB)

A. Search with Subscriber ID

- Search result with unique hit, Go to B.
- Search result with multiple hits, Go to B.
- Search result with no hits, Go to J.

B. Filter with DOB

- Filter result with unique hit, positive response

- Filter result with multiple hits, Go to C.
- Filter result with no hits, Go to H.

C. Filter with Last Name

- Filter result with unique hit, positive response
- Filter result with multiple hits, Go to D.
- Filter result with no hits, Go to F.

D. Filter with first 3 letters of First Name

- Filter result with unique hit, positive response
- Filter result with multiple hits, Go to E.
- Filter result with no hits
    a) If Subscriber ("Invalid Missing Subscriber/Insured Name"–73)
    b) If Dependent ("Invalid Missing Patient Name"–65)

E. Filter with full First Name

- Filter result with unique hit, positive response
- Filter result with multiple hits
    a) If Subscriber ("Duplicate Subscriber/Insured ID"–76)
    b) If Dependent ("Duplicate Patient ID"–68)
- Filter result with no hits.
    a) If Subscriber ("Invalid Missing Subscriber/Insured Name"–73)
    b) If Dependent ("Invalid Missing Patient Name"–65)

F. Start over with B results and filter with first 3 letters of First Name

- Filter result with unique hit, positive response
- Filter result with multiple hits, Go to G.
- Filter result with no hits.
    a) If Subscriber ("Invalid Missing Subscriber/Insured Name"–73)
    b) If Dependent ("Invalid Missing Patient Name"–65)

G. Filter with full First Name

- Filter result with unique hit, positive response
- Filter result with multiple hits.
    a) If Subscriber ("Invalid Missing Subscriber/Insured Name"–73)
    b) If Dependent ("Invalid Missing Patient Name"–65)
- Filter result with no hits.
    a) If Subscriber ("Invalid Missing Subscriber/Insured Name"–73)
    b) If Dependent ("Invalid Missing Patient Name"–65)

H. Start over with A results and filter with Last Name and first 3 letters of First Name

- Filter result with unique hit, positive response
- Filter result with multiple hits, Go to I.
- Filter result with no hits, Go to J.

I. Filter with full First Name

- Filter result with unique hit, positive response
- Filter result with multiple hits ("Patient DOB does not match that for the patient on the database"– 71)
- Filter result with no hits
    a) If Subscriber ("Invalid Missing Subscriber/Insured Name"–73 and "Patient DOB does not match that for the patient on the database"– 71)
    b) If Dependent ("Invalid Missing Patient Name"–65 and "Patient DOB does not match that for the patient on the database"– 71)

J. Start over and search with Last Name, first 3 letters First Name, and DOB.

- Search result with unique hit, positive response
- Search result with multiple hits, Go to K.
- Search result with no hits
    a) If reached from Step A
        a. If Subscriber ("Invalid Missing Subscriber/Insured ID"–72 and "Invalid Missing Subscriber/Insured Name"–73 and "Patient DOB does not match that for the patient on the database"– 71)
        b. If Dependent ("Invalid Missing Patient ID"–64 and "Invalid Missing Patient Name"–65 and "Patient DOB does not match that for the patient on the database"– 71)
    b) Else
        a. If Subscriber ("Invalid Missing Subscriber/Insured Name"–73 and "Patient DOB does not match that for the patient on the database"– 71)
        b. If Dependent ("Invalid Missing Patient Name"–65 and "Patient DOB does not match that for the patient on the database"– 71)

K. Filter with full First Name

- Filter result with unique hit, positive response
- Filter result with multiple hits
    a) If Subscriber ("Invalid Missing Subscriber/Insured ID"–72)
    b) If Dependent ("Invalid Missing Patient ID"–64)
- Filter result with no hits
    c) If reached from Step A and then J
        1) If Subscriber ("Invalid Missing Subscriber/Insured ID"–72 and "Invalid Missing Subscriber/Insured Name"–73)
        2) If Dependent ("Invalid Missing Patient ID"–64 and "Invalid Missing Patient Name"–65)
    d) Else
        1) If Subscriber ("Invalid Missing Subscriber/Insured Name"–73)
        2) If Dependent ("Invalid Missing Patient Name"–65)

6.1.1.2 Option #2: (Subscriber ID, Last Name, DOB)

A. Search with Subscriber ID

- Search result with unique hit, Go to B.
- Search result with multiple hits, Go to B.
- Search result with no hits
  a) If Subscriber ("Invalid Missing Subscriber/Insured ID"–72)
  b) If Dependent ("Invalid Missing Patient ID"–64)

B. Filter with DOB

- Filter result with unique hit, positive response
- Filter result with multiple hits, Go to C.
- Filter result with no hits ("Patient DOB does not match that for the patient on the database"– 71)

C. Filter with Last Name

- Filter result with unique hit, positive response
- Filter result with multiple hits
  a) If Subscriber ("Invalid Missing Subscriber/Insured Name"-(73)
  b) If Dependent ("Invalid Missing Patient Name"–65)
- Filter result with no hits
  a) If Subscriber ("Invalid Missing Subscriber/Insured Name"–73)
  b) If Dependent ("Invalid Missing Patient Name"–65)

6.1.1.3 Option #3: (Subscriber ID, Last Name, First Name)

A. Search with Subscriber ID

- Search result with unique hit, Go to B.
- Search result with multiple hits, Go to B.
- Search result with no hits
  a) If Subscriber ("Invalid Missing Subscriber/Insured ID"–72)
  b) If Dependent ("Invalid Missing Patient ID"–64)

B. Filter with Last Name

- Filter result with unique hit, Go to C.
- Filter result with multiple hits, Go to C.
- Filter result with no hits
  a) If Subscriber ("Invalid Missing Subscriber/Insured Name"–73)
  b) If Dependent ("Invalid Missing Patient Name"–65)

C. Filter with first 3 letters of First Name

- Filter result with unique hit, positive response
- Filter result with multiple hits, Go to D.

- Filter result with no hits
    a) If Subscriber ("Invalid Missing Subscriber/Insured Name"–73)
    b) If Dependent ("Invalid Missing Patient Name"–65)

D. Filter with full First Name

- Filter result with unique hit, positive response
- Filter result with multiple hits ("Invalid/Missing DOB"– 58)
- Filter result with no hits
    a) If Subscriber ("Invalid Missing Subscriber/Insured Name"–73)
    b) If Dependent ("Invalid Missing Patient Name"–65)

6.1.1.4 Option #4: (Last Name, First Name, DOB)

A. Search with Last Name, first 3 letters First Name, and DOB.

- Search result with unique hit, positive response
- Search result with multiple hits, Go to B.
- Search result with no hits
    a) If Subscriber ("Invalid Missing Subscriber/Insured Name"–73 and "Patient DOB does not match that for the patient on the database"– 71)
    b) If Dependent ("Invalid Missing Patient Name"–65 and "Patient DOB does not match that for the patient on the database"– 71)

B. Filter with full First Name

- Filter result with unique hit, positive response
- Filter result with multiple hits
    a) If Subscriber ("Invalid Missing Subscriber/Insured ID"–72)
    b) If Dependent ("Invalid Missing Patient ID"–64)
- Filter result with no hits
    a) If Subscriber ("Invalid Missing Subscriber/Insured Name"–73)
    b) If Dependent ("Invalid Missing Patient Name"–65)

6.1.1.5 Option #5: (Subscriber ID, First Name, DOB)

A. Search with Subscriber ID

- Search result with unique hit, Go to B.
- Search result with multiple hits, Go to B.
- Search result with no hits
    a) If Subscriber ("Invalid Missing Subscriber/Insured ID"–72)
    b) If Dependent ("Invalid Missing Patient ID"–64)

B. Filter with DOB

- Filter result with unique hit, positive response
- Filter result with multiple hits, Go to C.

- Filter result with no hits ("Patient DOB does not match that for the patient on the database"– 71)

C. Filter with first 3 letters of First Name

- Filter result with unique hit, positive response
- Filter result with multiple hits, Go to D.
- Filter result with no hits
  a) If Subscriber ("Invalid Missing Subscriber/Insured Name"–73)
  b) If Dependent ("Invalid Missing Patient Name"–65)

D. Filter with full First Name

- Filter result with unique hit, positive response
- Filter result with multiple hits
  a) If Subscriber ("Invalid Missing Subscriber/Insured Name"–73)
  b) If Dependent ("Invalid Missing Patient Name"–65)
- Filter result with no hits
  a) If Subscriber ("Invalid Missing Subscriber/Insured Name"–73)
  b) If Dependent ("Invalid Missing Patient Name"–65)

6.1.1.6 Option #6: (Subscriber ID, DOB)

A. Search with Subscriber ID

- Search result with unique hit, Go to B.
- Search result with multiple hits, Go to B.
- Search result with no hits
  a) If Subscriber ("Invalid Missing Subscriber/Insured ID"–72)
  b) If Dependent ("Invalid Missing Patient ID"–64)

B. Filter with DOB

- Filter result with unique hit, positive response
- Filter result with multiple hits
  a) If Subscriber ("Invalid Missing Subscriber/Insured Name"–73)
  b) If Dependent ("Invalid Missing Patient Name"–65)
- Filter result with no hits ("Patient DOB does not match that for the patient on the database"– 71)

7 APPENDIX C : STATEMENT FROM THE OREGON HEALTH AUTHORITY

The 2009 Oregon Legislative Assembly directed the Office for Oregon Health Policy and Research (OHPR) to bring together a work group to recommend uniform standards for insurers for, at a minimum, eligibility verification, claims processes, payment remittance advice, and claims payment. The Oregon Health Policy Board asked the work group to expand the legislative direction and include a broad strategy for administrative simplification, including specifying the appropriate role for the state, and to estimate the potential for cost savings that can be achieved through administrative simplification.

The goal of administrative simplification is to reduce total system costs and reduce the amount of provider resources that must be devoted to administrative transactions between providers of care and payers by simplifying and streamlining these activities.

The keys to simplification are elimination, standardization, and automation of processes. In Oregon, many transactions that would be automated in other industries are still performed manually by most providers and many payers. The healthcare industry is unlikely to take major strides toward automated processes until there is greater standardization of the methods for conducting the transactions electronically. Standardization has proven difficult for the industry to achieve on a voluntary basis. Standardization requires each individual business to make upfront investment in changing systems and work processes. Such investments are rational only if all, or nearly all, providers and payers with which they deal are making similar investments at the same time. Therefore, the state has a central role in enabling the industry to move forward together to greater simplification and automation of administrative processes.

The work group made several recommendations and estimated that failure to take these steps outlined in this report would cost Oregon payers and providers nearly $100 million in administrative savings each year. The work group makes the following recommendations:

Recommendation #1:	Oregon should adopt the Minnesota approach to standardization and automation.
Recommendation #2:	Oregon requirements for standardization and automation should be phased-in. This means that providers and payers should be given time to adjust to the changes.
Recommendation #3:	Oregon should lead. Oregon should not wait for the federal government to standardize HIPAA transactions.
Recommendation #4:	Technical assistance to providers will be important to help providers adjust to and take full advantage of administrative simplification opportunities.

Recommendation #5: There is need for on-going public-private partnerships to identify successes, challenges, and opportunities for future administrative simplification.

To carry out these recommendations, the following steps will need to be taken:

- The Department of Consumer & Business Services must adopt by rule uniform companion guides for eligibility verification, claims, and payment remittance advice by adapting the Minnesota uniform companion guides. The rules should require insurers and the providers that do business with them to conduct the transactions electronically about a year after adoption of each uniform companion guide.

- The Legislature must enact legislation in 2011 giving DCBS authority to establish uniform standards for healthcare administrative transactions to all payers (including third party administrators and self-insured plans) and clearinghouses and to collect data from them to monitor progress and identify future opportunities.

- The Oregon Health Authority as a payer should follow the DCBS rules and require Medicaid managed care organizations, Medicaid providers, and others with which it deals to do so as well.

- DCBS must require insurers and other payers to perform additional transactions electronically on a phased-in basis between 2014 and 2016—setting the dates for each transaction to go "all-electronic" no later than one year after a HIPAA standard and uniform companion guide or uniform operating rules have been adopted by the U.S. Department of Human Services.

- The industry should bring forward its recommendation to develop a single sign-on to health plan web portals and a single source for information used in physician credentialing. In addition, the industry should identify and develop additional opportunities for standardization.

- The Insurance Commissioner and the Director of the Oregon Health Authority should take joint responsibility for continued progress toward greater administrative simplification. They should carry out these responsibilities in collaboration with providers and payers, collecting data to evaluate progress; establishing priorities, goals, benchmarks, and timelines; and using rulemaking authority as necessary.

8 APPENDIX D : REFERENCES AND BIBLIOGRAPHY

References:

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Bibliography:

1. Accredited Standards Committee X12, Insurance Subcommittee, ASC X12N. Patient Request (2110C or 2110D). Health Care Eligibility/Benefit Inquiry and Response (270/271), 005010X279. Washington Publishing Company, June, 2010. http://www.wpc-edi.com. Page 7

2. Accredited Standards Committee X12, Insurance Subcommittee, ASC X12N. Subscriber (2000C loop). « Health Care Eligibility/Benefit Inquiry and Response (270/271), 005010X279. Washington Publishing Company, June, 2010. http://www.wpc-edi.com. Page 5

3. Accredited Standards Committee X12, Insurance Subcommittee, ASC X12N. Dependent (2000D loop). Health Care Eligibility/Benefit Inquiry and Response (270/271), 005010X279. Washington Publishing Company, June, 2010. http://www.wpc-edi.com. Page 6

4. Accredited Standards Committee X12, Insurance Subcommittee, ASC X12N. Relationship to Subsequent X12 Transactions. Health Care Eligibility/Benefit Inquiry and Response (270/271), 005010X279. Washington Publishing Company, June, 2010. http://www.wpc-edi.com. Page 7

5. Accredited Standards Committee X12, Insurance Subcommittee, ASC X12N. 1.4.2 Basic Concepts. Health Care Eligibility/Benefit Inquiry and Response (270/271), 005010X279. Washington Publishing Company, June, 2010. http://www.wpc-edi.com. Pages 5-8

6. Accredited Standards Committee X12, Insurance Subcommittee, ASC X12N. Minimum Requirements for TR3 Compliance. Health Care Eligibility/Benefit Inquiry and Response (270/271), 005010X279. Washington Publishing Company, June, 2010. http://www.wpc-edi.com. Page 19

7. Accredited Standards Committee X12, Insurance Subcommittee, ASC X12N. 1.4.7.2 Recommended Additional Support. Health Care Eligibility/Benefit Inquiry and Response (270/271), 005010X279. Washington Publishing Company, June, 2010. http://www.wpc-edi.com. Pages 22-24

8. Accredited Standards Committee X12, Insurance Subcommittee, ASC X12N. 1.4.7.2 Recommended Additional Support. Health Care Eligibility/Benefit Inquiry and Response (270/271), 005010X279. Washington Publishing Company, June, 2010. http://www.wpc-edi.com. Pages 22-24

9. Accredited Standards Committee X12, Insurance Subcommittee, ASC X12N. 2.4 Segment Detail. Health Care Eligibility/Benefit Inquiry and Response (270/271), 005010X279. Washington Publishing Company, June, 2010. http://www.wpc-edi.com. Pages 60-200

10. Accredited Standards Committee X12, Insurance Subcommittee, ASC X12N. 2.6 Segment Detail. Health Care Eligibility/Benefit Inquiry and Response (270/271), 005010X279. Washington Publishing Company, June, 2010. http://www.wpc-edi.com. Pages 208-450

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