Phase II CAQH CORE 260: Eligibility & Benefits Data Content (270/271) Rule
version 2.1.0 March 2011

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1 BACKGROUND SUMMARY

CORE determined that Phase I CORE should focus on improving electronic eligibility and benefits verification, as eligibility is the first transaction in the claims process. Thus, if eligibility and benefits are accurately known to healthcare providers, all the associated electronic transactions that follow will be more effective and efficient. The Phase I CORE 154 Eligibility & Benefits Data Content (270/271) Rule primarily outlined a set of requirements for health plans to return base (not remaining or accumulated) patient financial responsibility related to the deductible, co-pay and co-insurance for a set of 12 services in the HIPAA-adopted ASC X12 005010X279A1 Eligibility Benefit Request and Response (270/271) (hereafter v5010 270/271, v5010 270, v5010 271) transactions, and for vendors, clearinghouse and providers to transmit and use this financial data. The Phase II CORE 260 Eligibility& Benefits (270/271) Data Content Rule extends and enhances the Phase I v5010 271 transaction by requiring the provision of remaining deductible amounts for both the Phase I required 12 Service Type Codes and an additional set of 39 other Service Type Codes.

2 ISSUE TO BE ADDRESSED AND BUSINESS REQUIREMENT JUSTIFICATION

In order to electronically determine a patient's eligibility and benefits, providers need to have a robust v5010 271. This robust response includes the health plans providing financial information, especially remaining deductible amounts, and coverage information for those service types that are heavily used by patients.

HIPAA provides a foundation for the electronic exchange of eligibility and benefits information, but does not go far enough to ensure that today's paper-based system can be replaced by an electronic, interoperable system. HIPAA's current mandated data scope does not require all financial information needed by providers, and HIPAA neither addresses the standardization of data definitions nor contains business requirements by which the HIPAA-outlined data can flow. Future standards developed by ASC X12 and adopted by HIPAA may address these issues. In the meantime, businesses are seeking solutions that can be used today.

Using the available but not-required (situational) elements of the v5010 270/271, the Phase I and II CORE Data Content Rules define the specific business information requirements that health plans must return and vendors, clearinghouses and providers must use if they want to be CORE-certified. As with all CORE rules, these requirements are base requirements, and it is expected many CORE-certified entities will add to these requirements as they work towards the goal of administrative interoperability. This Phase II CORE 260 Eligibility & Benefits Data Content (270/271) Rule requires the delivery of the remaining deductible amount (in addition to base contract deductible amount, which is required in Phase I), outlines how a health plan deductible vs. a benefit or service type-specific deductible is to be specified in the v5010 271, and provides an expanded list of CORE-required service type codes, which are additions to the 12 Service Type Codes that the Phase I CORE 154 Eligibility & Benefits (270/271) Data Content Rule requires.

By requiring the delivery and use of this financial information via the existing v5010 270/271 HIPAA-adopted standard, the Phase II CORE 260 Eligibility & Benefits (270/271) Data Content Rule helps provide the information that is necessary to more fully automate electronic eligibility and benefits inquiry processes and thus reduce the cost of today's more manual processes. Moreover, to ensure industry coordination, the Phase I and Phase II CORE 154/260 Eligibility & Benefits (270/271) Data Content Rules take into consideration many of the requirements included in the ASC X12 005010X279A1 Health Care Eligibility Benefit Inquiry and Response (270/271) Technical Report Type 3 (TR3) (hereafter v5010 TR3) implementation guide, thus enabling the industry to realize many of these benefits now.

3 SCOPE

3.1 What the Rule Applies To

This CORE rule conforms with and builds upon the ASC X12 005010X279A1 Health Care Eligibility Benefit Inquiry and Response (270/271) Technical Report Type 3 (TR3) implementation guide specifies the minimum content that a CORE-certified entity must include in the v5010 271.

This rule builds upon and extends the Phase I CORE 154 Eligibility& Benefits (270/271) Data Content Rule Version 1.1.0 by addressing ambiguities, extending requirements and adding CORE constraints to the v5010 271 content that a CORE-certified entity must include in the v5010 271 (See §3.6.1.).

3.2 When the Rule Applies

This rule applies when:

- The individual is located in the health plan's (or information source's) eligibility system

And

- A health plan (or information source) receives a generic v5010 270;

Or

- A health plan (or information source) receives an explicit v5010 270 for a specific service type required in §4.1.1.1 of this rule.

3.3 What the Rule Does Not Require

This rule does not require any CORE-certified entity to modify its use and content of:

- Other loops and data elements that may be submitted in the v5010 270 not addressed in this rule (see §3.4)

And

- Other loops and data elements that may be returned in the v5010 271 not addressed in this rule (see §3.4).

3.4 Applicable Loops & Data Elements

This rule covers the following specified loops, segments and data elements in the v5010 270/271 transactions:[1]

In the v5010 270:

- Loop 2110C Subscriber Eligibility or Benefit Inquiry Information
  - EQ Subscriber Eligibility or Benefit Inquiry Information Segment
- Loop 2110D Dependent Eligibility or Benefit Inquiry Information
  - EQ Dependent Eligibility or Benefit Inquiry Information Segment

In the v5010 271:

- Loop 2100C Subscriber Name
  - DTP01-374 Date/Time Qualifier
  - DTP02-1250 Date Time Period Format Qualifier
  - DTP03-1251 Date Time Period
- Loop 2110C Subscriber Eligibility or Benefit Information
  - EB01-1390 Eligibility or Benefit Information
  - EB02-1207 Coverage Level Code
  - EB03-1365 Service Type Code
  - EB06-615 Time Period Qualifier
  - EB07-782 Monetary Amount
  - EB08-954 Percent
  - EB12-1073 Yes/No – In Plan Network Indicator
  - DTP01-374 Date/Time Qualifier
  - DTP02-1250 Date Time Period Format Qualifier

[1] Loops, segments and data elements in normal font are addressed in Phase I CORE 154 Eligibility & Benefits 270/271 Data Content Rule Version 1.1.0 and any subsequent versions. Loops, segments and data element in bold font are addressed only in this CORE Phase II Data Content Rule.

- DTP03-1251 Date Time Period

- Loop 2100D Dependent Name
  - DTP01-374 Date/Time Qualifier
  - DTP02-1250 Date Time Period Format Qualifier
  - DTP03-1251 Date Time Period
- Loop 2110D Dependent Eligibility or Benefit Information
  - EB01-1390 Eligibility or Benefit Information
  - EB02-1207 Coverage Level Code
  - EB03-1365 Service Type Code
  - EB06-615 Time Period Qualifier
  - EB07-782 Monetary Amount
  - EB08-954 Percent
  - EB12-1073 Yes/No – In-Plan Network Indicator
  - DTP01-374 Date/Time Qualifier
  - DTP02-1250 Date Time Period Format Qualifier
  - DTP03-1251 Date Time Period

3.5 Outside the Scope of this Rule

This rule does not:

Require CORE-certified entities to internally store the data elements listed in §3.4 or any other data elements in conformance with this rule, but rather requires that all CORE-certified entities conform to this rule when conducting the v5010 270/271 transactions electronically. Entities may store data internally any way they wish, but must ensure the data conform to applicable CORE rules when inserting that data into outbound transactions.

3.6 Assumptions

The following assumptions apply to this rule:

- This rule is a component of the larger set of Phase II CORE rules; as such, all the CORE Guiding Principles apply to this rule and all other rules.
- All entities seeking Phase II certification must be Phase I certified as Phase I CORE provides a foundation for Phase II CORE.
- Requirements for the use of the applicable loops and data elements apply only to the v5010 270/271.
- Health plans (and information sources) are able to accurately maintain benefit and eligibility data received or created in a reasonable timeframe.
- The terms used in this rule are defined in §3.7 and in the Phase II CORE Glossary of Data Content Terms, which is an Appendix to this rule.
- This rule is not a comprehensive companion document specifying the complete content of either the v5010 270 or v5010 271 transactions. The focus in this rule is on specifying requirements for the v5010 271 to address the Phase II CORE data content requirements for health plan benefits and services and related patient financial responsibility.

3.6.1 Builds on Phase I Eligibility and Benefits Data Content v5010 270/271 Rule

This rule builds upon and extends the Phase I CORE 154 Eligibility & Benefits Data Content (270/271) Rule Version 1.1.0 by addressing ambiguities, extending requirements and adding new CORE constraints to the v5010 271 content of the v5010 271 transaction.

Given that any entity seeking Phase II certification will need to be Phase I certified (see Phase II CORE Guiding Principles) and because the Phase II Data Content rule is built upon the Phase I Data Content Rule, the Phase II Data Content rule incorporates by reference all the requirements of the Phase I CORE 154 Eligibility & Benefits Data Content (270/271) Rule Version 1.1.0.

3.7 Abbreviations and Definitions Used in this Rule

Health Plan Base Deductible: *The dollar amount of covered services based on the allowed benefit that must be paid by an individual or family per benefit period before the health benefit plan begins to pay its portion of claims. The benefit period may be a specific date range of one year or other as specified in the plan. (See the entry for Health Plan Deductible in the Phase II CORE Glossary of Data Content Terms.)*

Benefit-specific Base Deductible*: The dollar amount of a specific covered service based on the allowed benefit that is separate and distinct from the Health Plan Base Deductible that must be paid by an individual or family before the health benefit plan begins to pay its portion of claims. The specific benefit period may be a specific date, date range, or otherwise as specified in the plan.*

Explicit Inquiry: *In contrast to a Generic Inquiry, an Explicit Inquiry is a v5010 270 Health Care Eligibility Benefit Inquiry that contains a Service Type Code other than and not including "30" (Health Benefit Plan Coverage) in the EQ01 segment of the transaction. An Explicit Inquiry asks about coverage of a specific type of benefit, for example, "78" (Chemotherapy). (See* ***§****4.1.1.1.)*

Generic Inquiry: *In contrast to an Explicit Inquiry, a Generic Inquiry is a v5010 270 Health Care Eligibility Benefit Inquiry that contains only Service Type Code "30" (Health Benefit Plan Coverage) in the EQ01 segment of the transaction.*

Health Plan Coverage Date for the Individual: *The effective date of health plan coverage actually in operation and in force for the individual.*

Support [Supported] Service Type: *Support [or Supported] means that the health plan (or information source) must have the capability to receive a v5010 270 inquiry for a specific Service Type Code and to respond in the corresponding v5010 271 response in accordance with this rule.*

Other terms and concepts used in this rule are defined in the Phase II CORE Glossary of Data Content Terms, which is an Appendix to this rule.

4 RULE

4.1 Basic Requirements for Health Plans and Information Sources

A CORE Phase II-certified health plan (or information source) is required to comply with all requirements specified in this rule when returning the v5010 271 when the individual is located in the health plan's (or information source's) system.

4.1.1 Specifying Health Benefits Coverage

4.1.1.1 Requirements for a Response to an Explicit Inquiry for a CORE Required Service Type

A CORE-certified health plan (or information source) must support an explicit v5010 270 for each of the CORE service types specified in Table 4.1.1.1 by returning a v5010 271 as specified in §4.1.2 through §4.1.5.

Table 4.1.1.1 specifies 51 Service Type Codes, 12 of which are required in the Phase I CORE Rule. These 12 required service types specified in Phase I CORE 154 Eligibility & Benefits (270/271) Data Content Rule are included in this Phase II rule by reference and are identified in Table 4.1.1.1 in italic font.

TABLE 4.1.1.1 CORE REQUIRED SERVICE TYPES FOR AN EXPLICIT INQUIRY	
CORE REQUIRED EXPLICIT INQUIRY SERVICE TYPES (v5010 X12 270/271 Code and Definition)	**CORE SUPPLEMENTAL DESCRIPTION[2]**
1 Medical Care	*Medical care services to diagnose and/or treat medical condition, illness or injury. Medical services and supplies provided by physicians and other healthcare professionals.*
2 Surgical	footnote 2
4 Diagnostic X-Ray	footnote 2
5 Diagnostic Lab	footnote 2
6 Radiation Therapy	footnote 2
7 Anesthesia	footnote 2
8 Surgical Assistance	Assistant Surgeon/surgical assistance provided by a physician if required because of the complexity of the surgical procedures.
12 Durable Medical Equipment Purchase	Purchase of medically necessary equipment and supplies prescribed by a physician or other healthcare provider that can withstand repeated use, is medically necessary for the patient, is not useful if the patient is not ill or injured, and can be used in the home.
13 Ambulatory Service Center Facility	A freestanding facility that provides services on an outpatient basis, primarily for the purpose of performing medical or surgical procedures.
18 Durable Medical Equipment Rental	Rental of medically necessary equipment and supplies prescribed by a physician or other healthcare provider that can withstand repeated use, is medically necessary for the patient, is not useful if the patient is not ill or injured, and can be used in the home.
20 Second Surgical Opinion	footnote 2
33 Chiropractic	*Professional services which may include office visits, manipulations, lab, x-rays, and supplies.*
35 Dental Care	*Benefits for services, supplies or appliances for care of teeth.*
40 Oral Surgery	footnote 2
42 Home Health Care	footnote 2
45 Hospice	footnote 2
47 Hospital	footnote 2
48 Hospital - Inpatient	*Hospital services and supplies for a patient who has been admitted to a hospital for the purpose of receiving medical care or other health services.*
50 Hospital - Outpatient	*Hospital services and supplies for a patient who has not been admitted to a hospital for the purpose of receiving medical care or other health services.*
51 Hospital - Emergency Accident	Hospital services and supplies for the treatment of a sudden and unexpected injury that requires immediate medical attention.
52 Hospital - Emergency Medical	Hospital services and supplies for the treatment of a sudden and unexpected condition that requires immediate medical attention.
53 Hospital - Ambulatory Surgical	footnote 2
62 MRI/CAT Scan	footnote 2
65 Newborn Care	footnote 2
68 Well Baby Care	footnote 2
73 Diagnostic Medical	footnote 2

[2] The CORE supplemental descriptions (clarification/meaning) are for guidance until definitive clarified definitions can be obtained within the ASC X12 standards. They provide a general understanding of the specific services which are included in each service type, but the description may not be all inclusive. No CORE description is provided for Service Type Codes where there was agreement among the CORE participants that the ASC X12 Standard Code Definition is sufficiently clear and commonly understood.

TABLE 4.1.1.1 CORE REQUIRED SERVICE TYPES FOR AN EXPLICIT INQUIRY	
CORE REQUIRED EXPLICIT INQUIRY SERVICE TYPES (v5010 X12 270/271 Code and Definition)	**CORE SUPPLEMENTAL DESCRIPTION[2]**
76 Dialysis	footnote 2
78 Chemotherapy	footnote 2
80 Immunizations	footnote 2
81 Routine Physical	footnote 2
82 Family Planning	footnote 2
86 Emergency Services	*Medical services and supplies provided by physicians, Hospitals, and other healthcare professionals for the treatment of a sudden and unexpected medical condition or injury which requires immediate medical attention.*
88 Pharmacy	*Drugs and supplies dispensed by a licensed Pharmacist, which may include mail order or internet dispensary.*
93 Podiatry	footnote 2
98 Professional (Physician) Visit - Office	footnote 2
99 Professional (Physician) Visit - Inpatient	footnote 2
A0 Professional (Physician) Visit - Outpatient	footnote 2
A3 Professional (Physician) Visit - Home	footnote 2
A6 Psychotherapy	footnote 2
A7 Psychiatric - Inpatient	footnote 2
A8 Psychiatric - Outpatient	footnote 2
AD Occupational Therapy	footnote 2
AE Physical Medicine	footnote 2
AF Speech Therapy	footnote 2
AG Skilled Nursing Care	Services and supplies for a patient who has been admitted to a skilled nursing facility for the purpose of receiving medical care or other health services.
AI Substance Abuse	footnote 2
AL Vision (Optometry)	*Routine vision services furnished by an optometrist. May include coverage for eyeglasses, contact lenses, routine eye exams, and/or vision testing for the prescribing or fitting of eyeglasses or contact lenses.*
BG Cardiac Rehabilitation	footnote 2
BH Pediatric	footnote 2
MH Mental Health	footnote 2
UC Urgent Care	footnote 2

4.1.2 Specifying Status of Health Benefits Coverage

For the discretionary Service Type Codes identified in §4.1.3, when the health plan is exercising its discretion to not return patient financial responsibility, the status of the specific benefit (service type) must be returned regardless of whether or not that status is separate and distinct from the status of the health plan coverage.

When a service type covered by this rule is a covered benefit for in-network providers only and not a covered benefit for out-of-network providers, a CORE-certified health plan (or information source) must indicate the non-

covered status for out-of-network providers for each service type using EB12-1073 Yes/No – In Plan Network Indicator as follows:

EB01 = I−Non Covered

EB03 = <Applicable Service Type Code>

EB12 = N

4.1.3 Patient Financial Responsibility

A CORE-certified health plan (or information source) must return the patient financial responsibility for base and remaining deductible, co-insurance and co-payment as specified in §4.1.3.1 through §4.1.3.3 for each of the service type codes returned. The health plan (or information source) may, at its discretion, elect not to return patient financial responsibility information (deductible, co-payment or co-insurance) for the following Service Type Codes specified in EB03-1365:

- 1 – Medical Care;
- 35 – Dental Care;
- 88 – Pharmacy;
- A6 – Psychotherapy;
- A7 – Psychiatric – Inpatient;
- A8 – Psychiatric – Outpatient;
- AI – Substance Abuse; and
- AL – Vision (Optometry);
- MH – Mental Health.

This discretionary reporting of patient financial responsibility information does not preempt the health plan's (or information source's) requirement to report patient financial responsibility for deductible, co-payment and co-insurance for all other Service Type Codes as specified in Table 4.1.1.1.

Service Type Code 30−Health Benefit Plan Coverage is not included in this group of discretionary service types since this rule requires that a CORE-certified health plan (or information source) must return base and remaining Health Plan Deductibles using Service Type Code 30.

CORE made these codes discretionary for one of three main reasons:

- A code is too general for a response to be meaningful (e.g., 1 – Medical), especially given the new specific codes added in Phase II;
- A code is typically a "carve-out" benefit (e.g., AL – Vision) where the specific benefit information is not available to the health plan or information source; or
- A code is related to behavioral health or substance abuse (e.g., AI - Substance Abuse) where privacy issues may impact a health plan or information source's ability to return information.

See §6.1 Appendix 1 for a visual view of Service Type Codes and reporting requirements.

All date and date range reporting requirements for Patient Financial Responsibility are specified in §4.1.4.

4.1.3.1 Specifying Deductible Amounts

A CORE-certified health plan (or information source) must return the dollar amount of the base and remaining deductible for all Service Type Codes required by §4.1.1.1 and for Service Type Code 30 (See §4.1.1.1.), with consideration of §4.1.3 for discretionary reporting exceptions.

The deductible amount returned must be in U.S. dollars only.

4.1.3.1.1 Specifying the Health Plan Base Deductible

A CORE-certified health plan (or information source) must return the Health Plan base deductible as defined in §3.7 of this rule that is the patient financial responsibility, including both individual and family deductibles (when

applicable) in Loops 2110C/2110D only when the status of the health plan coverage as required in §4.1.2 is equal to one of the active coverage codes 1 through 5 and EB03=30 – Health Benefit Plan Coverage as follows:

EB01 = C–Deductible

EB02 = FAM–Family or IND–Individual as appropriate

EB03 = 30 – Health Benefit Plan Coverage

EB06 = <Applicable Time Period Qualifier code; see Table 4.1.3.1.1 for recommended qualifiers.>

EB07 = Monetary amount of Health Plan base deductible

TABLE 4.1.3.1.1 CORE Recommended Time Period Qualifier Codes	
CORE RECOMMENDED TIME PERIOD QUALIFIER CODES (v5010 X12 270/271 Code and Definition)	**CORE SUPPLEMENTAL DESCRIPTION[3]**
22 Service Year	A 365-day (366 in leap year) period. This period may not necessarily be a Calendar Year (for example April 1 through March 31).
23 Calendar Year	January 1 through December 31 of the same year.
25 Contract	The duration of the patient's specific coverage with the health plan.

When a service type does not have a base deductible separate and distinct from the Health Plan base deductible, the Health Plan base deductible must not be returned on any EB segment where EB03≠30 − Health Benefit Plan Coverage.

When the Health Plan base deductible differs for in- and out-of-network, two occurrences of the EB segment must be returned using EB12-1073 with codes N and Y as follows:

EB12 = N or Y as applicable

4.1.3.1.2 Specifying the Health Plan Remaining Deductible

A CORE-certified health plan (or information source) must return the Health Plan remaining deductible as defined in the Phase II CORE Glossary of Data Content Terms, which is an Appendix to this rule, that is the patient financial responsibility, including both individual and family remaining deductibles (when applicable) in Loops 2110C/2110D only when the status of the health plan coverage as required in §4.1.2 is equal to one of the active coverage codes 1 through 5 and EB03=30 – Health Benefit Plan Coverage as follows:

EB01 = C–Deductible

EB02 = FAM–Family or IND–Individual as appropriate

EB03 = 30 – Health Benefit Plan Coverage

EB06 = 29–Remaining

EB07 = Monetary amount of Health Plan remaining deductible

When a service type does not have a specific remaining deductible that is separate and distinct from the Health Plan remaining deductible, the Health Plan remaining deductible must not be returned on any EB segment where EB03≠30−Health Benefit Plan Coverage.

When the Health Plan remaining deductible differs for in- and out-of-network, two occurrences of the EB segment must be returned using EB12-1073 with codes N and Y as follows.

[3] CORE descriptions (clarification/meaning) provide a more explicit understanding of the specific time period applicable to the health plan deductible amounts.

EB12 = N or Y as applicable

The Health Plan remaining deductible returned is for the current time period only, i.e., as of the date of the v5010 271. When the v5010 270 is for a time period other than the current time period, no Health Plan remaining deductible is returned.

4.1.3.1.3 Specifying the Benefit-specific Base Deductible

A CORE-certified health plan (or information source) must return the Benefit-specific base deductible as defined in §3.7 of this rule that is the patient financial responsibility, including both individual and family deductibles (when applicable) in Loops 2110C/2110D only when the status of the health plan coverage and the status of the specific benefit as required in §4.1.2 is equal to one of the active coverage codes 1 through 5 and EB03≠30–Health Benefit Plan Coverage as follows:

EB01 = C–Deductible

EB02 = FAM–Family or IND–Individual as appropriate

EB03 = <the Service Type Code indicating the specific benefit to which the deductible applies>

EB06 = <Applicable Time Period Qualifier code; see Table 4.1.3.1.1 for recommended qualifiers.>

EB07 = Monetary amount of Benefit-specific base deductible

When the Benefit-specific base deductible differs for in- and out-of-network, two occurrences of the EB segment must be returned using EB12-1073 with codes N and Y as follows:

EB12 = N or Y as applicable

4.1.3.1.4 Specifying the Benefit-specific Remaining Deductible

A CORE-certified health plan (or information source) must return the Benefit-specific remaining deductible as defined in the Phase II CORE Glossary of Data Content Terms, which is an Appendix to this rule, that is patient financial responsibility, including both individual and family deductibles (when applicable) in Loops 2110C/2110D only when the status of the health plan coverage and the status of the specific benefit as required in §4.1.2 is equal to one of the active coverage codes 1 through 5 and EB03≠30–Health Benefit Plan Coverage as follows:

EB01 = C–Deductible

EB02 = FAM–Family or IND–Individual as appropriate

EB03 = <the Service Type Code indicating the specific benefit to which the deductible applies>

EB06 = 29 – Remaining

EB07 = Monetary amount of Benefit-specific remaining deductible

When the Benefit-specific remaining deductible differs for in- and out-of-network, two occurrences of the EB segment must be returned using EB12-1073 with codes N and Y as follows:

EB12 = N or Y as applicable

The benefit-specific remaining deductible returned is for the current time period only, i.e., as of the date of the v5010 271. When the v5010 270 is for a time period other than the current time period, no Benefit-specific remaining deductible is returned.

Returning the Benefit-specific remaining deductible is required except for those service types specified as exceptions for discretionary reporting in §4.1.3.

4.1.3.2 Specifying Co-Payment Amounts

A CORE-certified health plan (or information source) must return the patient financial responsibility for co-payment for each of the Service Type Codes returned as specified as follows:

EB01 = B–Co-Payment

EB02 = FAM–Family or IND–Individual as appropriate

EB07 = Monetary amount of Benefit-specific Co-payment

When the patient financial responsibility amounts differ for in- and out-of-network, two occurrences of the EB segment must be returned using EB12-1073 with codes N and Y as follows:

EB12 = N or Y as applicable

See §4.1.3 for discretionary reporting exceptions.

4.1.3.3 Specifying Co-Insurance Amounts

A CORE-certified health plan (or information source) must return the patient financial responsibility for co-insurance for each of the Service Type Codes returned as follows:

EB01 = A–Co-Insurance

EB02 = FAM–Family or IND–Individual as appropriate

EB08 = Percent for each Benefit-specific Co-insurance

When the patient financial responsibility amounts differ for in- and out-of-network, two occurrences of the EB segment must be returned using EB12-1073 with codes N and Y as follows:

EB12 = N or Y as applicable

See §4.1.3 for discretionary reporting exceptions.

4.1.4 Specifying the Health Plan Base Deductible Dates

When the Health Plan Base Deductible date is not the same date as the Health Plan Coverage Date for the Individual a CORE-certified health plan (or information source) must return date specifying the begin date for the base Health Plan deductible only in Loops 2110C/2110D where EB01= active coverage code 1 through 5 and EB03=30–Health Plan Benefit Coverage and EB01=C−Deductible as follows:

DTP01 = 346 Plan Begin

DTP02 = D8–Date Expressed in Format CCYYMMDD

DTP03 = the date applicable to the time period as specified in EB06

Do not return the DTP segment when the date is the same as the Health Plan Coverage Dates for the Individual.

Alternatively, a CORE-certified health plan (or information source) may return a range of dates specifying the begin and end dates for the base Health Plan Base deductible only in Loops 2110C/2110D where EB01 = active coverage code 1 through 5 and EB03=30–Health Plan Benefit Coverage and EB01 = C−Deductible as follows:

DTP01 = 291–Plan

DTP02 = RD8–Date Expressed in Format CCYYMMDD-CCYYMMDD

DTP03 = the range of dates applicable to the time period as specified in EB06

Do not return the DTP segment when the date range is the same as the Health Plan Coverage Dates for the Individual.

4.1.5 Specifying Benefit-specific Base Deductible Dates

When the Benefit-specific Base Deductible date is not the same date as the Health Plan Coverage Dates for the Individual, a CORE-certified health plan (or information source) must return a date specifying the begin date for the base Benefit-specific deductible only in Loops 2110C/2110D where EB01= active coverage code 1 through 5 and EB03≠30–Health Plan Benefit Coverage and EB01=C−Deductible as follows:

DTP01 = 348–Benefit Begin

DTP02 = D8–Date Expressed in Format CCYYMMDD

DTP03 = the date applicable to the time period as specified in EB06

Do not return the DTP segment when the date is the same as the Health Plan Coverage Dates for the Individual.

Alternatively, a CORE-certified health plan (or information source) may return a range of dates specifying the begin and end dates for the base Benefit-specific deductible only in Loops 2110C/2110D where EB01= active coverage code 1 through 5 and EB03≠30–Health Plan Benefit Coverage and EB01=C−Deductible as follows:

DTP01 = 292–Benefit

DTP02 = RD8–Date Expressed in Format CCYYMMDD-CCYYMMDD

DTP03 = the range of dates applicable to the time period as specified in EB06

Do not return the DTP segment when the date range is the same as the Health Plan Coverage Dates for the Individual.

4.2 Basic Requirements for Submitters (Providers, Provider Vendors and Information Receivers)

The receiver of a v5010 271 (defined in the context of this CORE rule as the system originating the v5010 270) is required to detect and extract all data elements to which this rule applies as returned by the health plan (or information source) in the v5010 271.

The receiver must display or otherwise make the data appropriately available to the end user without altering the semantic meaning of the v5010 271 data content.

5 CONFORMANCE REQUIREMENTS

Conformance with this rule is considered achieved when all of the required detailed step-by-step test scripts specified in the Phase II CORE Certification Test Suite are successfully passed.

For Phase II Data Content, the certification testing approach will be similar to the Phase I testing approach. In Phase I, entities were not tested for their compliance with all sections of the Data Content rule, rather just certain sections as testing is not exhaustive and is paired with the CORE Enforcement policy. CORE certification requires entities to be compliant with all aspects of the rule when working with all trading partners, unless the CORE-certified entity has an exemption. Refer to the CORE Certification Test Suite for details.

6 APPENDIX

The purpose of the Appendix is to provide additional background on the Phase II CORE Data Content rule. It is non-normative information and in a case of conflict, the actual rule language applies.

6.1 Appendix 1: Phase II CORE Service Type Codes

Appendix 1 shows the full list of Service Type Codes required in Phase II CORE. It includes the generic code 30 (Health Benefit Plan Coverage) and the twelve specific codes required in the Phase I CORE 154 Eligibility & Benefits (270/271) Data Content Rule. Phase II adds 39 additional Service Type Codes required to be supported for explicit inquiries. The Phase I Service Type Codes appear as green-shaded boxes. In Phase II these twelve Service Type Codes continue to be required for a v5010 271 response to a generic v5010 270 (Code 30 request).

Phase II continues the discretionary reporting of patient financial responsibility for five of the Phase I Service Type Codes and adds four of the 39 new Phase II Service Type Codes to the list of service types for which patient financial responsibility reporting is discretionary.

The right-hand column describes the required and discretionary status for returning patient financial responsibility information (static co-pay and co-insurance information and remaining deductible amount) for each of the 52 Service Type Codes in Phase II, including Service Type Code 30 – Health Benefit Plan Coverage.

Phase II CORE 260: Eligibility & Benefits Data Content (270/271) Rule
version 2.1.0 March 2011

Expanded Subset of Service Type Codes for Phase II (X12 270/271 Code and Definition)	Service Type Codes Required for a Generic Inquiry	Service Type Codes Required for an Explicit Inquiry	Return patient financial responsibility information (static co-pay and co-insurance information and remaining deductible amount)?
1 Medical Care	Y	Y (Phase I)	**Discretionary**
2 Surgical		Y	Mandatory
4 Diagnostic X-Ray		Y	Mandatory
5 Diagnostic Lab		Y	Mandatory
6 Radiation Therapy		Y	Mandatory
7 Anesthesia		Y	Mandatory
8 Surgical Assistance		Y	Mandatory
12 Durable Medical Equipment Purchase		Y	Mandatory
13 Ambulatory Service Center Facility		Y	Mandatory
18 Durable Medical Equipment Rental		Y	Mandatory
20 Second Surgical Opinion		Y	Mandatory
30 Health Benefit Plan Coverage	Y		Mandatory
33 Chiropractic	Y	Y (Phase I)	Mandatory
35 Dental Care	Y	Y (Phase I)	**Discretionary**
40 Oral Surgery		Y	Mandatory
42 Home Health Care		Y	Mandatory
45 Hospice		Y	Mandatory
47 Hospital	Y	Y (Phase I)	Mandatory
48 Hospital - Inpatient	Y	Y (Phase I)	Mandatory
50 Hospital - Outpatient	Y	Y (Phase I)	Mandatory
51 Hospital - Emergency Accident		Y	Mandatory
52 Hospital - Emergency Medical		Y	Mandatory
53 Hospital - Ambulatory Surgical		Y	Mandatory
62 MRI/CAT Scan		Y	Mandatory
65 Newborn Care		Y	Mandatory
68 Well Baby Care		Y	Mandatory
73 Diagnostic Medical		Y	Mandatory
76 Dialysis		Y	Mandatory
78 Chemotherapy		Y	Mandatory
80 Immunizations		Y	Mandatory
81 Routine Physical		Y	Mandatory
82 Family Planning		Y	Mandatory
86 Emergency Services	Y	Y (Phase I)	Mandatory
88 Pharmacy	Y	Y (Phase I)	**Discretionary**
93 Podiatry		Y	Mandatory
98 Professional (Physician) Visit - Office	Y	Y (Phase I)	Mandatory
99 Professional (Physician) Visit - Inpatient		Y	Mandatory
A0 Professional (Physician) Visit - Outpatient		Y	Mandatory
A3 Professional (Physician) Visit - Home		Y	Mandatory
A6 Psychotherapy		Y	**Discretionary**
A7 Psychiatric - Inpatient		Y	**Discretionary**
A8 Psychiatric - Outpatient		Y	**Discretionary**
AD Occupational Therapy		Y	Mandatory
AE Physical Medicine		Y	Mandatory
AF Speech Therapy		Y	Mandatory
AG Skilled Nursing Care		Y	Mandatory
AI Substance Abuse		Y	**Discretionary**
AL Vision (Optometry)	Y	Y (Phase I)	**Discretionary**
BG Cardiac Rehabilitation		Y	Mandatory
BH Pediatric		Y	Mandatory
MH Mental Health	Y	Y (Phase I)	**Discretionary**
UC Urgent Care	Y	Y (Phase I)	Mandatory

6.2 Appendix 2: Glossary of Data Content Terms

The glossary is advisory only and is available for download from the CAQH Website.