DRAFT CAQH CORE Eligibility & Benefits (270/271) Data Content Rule

Draft for CAQH CORE RWG Straw Poll

Revision History for CAQH CORE Eligibility & Benefits (270/271) Data Content Rule

Version	Revision	Description	Date
1.0.0	Major	Phase I CORE 154: Eligibility and Benefits (270/271) Data Content Rule balloted and approved via the CAQH CORE Voting Process.	July 2008
2.0.0	Major	Three Phase II CAQH CORE Eligibility & Benefits Data Content Operating Rules balloted and approved via CAQH CORE Voting Process: 1. Phase II CORE 258: Eligibility and Benefits Normalizing (270/271) Patient Last Name Rule 2. Phase II CORE 259: Eligibility and Benefits (270/271) AAA Error Code Reporting Rule 3. Phase II CORE 260: Eligibility and Benefits (270/271) Data Content Rule	2009
1.1.0; 2.1.0	Minor	Adjustments to the Phase I & II CAQH CORE Eligibility and Data Content Operating Rules to support ASC X12 HIPAA-adopted v5010.	March 2011
EB.1.0	Minor	Four CAQH CORE Eligibility & Benefits Data Content Operating Rules combined into a single CAQH CORE Eligibility & Benefits Infrastructure Rule; no substantive adjustments to rule requirements: 1. Phase I CORE 154: Eligibility and Benefits (270/271) Data Content Rule 2. Phase II CORE 258: Eligibility and Benefits Normalizing (270/271) Patient Last Name Rule 3. Phase II CORE 259: Eligibility and Benefits (270/271) AAA Error Code Reporting Rule 4. Phase II CORE 260: Eligibility and Benefits (270/271) Data Content Rule • Non-substantive adjustments to support re-organization of operating rules into rule sets organized by business transaction (e.g., eligibility, claims, etc.) rather than phase (e.g., Phase I, II, etc.) as approved by the CAQH CORE Board in 2019. • Operating rule naming, versioning and numbering methodologies updated to align with business transaction-based rule sets.	May 2020
EB.2.0	Major	Enhancements made to the Electronic Delivery of Patient Financial and Benefit Information operating rule requirements to address: • Delivery of Telemedicine Benefits • Expansion CORE-required Service Type Code • Maximum and Remaining Coverage Benefits • Procedure Codes Requests and Responses • Authorization or Certification Determination • Communication of Tiered Benefits	TBD

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Introduction

Four Phase I & II CAQH CORE Eligibility & Benefits (270/271) Data Content Operating Rules were combined in 2020 to create the CAQH CORE Eligibility & Benefits (270/271) Data Content Rule (see Revision History) as part of the CAQH CORE Eligibility & Benefit Rule Set. A single rule to support all data content operating rule requirements is consistent with all other CAQH CORE rule sets and simplifies ongoing maintenance. The rule is divided into three main sections:

1. Electronic Delivery of Patient Financial and Benefit Information
2. Normalizing Patient Last Name
3. AAA Error Code Reporting

In 2021, CAQH CORE launched a Task Group to evaluate opportunity areas for operating rule enhancement for the Electronic Delivery of Patient Financial and Benefit Information Rule. For ease of reference, updated or the addition of new rule requirements are highlighted in grey.

1. Electronic Delivery of Patient Financial and Benefit Information

1.1. 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 ASC X12 005010X279A1 Eligibility Benefit Request and Response (270/271) (hereafter v5010 270/271). This robust response includes the health plans providing financial information for base and remaining deductible, co-insurance, co-payment and benefit information pertaining to telemedicine, authorization or certification indication, and tiered benefits for those service types and procedures 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 and benefit 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 CAQH CORE Eligibility & Benefits (270/271) Data Content Rule defines 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 CAQH 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 rule requires: the delivery of base, remaining and benefit-specific deductibles; return of co-payment and co-insurance amounts; communication of telemedicine, remaining coverage, and tiered benefits; indication if authorization or certification is required; and provides a list of CORE-required service type codes and CORE-required categories of service for procedure codes.

By requiring the delivery and use of this financial and benefit information via the existing v5010 270/271 HIPAA-adopted standard, the CAQH CORE 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.

1.2. Scope

1.2.1. What the Rule Applies To

This CAQH CORE rule conforms with and builds upon the v5010 TR3 implementation guide and specifies the minimum content that an entity must include in the v5010 271.

1.2.2. When the Rule Applies

This rule applies when:

- The individual is located in the health plan and its agent eligibility system;

  And

One of the following is true:

- A health plan and its agent receives a generic v5010 270;

  Or

- A health plan and its agent receives an explicit v5010 270 for a specific service type required in §1.3.2.3 of this rule;

  Or

- A health plan and its agent receives an explicit v5010 270 for a specific procedure code specified in §1.4.2.3 of this rule.

1.2.3. What the Rule Does Not Require

This rule does not require any 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 §1.2.4)

  And

- Other loops and data elements that may be returned in the v5010 271 not addressed in this rule (see §1.2.4).

1.2.4. Applicable Loops & Data Elements

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

- Segment in the v5010 270:

Loop ID and Name
Loop ID – 2100B Information Receiver Name
Data Element Segment Position, Number & Name
NM1 Information Receiver Name
REF Information Receiver Additional Identification
PRV Information Receiver Provider Information
Loop ID and Name
Loop 2110C Subscriber Eligibility or Benefit Inquiry Information
Data Element Segment Position, Number & Name
EQ Subscriber Eligibility or Benefit Inquiry Information Segment
Loop ID and Name
Loop 2110D Dependent Eligibility or Benefit Inquiry Information
Data Element Segment Position, Number & Name

EQ Dependent Eligibility or Benefit Inquiry Information

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Loop ID and Name
Loop 2100C Subscriber Name
Data Element Segment Position, Number & Name
DTP01-374 Date/Time Qualifier
DTP02-1250 Date Time Period Format Qualifier
DTP03-1251 Date Time Period
Loop ID and Name
Loop 2110C Subscriber Eligibility or Benefit Information
Data Element Segment Position, Number & Name
EB01-1390 Eligibility or Benefit Information
EB02-1207 Coverage Level Code
EB03-1365 Service Type Code
EB05-1204 Plan Coverage Description
EB06-615 Time Period Qualifier
EB07-782 Monetary Amount
EB08-954 Percent
EB09-673 Quantity Qualifier
EB10-380 Quantity
EB11-1073 Yes/No – Authorization or Certification Indicator
EB12-1073 Yes/No – In Plan Network Indicator
EB13-C003 Composite Medical Procedure Identifier
EB13 - 1 235 Product/Service ID Qualifier
EB13 - 2 234 Product/Service ID
EB13 - 3 1339 Procedure Modifier
Data Element Segment Position, Number & Name
Msg-01 Free-Form Message Txt
Loop ID and Name
Loop 2115C Subscriber Eligibility or Benefit Additional Information
Data Element Segment Position, Number & Name
III Subscriber Eligibility or Benefit Additional Information
III01 1270 Code List Qualifier Code
III02 1271 Industry Code
Loop ID and Name
Loop 2100D Dependent Name

Data Element Segment Position, Number & Name
DTP01-374 Date/Time Qualifier
DTP02-1250 Date Time Period Format Qualifier
DTP03-1251 Date Time Period
Loop ID and Name
Loop 2110D Dependent Eligibility or Benefit Information
Data Element Segment Position, Number & Name
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
EB09-673 Quantity Qualifier
EB10-380 Quantity
EB11-1073 Yes/No – Authorization or Certification Indicator
EB12-1073 Yes/No – In-Plan Network Indicator
EB13-C003 Composite Medical Procedure Identifier
EB13 - 1 235 Product/Service ID Qualifier
EB13 - 2 234 Product/Service ID
EB13 - 3 1339 Procedure Modifier
Data Element Segment Position, Number & Name
Msg-01 Free-Form Message Txt
Loop ID and Name
Loop 2115D Subscriber Eligibility or Benefit Additional Information
Data Element Segment Position, Number & Name
III Subscriber Eligibility or Benefit Additional Information
III01 1270 Code List Qualifier Code
III02 1271 Industry Code

1.2.5. Outside the Scope of this Rule

This rule does not require entities to internally store the data elements listed in §1.2.4 or any other data elements in conformance with this rule, but rather requires that all 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 CAQH CORE rules when inserting that data into outbound transactions.

1.2.6. Assumptions

The following assumptions apply to this rule:

- This rule is a component of the larger set of CAQH CORE Eligibility & Benefits Operating Rules; as such, all the CAQH CORE Guiding Principles apply to this rule and all other rules.
- Requirements for the use of the applicable loops and data elements apply only to the v5010 270/271.
- Health plans and their agents are able to accurately maintain benefit and eligibility data received or created in a reasonable timeframe.
- 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 CAQH CORE eligibility and benefits data content requirements for health plan benefits and services and related patient financial responsibility.

1.2.7. Abbreviations and Definitions Used in this Rule

Authorization/Certification: Provider prior authorization or certification received from the health plan to enable the provider to deliver more accurate patient financial responsibility for procedures, treatment, and diagnostic testing.

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 §1.3.2.3)

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 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.

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

In/Out of Network[1]: A provider network is a list of the doctors, other health care providers, and hospitals that a plan contracts with to provide medical care to its members. These providers are called “network providers” or “in-network providers.” A provider that isn’t contracted with the plan is called an “out-of-network provider.”

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

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

[1] https://marketplace.cms.gov/outreach-and-education/what-you-should-know-provider-networks.pdf

Telemedicine: Sometimes called Telehealth — is when a provider delivers care for a patient without an in-person office visit, for example, online with internet access on a computer, tablet, or smartphone or via telephone.

Tiered Benefit: For the purposes of this rule a tiered benefit is when an insurance plan divides the in-network providers into multiple levels (tiers) where the benefit coverage may change based on the provider's contractual participation.

1.3. Service Type Codes: Electronic Delivery of Patient Financial and Benefit Information Rule Requirements

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

The receiver of a v5010 271 (defined in the context of this CAQH 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.

1.3.2. Basic Requirements for Health Plans and Information Sources

A health plan and its agent must 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.

1.3.2.1. Health Plan Name

When the individual is located in the health plan and its agent system the health plan name must be returned (if one exists within the health plan and its agent's system) in EB05-1204 Plan Coverage Description. Neither the health plan nor its agent is required to obtain such a health plan name from outside its own organization.

1.3.2.2. Eligibility Dates

The v5010 270 may request a benefit coverage date 12 months in the past or up to the end of the current month. If the inquiry is outside of this date range and the health plan (or information source) does not support eligibility inquiries outside of this date range, the v5010 271 must include the AAA segment with code "62" Date of Service Not Within Allowable Inquiry Period in the AAA03-901 Reject Reason Code data element.

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

A health plan and its agent must support an explicit v5010 270 for each of the CORE service types specified in §5.1 returning a v5010 271 as specified in §1.3.2.4 through §1.3.2.13.

1.3.2.4. Specifying Status of Health Benefits Coverage

For the discretionary Service Type Codes identified in §5.1, 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 health plan and its agent 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

1.3.2.5. Patient Financial Responsibility and Benefit Information

A health plan and its agent must return the patient financial responsibility for base and remaining deductible, co-insurance and co-payment and benefit information pertaining to telemedicine and authorization/certification indication as specified in §1.3.2.6 through §1.3.2.13. 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 and benefit information (deductible, co-payment co-insurance, telemedicine, authorization/certification) for service type codes indicated as discretionary as specified in §5.1.

This discretionary reporting of patient financial responsibility and benefit information does not preempt the health plan's (or information source's) requirement to report patient financial responsibility and benefit information for deductible, co-payment, co- insurance, telemedicine, and authorizations/certification for all other Service Type Codes as specified in §5.1.

Service Type Code 30−Health Benefit Plan Coverage is not included in this group of discretionary service types since this rule requires that a health plan and its agent must return base and remaining Health Plan Deductibles using Service Type Code 30.

CAQH 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);
- 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 §5.1 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 §1.3.2.9.

1.3.2.6. Specifying Deductible Amounts

A health plan and its agent must return the dollar amount of the base and remaining deductible for all Service Type Codes required by §1.3.2.3 and for Service Type Code 30 (See §1.3.2.3), with consideration of §1.3.2.5 for discretionary reporting exceptions.

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

1.3.2.6.1. Specifying the Health Plan Base Deductible

A health plan and its agent must return the Health Plan base deductible as defined in §1.2.7 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 §1.3.2.4 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 §5.2 recommended qualifiers.>
- EB07 = Monetary amount of Health Plan base deductible

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

1.3.2.6.2. Specifying the Health Plan Remaining Deductible

A health plan and its agent must return the Health Plan remaining deductible, 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 §1.3.2.4 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.

- 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.

1.3.2.6.3. Specifying the Benefit-specific Base Deductible

A health plan and its agent must return the Benefit-specific base deductible as defined in §1.2.7 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 §1.3.2.4 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 for §5.2 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

1.3.2.6.4. Specifying the Benefit-specific Remaining Deductible

A health plan and its agent must return the Benefit-specific remaining deductible, 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 §1.3.2.4 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 §1.3.2.5.

1.3.2.7. Specifying Co-Payment Amounts

A health plan and its agent 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 §1.3.2.5 for discretionary reporting exceptions.

1.3.2.8. Specifying Co-Insurance Amounts

A health plan and its agent 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 §1.3.2.5 for discretionary reporting exceptions.

1.3.2.9. Specifying the Health Plan Base Deductible Date

When the Health Plan Base Deductible date is not the same date as the Health Plan Coverage Date for the Individual a health plan and its agent 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 health plan and its agent 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.

1.3.2.10. 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 health plan and its agent 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 health plan and its agent 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.

1.3.2.11. Specifying Telemedicine Benefits

When a service type code is covered for telemedicine[2], a health plan and its agent must use the Centers for Medicare and Medicaid Services External Place of Service Codes for Professional Claims Code 02 (TELEHEALTH)[3], in Segment III[4] (SUBSCRIBER/DEPENDENT ELIGIBILITY OR BENEFIT ADDITIONAL INFORMATION), within Data Element III02 (INDUSTRY CODE) to indicate what service or benefit is available for telemedicine as follows.

EB Segment:

- EB01 = Eligibility or Benefit Information Code used to Identify the Eligibility or Benefit Information
- EB02 = FAM–Family or IND–Individual as appropriate
- EB03 = <Service Type Code that is available for Telemedicine>

III Segment:

- III01 = ZZ Place of Service Codes for CMS Professional Services

[2] Service type codes may have varying applicability or limitations based on a multitude of factors, such as place of service. Rule requirements specify when to send place of service codes for telemedicine specifically, when needed.

[3] For more information about Centers for Medicare and Medicaid Services Place of Service Code Set, visit https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.

[4] Reference ASC X12N v5010X279 271/2115C/2115D III Segment

- III02 = 02 Telehealth (Code indicating a code from a specific industry code list)

When telemedicine benefits differ for in- and out-of-network, two occurrences of the EB segment must be returned using EB12 with codes N and Y as follows:

- EB12 = N or Y as applicable

1.3.2.12. Specifying Maximum and Remaining Coverage Benefits

A health plan and its agent must return maximum benefit limitations and return remaining benefits for each limitation for the 10 CORE-required remaining coverage benefit service types specified in §5.1 using two EB loop occurrences.

1.3.2.12.1. Specifying Maximum Benefit

A health plan and its agent must return maximum benefit limitations in the first occurrence of the EB Loop as follows.

- EB Segment
  - EB01 = F Limitations
  - EB03 = <Applicable CORE-required STC for Remaining Benefits>
  - EB06 = <Applicable Time Period Qualifier code; see §5.2 recommended qualifiers>
  - EB07 = Monetary Amount as qualified by EB01 (when applicable)
  - EB08 = Percentage Rate as qualified by EB01 (when applicable)
  - EB09 = M2 Maximum - Use to specify the units conveyed in EB10 (when applicable)
  - EB10 = Benefit Quantity (when applicable)

1.3.2.12.2. Specifying Remaining Benefit

A health plan and its agent must return the remaining benefits in the related occurrence of the EB Loop as follows:

- EB Segment
  - EB01 = F Limitations
  - EB03 = < Applicable CORE-required STC for Remaining Benefits>
  - EB06 = 29 Remaining
  - EB07 = Monetary Amount as qualified by EB01 (when applicable)
  - EB08 = Percentage Rate as qualified by EB01 (when applicable)
  - EB09 = Quantity Qualifier (when applicable)
  - EB10 = Benefit Quantity (when applicable)

1.3.2.12.3. Remaining Benefit with Date

A health plan and its agent must return the next eligible date, when applicable, for a benefit when a service type has a date limitation using the EB and DTP Segment as follows:

- EB Segment
  - EB03 = < Applicable CORE-required STC for Remaining Benefits >
  - EB06 = <Applicable Time Period Qualifier code; see §5.2 recommended qualifiers>

- DTP Segment

- DTP01 = 348 Benefit Begin
- DTP02 = D8 Date Expressed in Format CCYYMMDD
- DTP03 = Next Eligible Date as applicable to the time period specified in EB06

1.3.2.13. Specifying Authorization/Certification

When a service type code covered by this rule is a covered benefit, a health plan and its agent must indicate if authorization or certification is required using EB11 with codes N or Y per plan provisions when authorization or certification requirements can be determined by the health plan for each service type as follows:

- EB11 = N or Y as applicable

If authorization or certification requirements cannot be determined for the inquired service type code and by using data sent in the v5010 270, a health plan and its agent must use EB11 with code U if authorization or certification requirements are not accessible as follows:

- EB11 = U

When authorization or certification requirements differ for in- and out-of-network, two occurrences of the EB segment must be returned using EB12 with codes N and Y as follows:

- EB12 = N or Y as applicable

1.4. Procedure Codes: Electronic Delivery of Patient Financial and Benefit Information Rule Requirements

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

The receiver of a v5010 271 (defined in the context of this CAQH 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 and its agent 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.

1.4.2. Basic Requirements for Health Plans and Information Sources

A health plan and its agent must 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.

1.4.2.1. Health Plan Name

When the individual is located in the health plan's and its agent's system the health plan name must be returned (if one exists within the health plan's or information source's system) in EB05-1204 Plan Coverage Description. Neither the health plan nor the information source is required to obtain such a health plan name from outside its own organization.

1.4.2.2. Eligibility Dates

The v5010 270 may request a benefit coverage date 12 months in the past or up to the end of the current month. If the inquiry is outside of this date range and the health plan (or information source) does not support eligibility inquiries outside of this date range, the v5010 271 must include the AAA segment with code "62" Date of Service Not Within Allowable Inquiry Period in the AAA03-901 Reject Reason Code data element.

1.4.2.3. Requirements for a Response to an Explicit Inquiry for a CORE Required Procedure Code

A health plan and its agent must support an explicit v5010 270 for each procedure code (CPT or HCPCS) received that can be placed by the health plan into one or more of the categories of service as specified in Table 1.4.2.3 returning a v5010 271 as specified in §1.4.2.4 through §1.4.2.10.

Table 1.4.2.3

CORE-required Categories of Service for Procedure Codes (CPT or HCPCS)
Physical Therapy
Occupational Therapy
Imaging
Surgery

When the procedure code(s) received in the v5010 270 cannot be placed by the health plan and its agent into any of the above types of service categories, as specified in Table 1.4.2.3, the health plan and its agent should attempt to evaluate and respond appropriately to the request. Note: The health plan and its agent are strongly encouraged to evaluate and respond to all received procedure code(s).

1.4.2.4. Specifying Status of Health Benefits Coverage

When a procedure code covered by this rule is a covered benefit for in-network providers only and not a covered benefit for out-of-network providers, a health plan and its agent 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

1.4.2.5. Patient Financial Responsibility

A health plan and its agent must return the patient financial responsibility for base and remaining deductible, co-insurance and co-payment as specified in §1.4.2.6 through §1.4.2.8. for each procedure code returned.

All date and date range reporting requirements for Patient Financial Responsibility are specified in §1.4.2.9.

1.4.2.6. Specifying Deductible Amounts

A health plan and its agent must return the dollar amount of the base and remaining deductible for all procedure codes required by §1.4.2.3.

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

1.4.2.6.1. Specifying the Benefit-specific Base Deductible

A health plan and its agent must return the Benefit-specific base deductible as defined in §1.2.7 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 §1.4.2.4 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
- EB06 = < Applicable Time Period Qualifier code; see §5.2 recommended qualifiers>

- EB07 = Monetary amount of Benefit-specific base deductible
- EB13 = < the Procedure Code indicating the specific benefit to which the deductible applies>

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

1.4.2.6.2. Specifying the Benefit-specific Remaining Deductible

A health plan and its agent must return the Benefit-specific remaining deductible, 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 §1.3.2.4 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
- EB06 = 29 – Remaining
- EB07 = Monetary amount of Benefit-specific remaining deductible
- EB13 = < the Procedure Code indicating the specific benefit to which the deductible applies>

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.

1.4.2.7. Specifying Co-Payment Amounts

A health plan and its agent must return the patient financial responsibility for co- payment for each Procedure Code 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

1.4.2.8. Specifying Co-Insurance Amounts

A health plan and its agent must return the patient financial responsibility for co- insurance for each Procedure Code 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

1.4.2.9. Specifying Procedure Code-specific Base Deductible Dates

When the Procedure Code-specific Base Deductible date is not the same date as the Health Plan Coverage Dates for the Individual, a health plan and its agent must return a date specifying the begin date for the base Procedure Code-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 health plan and its agent 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.

1.4.2.10. Specifying Authorization/Certification

When a Procedure Code covered by this rule is a covered benefit, a health plan and its agent must indicate if authorization or certification is required using EB11 with codes N or Y per plan provisions when authorization or certification requirements can be determined by the health plan for each service type as follows:

- EB11 = N or Y as applicable

If authorization or certification requirements cannot be determined for the inquired procedure code and by using data sent in the v5010 270, a health plan and its agent must use EB11 with code U if authorization or certification requirements are not accessible as follows:

- EB11 = U

When authorization or certification requirements differ for in- and out-of-network, two occurrences of the EB segment must be returned using EB12 with codes N and Y as follows:

- EB12 = N or Y as applicable.

1.5. Tiered Benefits

1.5.1. Member Tiered Benefit Coverage

When the v5010 270 includes a CORE-required service type or procedure code, as specified in §1.3.2 and §1.4.2, and it is determined to be a tiered benefit for the *patient identified*, the v5010 271 must include the following data in EB Loops 2110C/2110D for each applicable tiered benefit. Each EB loop must also include a MSG segment identifying the benefit tier and the MSG segment content must begin with “MSG*BenefitTier…”.

- Coverage Status of Benefit
- Benefit-Specific Base Deductible
- Benefit-Specific Remaining Deductible
- Co-Pay Amount

- Co-Insurance Amount
- Coverage Level
- Benefit-specific Base Deductible Dates
- Remaining Benefit Coverage
- Authorization or Certification Indication
- In/Out of Network Indication

When a specific tiered benefit cannot be determined, all tiers must be returned along with the MSG segment with appropriate wording indicating how the provider can determine which tier is applicable to them.

1.5.2. Provider Tiered Benefit Reimbursement

When the health plan and its agent can appropriately identify the provider specified in Loop 2100B NM1/REF/PRV segments the v5010 271 must return the following:

- The tiered network status of in-network, out-of-network, or exclusive/preferred for the inquiring provider.

AND

- Benefit information only for the patient tier that applies to the inquiring provider if determination can be made.

When a patient benefit tier cannot be determined for the provider specified in Loop 2100B, information for all benefit tiers applicable to the patient must be returned in EB Loops 2110C/2110D along with the MSG segment with appropriate wording indicating how the provider can determine which tier is applicable to them.

2. Normalizing Patient Last Name [*Note: This section is out-of-scope and text has been removed to ease CAQH CORE Review Work Group review]*

3. AAA Error Code Reporting [*Note: This section is out-of-scope and text has been removed to ease CAQH CORE Review Work Group review]*

4. Conformance Requirements

Conformance with this CAQH CORE Operating Rule can be voluntarily demonstrated and certified through successful completion of the Eligibility & Benefits CAQH Certification Test Suite with a third party CAQH CORE-authorized Testing Vendor, followed by the entity's successful application for a CORE Certification Seal. A CORE Certification Seal demonstrates that an entity has successfully tested for conformity with all of the CAQH CORE Eligibility & Benefits Operating Rules, and the entity or its product has fulfilled all relevant conformance requirements.

5. Appendix

The purpose of the Appendix is to provide additional background on the CAQH CORE Eligibility & Benefits (270/271) Data Content Rule. It is non-normative information and in a case of conflict, the actual rule language applies.

5.1. Eligibility & Benefits CORE Service Type Codes

The table below shows the full list of Service Type Codes required in the CAQH CORE Eligibility & Benefits (270/271) Data Content Rule.

The right-hand column describes the required and discretionary status for returning patient financial responsibility and benefit information (static co-pay, co-insurance information, remaining deductible, telemedicine benefits, and authorization/certification indication) for each of the CORE-required Service Type Codes.

Expanded Subset of Service Type Codes (v5010 X12 270/271 Code)	Expanded Subset of Service Type Code Definitions (v5010 X12 270/271 Definition)	Service Type Codes Required for a Generic Inquiry	Service Type Codes Required for an Explicit Inquiry	Service Type Codes Required for Remaining Coverage Benefits	Return Patient Financial Responsibility information and Benefit Information
1	Medical Care	Y	Y		Discretionary
2	Surgical		Y		Mandatory
3	Consultation		Y		Discretionary
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
9	Other Medical		Y		Discretionary
10	Blood Charges		Y		Mandatory
11	Used Durable Medical Equipment		Y		Mandatory
12	Durable Medical Equipment Purchase		Y		Mandatory
13	Ambulatory Service Center Facility		Y		Mandatory

Expanded Subset of Service Type Codes (v5010 X12 270/271 Code)	Expanded Subset of Service Type Code Definitions (v5010 X12 270/271 Definition)	Service Type Codes Required for a Generic Inquiry	Service Type Codes Required for an Explicit Inquiry	Service Type Codes Required for Remaining Coverage Benefits	Return Patient Financial Responsibility information and Benefit Information
14	Renal Supplies in the Home		Y		Mandatory
15	Alternate Method Dialysis		Y		Mandatory
16	Chronic Renal Disease CRD Equipment		Y		Mandatory
17	Pre Admission Testing		Y		Mandatory
18	Durable Medical Equipment Rental		Y		Mandatory
19	Pneumonia Vaccine		Y		Discretionary
20	Second Surgical Opinion		Y		Mandatory
23	Diagnostic Dental		Y		Mandatory
24	Periodontics		Y		Mandatory
25	Restorative		Y		Mandatory
26	Endodontics		Y		Mandatory
27	Maxillofacial Prosthetics		Y		Discretionary
28	Adjunctive Dental Services		Y		Discretionary
30	Health Benefit Plan Coverage	Y			Mandatory
32	Plan Waiting Period		Y		Discretionary
33	Chiropractic	Y	Y	Y	Mandatory
34	Chiropractic Office Visits		Y	Y	Discretionary
35	Dental Care	Y	Y		Discretionary
36	Dental Crowns		Y		Discretionary
37	Dental Accident		Y		Mandatory
38	Orthodontics		Y		Mandatory
39	Prosthodontics		Y		Mandatory

Expanded Subset of Service Type Codes (v5010 X12 270/271 Code)	Expanded Subset of Service Type Code Definitions (v5010 X12 270/271 Definition)	Service Type Codes Required for a Generic Inquiry	Service Type Codes Required for an Explicit Inquiry	Service Type Codes Required for Remaining Coverage Benefits	Return Patient Financial Responsibility information and Benefit Information
40	Oral Surgery		Y		Mandatory
41	Routine Preventive Dental		Y		Mandatory
42	Home Health Care		Y		Mandatory
43	Home Health Prescriptions		Y		Discretionary
44	Home Health Visits		Y		Mandatory
45	Hospice		Y		Mandatory
46	Respite Care		Y		Discretionary
47	Hospital	Y	Y		Mandatory
48	Hospital - Inpatient	Y	Y		Mandatory
49	Hospital Room and Board		Y		Mandatory
50	Hospital - Outpatient	Y	Y		Mandatory
51	Hospital - Emergency Accident		Y		Mandatory
52	Hospital - Emergency Medical		Y		Mandatory
53	Hospital - Ambulatory Surgical		Y		Mandatory
54	Long Term Care		Y		Discretionary
55	Major Medical		Y		Discretionary
56	Medically Related Transportation		Y		Mandatory
57	Air Transportation		Y		Mandatory
58	Cabulance		Y		Mandatory
59	Licensed Ambulance		Y		Mandatory
60	General Benefits		Y		Mandatory
61	In vitro Fertilization		Y		Mandatory

Expanded Subset of Service Type Codes (v5010 X12 270/271 Code)	Expanded Subset of Service Type Code Definitions (v5010 X12 270/271 Definition)	Service Type Codes Required for a Generic Inquiry	Service Type Codes Required for an Explicit Inquiry	Service Type Codes Required for Remaining Coverage Benefits	Return Patient Financial Responsibility information and Benefit Information
62	MRI/CAT Scan		Y		Mandatory
63	Donor Procedures		Y		Mandatory
64	Acupuncture		Y		Discretionary
65	Newborn Care		Y		Mandatory
66	Pathology		Y		Mandatory
67	Smoking Cessation		Y		Discretionary
68	Well Baby Care		Y		Mandatory
69	Maternity		Y		Mandatory
70	Transplants		Y		Mandatory
71	Audiology Exam		Y		Mandatory
72	Inhalation Therapy		Y		Mandatory
73	Diagnostic Medical		Y		Mandatory
74	Private Duty Nursing		Y		Discretionary
75	Prosthetic Device		Y		Mandatory
76	Dialysis		Y		Mandatory
77	Otological Exam		Y		Mandatory
78	Chemotherapy		Y		Mandatory
79	Allergy Testing		Y		Mandatory
80	Immunizations		Y		Mandatory
81	Routine Physical		Y		Mandatory
82	Family Planning		Y		Mandatory
83	Infertility		Y		Mandatory

Expanded Subset of Service Type Codes (v5010 X12 270/271 Code)	Expanded Subset of Service Type Code Definitions (v5010 X12 270/271 Definition)	Service Type Codes Required for a Generic Inquiry	Service Type Codes Required for an Explicit Inquiry	Service Type Codes Required for Remaining Coverage Benefits	Return Patient Financial Responsibility information and Benefit Information
84	Abortion		Y		Discretionary
86	Emergency Services	Y	Y		Mandatory
87	Cancer		Y		Mandatory
88	Pharmacy	Y	Y		Discretionary
89	Free Standing Prescription Drug		Y		Discretionary
90	Mail Order Prescription Drug		Y		Discretionary
91	Brand Name Prescription Drug		Y		Discretionary
92	Generic Prescription Drug		Y		Discretionary
93	Podiatry		Y		Mandatory
94	Podiatry Office Visits		Y		Discretionary
95	Podiatry Nursing Home Visits		Y		Mandatory
96	Professional Physician		Y		Mandatory
97	Anesthesiologist		Y		Mandatory
98	Professional (Physician) Visit - Office	Y	Y		Mandatory
99	Professional (Physician) Visit - Inpatient		Y		Mandatory
A0	Professional (Physician) Visit - Outpatient		Y		Mandatory
A1	Professional Physician Visit Nursing Home		Y		Mandatory
A2	Professional Physician Visit Skilled Nursing Facility		Y	Y	Mandatory
A3	Professional (Physician) Visit - Home		Y		Mandatory
A4	Psychiatric		Y		Discretionary
A5	Psychiatric Room and Board		Y		Discretionary
A6	Psychotherapy		Y		Discretionary

Expanded Subset of Service Type Codes (v5010 X12 270/271 Code)	Expanded Subset of Service Type Code Definitions (v5010 X12 270/271 Definition)	Service Type Codes Required for a Generic Inquiry	Service Type Codes Required for an Explicit Inquiry	Service Type Codes Required for Remaining Coverage Benefits	Return Patient Financial Responsibility information and Benefit Information
A7	Psychiatric - Inpatient		Y		Discretionary
A8	Psychiatric - Outpatient		Y		Discretionary
A9	Rehabilitation		Y		Discretionary
AA	Rehabilitation Room and Board		Y		Discretionary
AB	Rehabilitation Inpatient		Y		Discretionary
AC	Rehabilitation Outpatient		Y		Discretionary
AD	Occupational Therapy		Y	Y	Mandatory
AE	Physical Medicine		Y	Y	Mandatory
AF	Speech Therapy		Y	Y	Mandatory
AG	Skilled Nursing Care		Y		Mandatory
AH	Skilled Nursing Care Room and Board		Y	Y	Mandatory
AI	Substance Abuse		Y		Discretionary
AJ	Alcoholism		Y		Discretionary
AK	Drug Addiction		Y		Discretionary
AL	Vision (Optometry)	Y	Y	Y	Discretionary
AM	Frames		Y		Mandatory
AN	Routine Exam		Y		Mandatory
AO	Lenses		Y		Discretionary
AQ	Nonmedically Necessary Physical		Y		Discretionary
AR	Experimental Drug Therapy		Y		Discretionary
B1	Burn Care		Y		Discretionary
B2	Brand Name Prescription Drug Formulary		Y		Discretionary

Expanded Subset of Service Type Codes (v5010 X12 270/271 Code)	Expanded Subset of Service Type Code Definitions (v5010 X12 270/271 Definition)	Service Type Codes Required for a Generic Inquiry	Service Type Codes Required for an Explicit Inquiry	Service Type Codes Required for Remaining Coverage Benefits	Return Patient Financial Responsibility information and Benefit Information
B3	Brand Name Prescription Drug Non Formulary		Y		Discretionary
BB	Partial Hospitalization Psychiatric		Y		Discretionary
BC	Day Care Psychiatric		Y		Discretionary
BD	Cognitive Therapy		Y		Discretionary
BE	Massage Therapy		Y		Discretionary
BF	Pulmonary Rehabilitation		Y		Discretionary
BG	Cardiac Rehabilitation		Y	Y	Mandatory
BH	Pediatric		Y		Mandatory
BI	Nursery		Y		Discretionary
BK	Orthopedic		Y		Mandatory
BL	Cardiac		Y		Mandatory
BN	Gastrointestinal		Y		Mandatory
BR	Eye		Y		Mandatory
BS	Invasive Procedures		Y		Mandatory
BT	Gynecological		Y		Mandatory
BU	Obstetrical		Y		Mandatory
BV	Obstetrical Gynecological		Y		Mandatory
BW	Mail Order Prescription Drug Brand Name		Y		Discretionary
BX	Mail Order Prescription Drug Generic		Y		Discretionary
BY	Physician Visit Office Sick		Y		Mandatory
BZ	Physician Visit Office Well		Y		Mandatory
C1	Coronary Care		Y		Mandatory

Expanded Subset of Service Type Codes (v5010 X12 270/271 Code)	Expanded Subset of Service Type Code Definitions (v5010 X12 270/271 Definition)	Service Type Codes Required for a Generic Inquiry	Service Type Codes Required for an Explicit Inquiry	Service Type Codes Required for Remaining Coverage Benefits	Return Patient Financial Responsibility information and Benefit Information
CA	Private Duty Nursing Inpatient		Y		Discretionary
CB	Private Duty Nursing Home		Y		Mandatory
CC	Surgical Benefits Professional Physician		Y		Mandatory
CD	Surgical Benefits Facility		Y		Mandatory
CE	Mental Health Provider Inpatient		Y		Discretionary
CF	Mental Health Provider Outpatient		Y		Discretionary
CG	Mental Health Facility Inpatient		Y		Discretionary
CH	Mental Health Facility Outpatient		Y		Discretionary
CI	Substance Abuse Facility Inpatient		Y		Discretionary
CJ	Substance Abuse Facility Outpatient		Y		Discretionary
CK	Screening X ray		Y		Discretionary
CL	Screening laboratory		Y		Mandatory
CM	Mammogram High Risk Patient		Y		Mandatory
CN	Mammogram Low Risk Patient		Y		Mandatory
CO	Flu Vaccination		Y		Discretionary
CP	Eyewear and Eyewear Accessories		Y		Discretionary
CQ	Case Management		Y		Discretionary
DG	Dermatology		Y		Mandatory
DM	Durable Medical Equipment		Y		Discretionary
DS	Diabetic Supplies		Y		Mandatory
GF	Generic Prescription Drug Formulary		Y		Discretionary
GN	Generic Prescription Drug Non Formulary		Y		Discretionary

Expanded Subset of Service Type Codes (v5010 X12 270/271 Code)	Expanded Subset of Service Type Code Definitions (v5010 X12 270/271 Definition)	Service Type Codes Required for a Generic Inquiry	Service Type Codes Required for an Explicit Inquiry	Service Type Codes Required for Remaining Coverage Benefits	Return Patient Financial Responsibility information and Benefit Information
GY	Allergy		Y		Mandatory
IC	Intensive Care		Y		Discretionary
MH	Mental Health	Y	Y		Discretionary
NI	Neonatal Intensive Care		Y		Discretionary
ON	Oncology		Y		Mandatory
PT	Physical Therapy		Y	Y	Discretionary
PU	Pulmonary		Y		Mandatory
RN	Renal		Y		Mandatory
RT	Residential Psychiatric Treatment		Y		Discretionary
TC	Transitional Care		Y		Discretionary
TN	Transitional Nursery Care		Y		Mandatory
UC	Urgent Care	Y	Y		Mandatory

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5.2. CORE Recommended Time Period Qualifier Codes

CORE Recommended Time Period Qualifier Codes (v5010 X12 270/271)	CORE Recommended Time Period Qualifier Code Definitions (v5010 X12 270/271)	CORE Supplemental Description[5]
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.

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