DRAFT CORE Eligibility & Benefits (270/271)

Data Content Rule Appendix

Version EB.2.1

November 2024

Revision History for 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 CORE Voting Process.	July 2008
2.0.0	Major	Three Phase II CORE Eligibility & Benefits Data Content Operating Rules balloted and approved via 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 CORE Eligibility and Data Content Operating Rules to support ASC X12 HIPAA-adopted v5010.	March 2011
EB.1.0	Minor	Four CORE Eligibility & Benefits Data Content Operating Rules combined into a single 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 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 Codes • Maximum and Remaining Coverage Benefits • Procedure Codes Requests and Responses • Authorization or Certification Determination • Communication of Tiered Benefits	April 2022
EB.2.1	Major	Expansion of: • CORE-required Service Type Codes • CORE-required Categories of Service	November 2024

		• Procedure Code Requests and Responses Additional requirements for: • Specifying Dental Benefit Limitations • Electronic Policy Access of Required Information Re-organization of Rule Contents: • Separation of Appendix into a companion document	

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1 Appendix

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

1.1. Abbreviations and Definitions Used in the Rule and Appendix

Authorization/Certification: Provider prior authorization or certification received from the health plan to enable the provider to be aware when they need to obtain payer approval prior to performing a service, procedure, or testing on the patient to deliver more accurate patient financial responsibility.

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 of the CORE Eligibility & Benefits Data Content Rule)

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 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."

Patient Financial Responsibility and Benefit Information: Includes static co-pay, co-insurance information, remaining deductible, telemedicine benefits, and authorization/certification indication, etc. as outlined in §1.3.2.5 of the CORE Eligibility & Benefits Data Content Rule.

Remaining Coverage Benefits: Information corresponding to benefit limitations as outlined in the CORE Eligibility & Benefits Data Content Rule. Maximum and remaining benefits, when applicable, may include time period, monetary, and benefit quantity limitations, depending on the scenario.

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. Examples referenced in this rule can include CPT, HCPCS, CDT, ICD-10-PCS, or NDC.

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

Telemedicine/Telehealth: 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.

1.2. Eligibility & Benefits CORE Service Type Codes

The table below shows the full list of Service Type Codes required in the 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.

Table 1 – Eligibility & Benefits CORE 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	Y	Mandatory
5	Diagnostic Lab		Y		Mandatory
6	Radiation Therapy		Y		Mandatory
7	Anesthesia		Y	Y	Mandatory
8	Surgical Assistance		Y	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

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
13	Ambulatory Service Center Facility		Y		Mandatory
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	Y	Mandatory
24	Periodontics		Y	Y	Mandatory
25	Restorative		Y	Y	Mandatory
26	Endodontics		Y	Y	Mandatory
27	Maxillofacial Prosthetics		Y	Y	Discretionary
28	Adjunctive Dental Services		Y	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	Y	Discretionary
36	Dental Crowns		Y	Y	Discretionary
37	Dental Accident		Y	Y	Mandatory
38	Orthodontics		Y	Y	Mandatory

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39	Prosthodontics		Y	Y	Mandatory
40	Oral Surgery		Y	Y	Mandatory
41	Routine Preventive Dental		Y	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	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

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61	In vitro Fertilization		Y		Mandatory
62	MRI/CAT Scan		Y	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

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83	Infertility		Y		Mandatory
84	Abortion		Y		Discretionary
86	Emergency Services	Y	Y	Y	Mandatory
87	Cancer		Y		Mandatory
88	Pharmacy	Y	Y	Y	Discretionary
89	Free Standing Prescription Drug		Y	Y	Discretionary
90	Mail Order Prescription Drug		Y		Discretionary
91	Brand Name Prescription Drug		Y	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

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A6	Psychotherapy		Y		Discretionary
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	Y	Discretionary
B1	Burn Care		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
B2	Brand Name Prescription Drug Formulary		Y		Discretionary
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

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
C1	Coronary Care		Y		Mandatory
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

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
GN	Generic Prescription Drug Non-Formulary		Y		Discretionary
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

1.3. CORE Recommended Time Period Qualifier Codes

Table 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[2]
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.

1.4. CORE Recommended Quantity Qualifier Codes

Table 3 – CORE Recommended Quantity Qualifier Codes

CORE Recommended Quantity Qualifier Codes (v5010 X12 270/271)	CORE Recommended Quantity Qualifier Code Definitions (v5010 X12 270/271)	CORE Supplemental Description[3]
DY	Days	The number of days corresponding to a benefit's time-based limitations.
MN	Month	The number of months corresponding to a benefit's time-based limitations.
S7	Age, High Value	The maximum age corresponding to a benefit's age-based limitations.
S8	Age, Low Value	The minimum age corresponding to a benefit's age-based limitations.
YY	Years	The number of years corresponding to a benefit's time-based limitations.

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

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